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Health Consequences of Interpersonal Violence and Organization of Primary Health Care Services for Survivors in the Region of Peel

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This report builds upon the ongoing work by the Peel Institute on Violence Prevention to improve services for those who have experienced violence in the Region of Peel. This literature review was undertaken in an effort to support our ongoing work in testing our hypothesis that the current organization and delivery of primary health care services in Ontario do not adequately meet the needs of survivors of interpersonal violence. This hypothesis is currently driven by the following two assumptions, which are currently supported by existing anecdotal evidence: (a) primary health care services are not effectively coordinated with social services to ensure a seamless flow of information and resources and this lack of service coordination diminishes not only service-providers response to and treatment of survivors, but it also negatively impacts survivors long-term health; and (b) while the Government of Ontario is working towards improving social services for survivors of interpersonal violence, by not exploring and making the connection between violence and chronic illness the government is hindering their goal of reducing the rates of chronic illness within the province. This literature review is meant to compliment three pieces of work by the Peel Institute on Violence Prevention. The first of which is a retrospective, pilot fact-finding study, the second is a catalogue of population-level domestic violence statistics, and the third is a preliminary literature review of how increased collaboration and coordination throughout the social services sector can strengthen the overall response to violence and reduce its prevalence in society.

This literature review is divided into two sections:

(1) a snapshot of the health care system and chronic illness prevention initiatives/priorities led by the Ontario government where we examined what health care looks like both in the Region of Peel and Ontario on the whole, looked at chronic illness rates in Ontario and how the government more broadly and MOHLTC are currently addressing the issue. Then we looked at the major chronic illnesses (cardiovascular disease, cancer, chronic respiratory illness, and diabetes) in-depth, and showed studies that demonstrated the association between the experience of interpersonal violence and elevated risk of chronic illness.

and

(2) an equity-lens based examination of provincial primary health care service delivery and organization and exploration of other successful integrated organizational models were we, focus on questions such as whether the organization of provincial primary health care services and service delivery are "equitable" based on the definitions of primary care equity by Barbara Starfield. After reviewing Ontario's health care through analysing accessibility, coordination, continuity of care, and longitudinal analysis, we asked if primary health care services are effectively coordinated with social services to make them more accessible and of better quality to survivors of violence and vulnerable populations.

Following this we offer two examples of equitable organizational models that have been successful in integrating the two sectors (primary health care and social services) that can perhaps be used in Ontario to better improve both services and outcomes not just for survivors of interpersonal violence, but for all Ontarians facing chronic illness. Given the numerous amount of studies and literature available in regards to the connection between the experience of interpersonal violence and chronic illness [[Chartier, Walker, & Naimark, 2010](#)] ([Tosevski, & Milovancevic, 2006](#)) ([Hager & Runtz, 2012](#)) ([Midei, Matthews, & Bromberger, 2010](#)) to name a few] and the pitfalls of the lack of integration and coordination between Ontario's health care and social services [[Hutchison, Levesque, Strumpf, & Coyle, 2011](#)] ([Pauly, MacKinnon, & Varcoe, 2009](#)) ([Asanin & Wilson, 2008](#)) ([Asada & Kephart, 2007](#)) to name a few], policy makers at all levels of government, as well as from the health and social sectors need to re-examine not only how chronic illness is being responded to, but the organization and delivery of health care in the Province.

The key questions behind this literature review are:

- What does primary health care look like in Ontario?
- What does primary health care look like in Peel?
- How prevalent is chronic illness in Ontario and how has/is the Government of Ontario attempted/attempting to address the issue?
- Does the experience of interpersonal violence place survivors at an increased risk of experiencing chronic illness?
- How are primary health care services and service delivery organized in Ontario? Is this organization "equitable" in the Barbara Starfield sense of the term; point of access, coordination, continuity of care, and longitudinally.
- Are primary health care services effectively coordinated with social services to make them more accessible and of better quality to survivors of violence and vulnerable populations? If not, are there past and/or current successful and equitable organizational models that have been developed that have integrated coordination that can be used instead?

Methodology

This literature scans the existing literature, including academic publications, government reports, policy papers and other grey literature to review findings in regards to chronic illness, the experience of interpersonal violence, and the health care system in Ontario. Out of 134 articles identified through a search using [Boolean] search terms, 112 were utilized for this report. The 24 articles that were not included in were deemed to be irrelevant after further review of the content. Also, articles that focused only on mental health, with no discussions of physical health

were excluded. Overall, the following inclusion and exclusion criteria were applied to the literature search:

Inclusion:

- Peer-reviewed articles and grey literature that explore the issue of services for women, men, immigrants, Aboriginals, elders, and disabled populations affected by interpersonal violence.
- Studies and reports written in English that focus on the following regions: North America, Great Britain, and Australia.
- Studies and reports published during the period of 2004-2014.

Exclusion:

- Violence related to workplace, military, street crime, and trafficking.

The literature review included the following databases. Due to the high amount of literature available, only two databases were utilized:

Databases	Search Terms Used
PUBMED http://www.pubmed.com	Health care in Ontario, primary health care in Ontario, Primary health care organization in Ontario, Chronic illness [and] World Health Organization, Ontario [and] chronic illness [or] chronic disease, Government of Canada [and] chronic illness, violence [and] chronic illness [or] chronic disease, chronic illness [and] violence [or] interpersonal violence, violence [and] chronic illness risk factors, violence [and] cardiovascular disease [or] CVD, violence [and] cancer, violence [and] respiratory illness [or] respiratory disease, violence [and] diabetes, violence [and] diabetes risk factors, violence [and] smoking [or] alcohol abuse [or] obesity [or] overeating, childhood sexual assault and adult health outcomes, sexual assault and cardiovascular disease [or] cancer [or] respiratory illness [or] diabetes, Ontario government and domestic violence, racialization and health care outcomes Ontario, immigrants and health care outcomes Ontario, Region of Peel health statistics, Primary Care Equity [and] Barbara Starfield, equity in primary care organization [and/or] delivery, Ontario health system performance, Accessible [and/or] First Contact Care in Ontario health care, Patient-Centered [and/or] Longitudinally in Ontario health care, Effective [and/or] Comprehensiveness in Ontario health care, Integrated [and/or] Coordination in Ontario health care, health care and social service coordination in Ontario, integrated health care and social services.
Google Scholar http://scholar.google.ca/	(This row shares the search terms listed in the previous row.)
U of T Summons http://library.utoronto.ca	(This row shares the search terms listed in the previous row.)

Overview of Health Care in Ontario

The Ministry of Health and Long-Term Care (MOHLTC) is responsible for the provision of health care in Ontario. The MOHLTC and the Government of Ontario proclaim that the health care system of Ontario is "one of the best in the world" ([Ministry of Health and Long-Term Care, 2013](#)) as Ontarians have access to a variety of health care services within their communities. Ontarians are covered by the Ontario Health Insurance Plan (OHIP); through taxes, the government pays all or part of the cost of a range of health care services including visits to family doctors and specialists, basic and emergency health care services, including surgery and hospital stays. However, it does not pay for services that the government deems as not medically necessary for the general public, which include prescription drugs, counselling, dental, and optometry, amongst others. In regards to primary health care, referred to by MOHLTC as family health care, the ministry promotes different practice models ranging from the traditional Comprehensive Care Model, services delivered by solo primary care physicians; to Family Health Teams, three or more physicians working together as a group; and Community Health Centres, interdisciplinary teams working in hard-to-serve areas and populations that have difficulty securing health care services. These different service models are united by an emphasis on group-based practice, interdisciplinary teams, health promotion, disease prevention, and disease management and treatment ([Health Force Ontario, 2013](#)).

In 2003, the MOHLTC began the long process of strengthening the foundation of the Provincial health care system through the goals of providing better access to care, higher quality care, and better value for money. To this end, legislation such as the Excellent Care for All Act (ECFAA) was passed to improve quality patient care. Health Quality Ontario (HQO) was established to promote evidence-based standards of care and recommend best practices. All hospitals are now required to publicly report on nine key patient safety indicators and process patient and employee satisfaction surveys and complaints. In 2012, the MOHLTC published a report on its successes, which include reduced waitlist times, primary care model and health care practitioner expansion, increased cervical, breast and colorectal cancer screening rates, 3,400 additional doctors, decreased smoking rates, and increased primary care access. Despite these changes, the MOHLTC acknowledges that Ontario's health care system still faces numerous challenges. 25% per cent of health care costs are due to preventable illnesses ([Ministry of Health and Long-Term Care, 2012](#)). The system needs to become more patient-centred and better equipped to handle the looming population age structure shift as baby boomers become senior citizens. Health providers, such as family health care, community care, hospitals and long-term care need to be better integrated to allow patients to move seamlessly across care settings ([Ministry of Health and Long-Term Care, 2012](#)). In addition, the issue of chronic illnesses ([Nelson, Cox, Hope, & Carson, 2010](#)) and the associated health care costs ([Nelson et al., 2010](#)) are two substantial

issues facing the Ontario's health care system.

Chronic illness is defined by the World Health Organization ([WHO, 2015](#)) as non-communicable diseases of long duration with generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes." ([WHO, 2015](#)). Chronic illness is an international health crisis. Across the globe, chronic diseases have surpassed infectious diseases as the number one cause of death and disability as they accounted for 63% of the 57 million global deaths in 2008 ([Ministry of Health and Long-Term Care, 2007](#)). In Ontario alone, chronic illnesses were responsible for 79% of all deaths within the Province in 2007 ([Cancer Care Ontario, 2012](#)). Statistics Canada estimates chronic illnesses account for 55% of direct and indirect health costs ([Ministry of Health and Long-Term Care, 2007](#)). Chronic illness can lead to premature death and negatively impacts one's quality of life, exacerbate inequities as they tend to disproportionately affect socioeconomically disadvantaged sub-populations and elderly individuals ([Bauer, Briss, Goodman, & Bowman, 2014](#)), and damage the economy, communities, and society on the whole ([Pearlman, Kaw, O'Connell, Jiang, & Goldman, 2014](#)).

To address this issue, the Government of Ontario has two coinciding initiatives. The first is the Chronic Disease Prevention and Management (CDPM) Framework, established by the [MOHLTC](#) in 2007 to guide the redesign of health care practices and systems with the goal of improving chronic disease prevention and management in Ontario. Based on the Chronic Care Model developed in the United States and British Columbia's Expanded Chronic Care Model, the CDPM framework aims to expand and be more proactive in prevention and health promotion in health care settings and reach out to all areas of the population.

The second is the Ontario's Action Plan for Health Care, which lists the overriding objectives of (a) Keeping Ontario Healthy; (b) Faster Access and a Stronger Link to Family Health Care, and (c) Right Care, Right Time, Right Place, as the government's strategy for improving Ontario's health care system. Keeping Ontario Healthy can be most easily applied to the prevention of chronic illnesses, as their goals of reducing smoking and childhood obesity, alongside increasing screening rates and mental health initiatives tie into the link between health behaviors, biological factors, and chronic illness. The MOHLTC is not alone in emphasizing how modifying health behaviors and biological factors have the potential to reduce chronic illnesses significantly.¹ Smoking, an unhealthy diet, physical inactivity, and alcohol are constantly touted internationally as risk factors associated with chronic illness. While promoting how health

¹ The World Health Organization (WHO), United Nations (UN), and Centers for Disease Control and Prevention (CDC) all have numerous publications available to the public in regards to the connection between modifying health behaviours and reaping positive health benefits including preventing and/or managing chronic illness.

behaviors and biological factors impact health and the benefits of making positive changes is an important step towards preventing and managing chronic illness, it is surprising that nowhere in any government action plan, framework, or ministry report does the issue of violence make an appearance.

Even at the federal level, the Government of Canada has failed to make the connection between violence and chronic illness. In the Public Health Agency of Canada's most recent action plan, [Preventing Chronic Disease Strategic Plan 2013-2016 \(2013\)](#), the focus is on tackling risk behaviours, alongside enhanced data collection and surveillance, mobilizing knowledge, and targeting specific diseases.

Studies have long shown the connection between the experience of violence and a wide range of chronic illnesses ([Chartier, Walker, & Naimark, 2010](#)) ([Tosevski & Milovancevic, 2006](#)) ([Hager & Runtz, 2012](#)) ([Midei, Matthews & Bromberger, 2010](#)) ([Goodwin & Stein, 2004](#)) ([Arnow, 2004](#)) ([Scott-Storey, 2013](#)) ([Bonomi, Cannon, Anderson, Rivara & Thompson, 2008](#)) ([Rich-Edwards et al., 2010](#)) ([Irish, Kobayashi, & Delahanty, 2009](#)) ([Lubkin, & Larsen, 2006](#)). Survivors of violence rarely reveal their history to their primary health care providers, let alone any doctor, yet they are more likely than those who have no experience of violence to suffer from multi-system medical complaints, indulge in high-risk behaviours, and acquire higher health care costs ([Myskow, 2006](#)). Whether these experiences of violence stem from childhood or are recent is immaterial; a large amount of literature on both sides indicates that regardless when violence occurred, it significantly increases the likelihood of chronic illness ([Wilson, Silberberg, Brown, & Yaggy, 2007](#)) ([Wilson, Rosenthal, & Austin, 2005](#)) ([Humphreys, & Lee, 2009](#)). For the sake of simplicity, this literature review will first explore association between violence and the four main types of chronic illness, (cardiovascular disease, cancer, chronic respiratory disease, and diabetes) ([WHO, 2015](#)), before looking at violence in relation to other chronic illnesses.

Cardiovascular Disease

Cardiovascular disease or heart disease is the number one killer in Canada. It accounts for 1 of every 3 deaths and as such is also the most costly disease in Canada, putting the greatest burden on our health care system ([Ministry of Health and Long-Term Care, 2012](#)). Furthermore, the WHO states that cardiovascular disease is the single leading cause of mortality among women worldwide. The cost to the Canadian economy is estimated to be more than \$22 billion annually in care services, medication costs, hospital visits, disability, and lost productivity ([Smith, 2009](#)). Studies have shown there is a strong association between the experience of violence and the development of cardiovascular disease. [Goodwin and Stein's \(2004\)](#) comprehensive study revealed that not only is childhood sexual abuse associated with increased risk of cardiac disease, but a host of other illnesses. According to the study, women are particularly susceptible to the elevated risk. [Mason et al.'s \(2012\)](#) study of 51,434 women found that women that had

experienced severe emotional abuse had a 24% increased rate of hypertension compared with women who had not been exposed to emotional abuse. Hypertension, or high blood pressure, puts a tremendous strain on the heart and can lead to hypertensive heart disease and coronary artery disease. Additionally, [Stene, Jacobsen, Dyb, Tverdal, & Schei \(2013\)](#), studied 5,593 women between the ages of 30-60 and discovered that women who reported physical and/or sexual violence were more likely to seek out and receive antihypertensive medication. Moreover, negative outcomes in regard to cardiovascular health are not limited to sexual abuse, as [Afifi, Mota, MacMillan, & Sareen \(2013\)](#) found that harsh physical punishment (pushing, grabbing, shoving, slapping, and hitting) was associated with higher odds of cardiovascular disease.

[Kelly A. Scott-Storey's \(2013\)](#) article contains a conceptual model derived from empirical and theoretical knowledge and shows how lifetime abuse (current and/or past) can increase the risk for cardiovascular disease among women. The experience of past or current violence, be it physical, emotional, or sexual, becomes a chronic source of stress which directly increases the risk of cardiovascular disease through physiological changes (ex: the development of depression) within the body and through subsequent coping strategies to deal with the stress. These coping strategies include smoking and overeating, known cardiovascular disease risk behaviors. Scott-Storey's conceptual model (figure 1) lays out the intertwined nature of violence, depression, risk behaviours, and cardiovascular disease. Negative coping strategies and poor health outcomes are a topic that will be addressed repeatedly throughout this literature review as it unites all of the different chronic illnesses that we have chosen to explore.

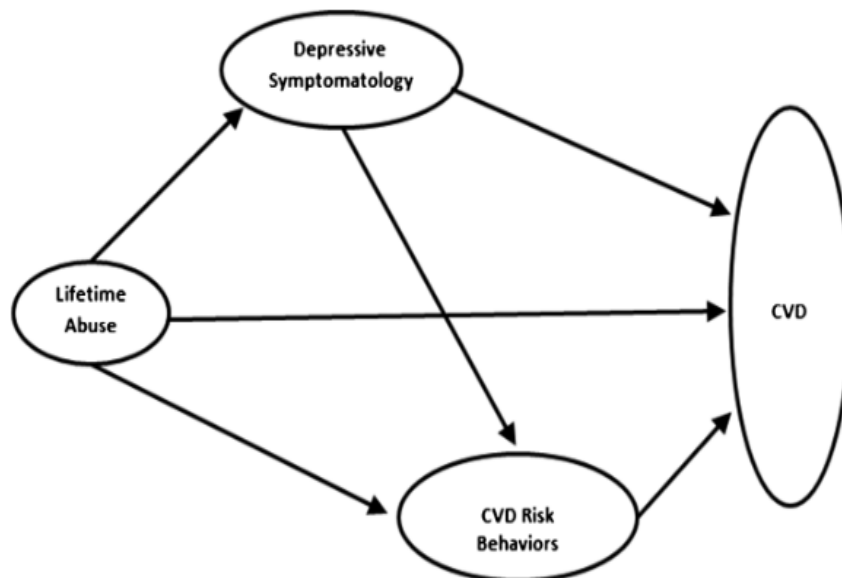


Figure 1: Conceptual model of the pathways through which violence elevates the risk for cardiovascular disease (CVD). ([Scott-Storey, 2013](#))

Cancer

Given that 2 out of 5 Canadians will develop cancer in their lifetime, and about 25% of those will die of cancer, like cardiovascular disease, cancer drains billions of dollars from the Canadian economy. Despite the positive statistics published by the MOHLTC in regards to decreasing smoking rates in Ontario, these improved numbers are for well-educated individuals from who earn a high level of income. Smoking rates for racialized communities continue to be higher than white groups. Studies show that reducing racial/ethnic disparities in smoking may require reducing differences in the psychosocial and societal factors that encourage smoking ([Ellickson, Orlando, Tucker & Klein, 2004](#)). In Ontario alone, an estimated 191,300 new cases of cancer and 76,600 deaths from cancer will occur in 2014 ([Canadian Cancer Society's Advisor Committee, 2014](#)). While prostate and breast cancer are the two most commonly diagnosed cancers for men and women respectively, lung cancer remains the most lethal of the cancers for both sexes. While unlike cardiovascular disease, there are only a few studies on the direct correlation between violence and cancer ([Coker, Hopenhayn, DeSimone, Bush, & Crofford, 2009](#)) ([Follingstad et al., 2012](#)) ([Lehavot & Simoni, 2011](#)) ([Modesitt et al., 2006](#)). [Modesitt et al. \(2006\)](#) found that out of 101 women treated for breast, cervical, endometrial, or ovarian cancer, 50% reported a history of physical or sexual violence by a partner, and 25% reported childhood sexual abuse. Moreover, women with cancer may be twice as likely to have experienced violence as women in the general population.

The association between cancer and violence has been more closely studied through the indirect connection of violence and increased likelihood for cancer-related risk behaviours. Smoking, alcohol abuse, and obesity are the three most commonly associated risk behaviours. Studies have found robust relationships between intimate partner violence and smoking, ([Crane, Pilver, & Weinberger, 2014](#)) ([Reingle, Jennings, Connell, Businelle, & Chartier, 2014](#)) ([Smith, Homish, Leonard & Cornelius, 2012](#)) ([Jun, Rich-Edwards, Boynton-Jarret, & Wilson, 2008](#)), alcohol abuse ([Heru, Stuart, Rainey, Eyre, & Recupero, 2006](#)) ([Reingle, Jennings, Connelle, Businelle, & Chartier, 2014](#)) ([Finney, 2004](#)) ([Min, Minnes, Kim, & Singer, 2013](#)), and obesity ([Midei et al., 2010](#)) ([Midei & Matthews, 2011](#)) ([Flett et al., 2012](#)) ([Noll, Zeller, Trickett, & Putnam, 2007](#)) ([Garcia et al., 2014](#)). Stress relief, be it through engaging in smoking, alcohol, or overeating, is sought out by survivors of violence, given the ongoing nature of violence and subsequent stress ([Naus, Ishler, Parrott, & Kovacs, 2009](#)). These studies conclude that individuals, men or women, who have experienced violence at some point within their lives are more likely to have risk behaviors associated with cancer.

Chronic Respiratory Diseases

The Public Health Agency of Canada defines chronic respiratory diseases as "chronic diseases of the airways and other parts of the lung. Some of the most common are asthma, chronic

obstructive pulmonary disease (COPD), lung cancer, cystic fibrosis, sleep apnea and occupational lung diseases." ([Public Health Agency of Canada, 2013](#)) Articles regarding the association between chronic respiratory disease and violence follow the pattern set out by cancer in that the focus of studies is on the effect that the experience of violence has on individuals and their increased likelihood to engage in negative, high risk behaviours. As such, the previously mentioned studies ([Crane, Pilver, & Weinberger, 2014](#)) ([Reingle et al., 2014](#)) ([Smith et al., 2012](#)) ([Jun et al., 2011](#)), regarding tobacco smoke are relevant to the connection between chronic respiratory diseases and violence. Between 2003 to 2010 smoking rates in adults aged 12 or older declined substantially. However, despite these improvements, one in five Ontarians aged 20 or older continue to engage in tobacco usage and one in ten high school students are either daily or occasional smokers.

Diabetes

The final chronic illness that this literature review will focus in-depth on is diabetes. Diabetes is a metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood ([Canadian Diabetes Association, nda](#)). Over nine million Canadians are living with diabetes or pre-diabetes. In Ontario, currently 1.46 million people suffer from diabetes. The prevalence of the disease in Ontario is increasing, as 2.2 million people in the province are expected to be living with diabetes in 2024 ([Canadian Diabetes Association, ndb](#)). As with cancer and chronic respiratory disease, the connection between the experience of violence and diabetes is largely explored in studies through risk behaviour prevalence. Aside from family history, obesity is the single most important risk factor for both type 1 and type 2 diabetes. While being overweight or obese is often seen as a consequence of poor diet and/or physical inactivity, studies on the connection between the experience of violence and obesity show how abuse can impact an individual's weight. Studies such as Noll et al. 2007 found that by young adulthood (ages 20–27), abused female subjects were significantly more likely to be obese (42.25%) than women who had not experienced violence (28.40%) ([Noll, Zeller, Trickett, & Putnam, 2007](#)). The reason for this is that unhealthy eating is also a possible consequence of the experience of abuse. Eating healthy can protect individuals against diabetes and it influences intermediate risk factors such as being overweight or obese and having high blood pressure. Unhealthy eating on the other hand including high sodium and dietary fat intake may increase risk of not only diabetes, but other major chronic illnesses. High intake of salty foods is associated with high blood pressure and an elevated increased risk of stomach cancer. Moreover, a poor diet is associated with a higher body mass index (BMI) and high blood pressure, which are associated risk factors of diabetes.

Numerous studies ([Afifi, Mota, & MacMillan, & Sareen 2013](#)) ([Duncan et al., 2010](#)) ([Midei & Matthews, 2011](#)) ([Scott-Storey, Wuest, & Ford-Gilboe, 2009](#)) ([Vives-Cases, 2010](#)) and ([Garcia et](#)

[al., 2014](#)) concluded that the experience of violence can contribute to unhealthy eating. As with engaging in tobacco usage or alcohol abuse, overeating or eating foods considered to be unhealthy serves as a coping mechanism to deal with the ongoing stress that the experience of violence can cause. Articles have found that when the incident of abuse occurred or the level of severity has little impact on diminishing the negative possible consequences in regards to violence and obesity. Experiences that happened decades prior, such as childhood sexual assault can have just as significant of an impact on a woman's BMI as the experience of current intimate partner violence. [Vives-Cases \(2010\)](#) found that children's exposure to domestic violence (correlates?) to an increased risk of unhealthy weight trajectories during adolescence in both boys and girls ([Vives-Cases, 2010](#)). Whereas [Midei and Matthews 2011](#) found that in a review of 36 studies, 81% of the studies reported a significant positive association between some type of childhood interpersonal violence and obesity.

Additional Chronic Illnesses and Health Problems

Outside of the four major chronic illnesses are further examples of how violence can negatively impact the long-term health of survivors. [Ciccone, Elliott, Chandler, Nayak, and Raphael \(2005\)](#) found that female survivors of sexual assault were 3.1 times more likely to have fibromyalgia syndrome. [Nelson, Baldwin, and Taylor's \(2012\)](#) study demonstrated that survivors of childhood sexual assault were at a higher risk of developing medically unexplained symptoms, irritable bowel syndrome, depression, and anxiety, than non-abused people. [Walsh, Jamieson, MacMillan & Boyle \(2007\)](#) was the first population-based study to back up the already substantial amount of literature ([Becker-Blease & Kendall-Tackett, 2004](#)) ([Ciccone et al., 2005](#)) ([Fillingim & Edwards, 2005](#)) ([Davis, Luecken, & Zautra, 2005](#)) on the association between a history of childhood physical abuse and chronic pain in adulthood. [Bonomi et al. \(2008\)](#) found that out of the 3500+ women who were surveyed, women who had a history of both physical and sexual child abuse had the poorest health status as they had adjusted for age and income, women with both abuse types had increased prevalence of depression, joint pain, and chronic digestive issues. The authors note however that their reliance on self-reported child abuse history may have caused ambiguity in results because of "forgotten or non-disclosed abuse or effects of current distress on recollections of abuse" ([Bonomi et al., 2008](#)). [Mayson and Teichman \(2009\)](#) reviewed the relationship between sexual abuse and interstitial cystitis, also known as painful bladder syndrome, and found that not only do survivors of violence and sexual assault have an increased risk for interstitial cystitis, but that they were also more likely to experience chronic pain, headaches, respiratory, gynecological, and gastrointestinal illnesses, neurological and physical health symptoms, and require more frequent visits to health care providers. In addition, pregnant women who experience interpersonal violence were found to be at a significantly increased risk for low birth weight infants, pre-term delivery and neonatal death as these

individuals reported high levels of anxiety and depression that often led to alcohol and drug abuse during pregnancy ([Sarkar, 2008](#)) ([Plichta, 2004](#)) ([Chambliss, 2004](#)).

Targeting Risk Behaviours through Violence Prevention

The Ontario government's action plan to preventing chronic disease states that evidence-informed interventions that focus on reducing exposure to these risk factors would reduce the burden of chronic diseases in Ontario ([Cancer Care Ontario, 2012](#)). As such, their action plan targets decreasing risk factors and behaviour engagement as a way to fight the issue of chronic illness. The 22 recommendations they list focus on either minimizing the accessibility of risk behaviours, (example: targeting smoking and alcohol abuse by increasing the tobacco tax and ensuring effective controls on alcohol availability) and increasing the accessibility of positive health behaviours, (example: requiring physical education credits and supporting healthy eating in publicly funded institutions) ([Cancer Care Ontario, 2012](#)). Out of the Ontario government's 22 recommendations none take the experience of violence or the impact of abuse on an individual's wellbeing into account. As all of the previously mentioned studies and articles discussed in this literature review have shown, this is a major oversight by the Ontario government.

While the government does have an action plan that targets violence; Changing Attitudes, Changing Lives: Ontario's Sexual Violence Action Plan focuses on strengthening the criminal justice system's and service providers' responses to sexual violence ([Ontario Women's Directorate, 2013](#)), a 2013 Annual Report of the Office of the Auditor General of Ontario determined that the Ministry of Community and Social Services (those behind the Action Plan) are not doing enough to meet the objectives they set out to do. The progress reports publicly issued to date by the Ontario Women's Directorate have been anecdotal, with no clear indication of each commitment's implementation status or of what outcomes have been achieved ([Ministry of Community and Social Services, 2013](#)). Moreover, while their plan includes providing better training for health care providers, by failing to label violence as a precursor to the risk behaviours associated with chronic illness the government is missing out on an opportunity to have additional resources, sectors, and ministries working towards reducing violence and reducing engagement in risk behaviours by association.

Overview of Health Care in the Region of Peel

Statistics Canada provides us with the most up-to-date picture of primary health care in Peel. Statistics Canada gathered their information from their Canadian Community Health Survey from 2011/2012 and Death Database and Demography Division (Canadian Vital Statistics) from 2005/2007, as well as the Canadian Institute for Health Information. Bear in mind that according to the 2011 Census, the population of Peel was 1,296,814 and has undoubtedly increased over

the past three years ([Statistics Canada, 2012](#)). The following statistics covering both men and women are according to [Statistics Canada's December 2013](#) Health Profile of the region:

Overall

- 60.2% perceive their health to be very good or excellent

Chronic Illnesses:

- 366.3 per 100,000 of the population have cancer.
- 2.1% suffer from chronic obstructive pulmonary disease, a respiratory illness
- 7.9% suffer from diabetes
- Cancer has a death rate of 133.3 (per 100,000 population), with lung cancer being the most lethal.
- Circulatory diseases have a death rate of 128.1 per 100,000 population.
- Respiratory diseases have a death rate of 36.2 per 100,000 population.

Chronic Illness Risk Behaviors

- 50.7% are overweight or obese.
- 15.5% are current smokers, daily or occasional.
- 12.5% are heavy drinkers ([Statistics Canada, 2013](#)).

While the Region of Peel's statistics are relatively comparative to the rest of Ontario in that either the region fares a bit better or bit worse, it is the doctor rate that holds the largest disparity. Although 92.9% of Peel citizens have a regular medical doctor as opposed to 91.1% of Ontarians, there are only 66 general/family physicians and 53 specialist physicians per 100,000 of the population. Ontario on the whole has 95 general/family physicians and 99 specialist physicians per 100,000 of the population ([Statistics Canada, 2013](#)). This has substantial implications in regards to how equitable primary health care is in Peel, particularly in regards to access. Although most people in Peel are registered with a family doctor, referrals to a new general or specialist physician and the availability to change doctors is a much more difficult, slow process. As such, wait times, be it in the waiting room or the time it takes to schedule and obtain an appointment are longer than elsewhere in Ontario ([Canadian Institute for Health Information, 2012](#)).

On a latter note, in 2006, the MOHLTC divided the Province into 14 regions or Local Health Integration Networks (LHINs). Peel has two LHINs, the Mississauga Halton Local Health Integration Network and the Central West Local Health Integration Network. The purpose of LHINs is to "effectively plan, coordinate, and fund local health systems making it easier for patients to access the care they need." ([Local Health Integration Networks, 2014a](#)). They are the only organizations in Ontario that bring together the sectors of hospital care, community care,

community support services, community mental health and addictions, community health centres and long-term care. As such, they serve as an excellent potential for addressing the complex, often cross-sectoral needs of survivors of interpersonal violence. Moreover, "LHINs fund the health service providers and can put local health dollars where they are most needed, based on community priorities. LHINs also work with communities to help integrate health services so care is better coordinated and more efficient." ([Local Health Integration Networks, 2014b](#)). As the remainder of this literature review will demonstrate, this is most certainly needed to address the gaps and barriers within Ontario's health care system, particularly in regards to survivors of interpersonal violence. Improving access to quality care, increased integration and coordination between the health care and social services systems, and addressing the unique needs of communities are all fundamental goals of LHINs and crucial to providing equitable health care services to all individuals.

Overview of Primary Care and Equity

Primary care, as defined by the late Dr. Barbara Starfield, "is the provision of first contact, person-focused, ongoing care over time that meets the health-related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care." ([Southey & Heydon, 2014](#)). Moreover, equity in health is "the absence of systematic and potentially remediable differences in one or more aspects of health across population groups defined geographically, demographically or socially." ([Starfield, 2009](#)). In order to obtain equity in health the following key attributes must be included in the delivery of primary care: (1) first contact care when needed; (2) person-focused care over time ("longitudinality"); (3) comprehensiveness of services; and (4) coordination of care (for times when services must be provided elsewhere). ([Starfield, 2009](#)). Achieving these features requires that people actually use the services the first time they are needed; that people are cared for over time regardless of the type of problem or need they have; that they receive all indicated services; and that their health-related needs and problems be adequately recognized over time, regardless of whether they are presented in primary care or elsewhere ([Starfield, 2009](#)). While Starfield provides the strongest definitions of primary care and equity in health, she is not alone in stressing the importance of equity in primary care organization and delivery. [Rao and Pilot \(2012\)](#), [Fleury and Grenier \(2012\)](#), [Stange and Ferrer \(2009\)](#), [Lionis, and Petelos \(2013\)](#), and [Rose et al. \(2013\)](#) all argue that an 'equity lens' is not only essential in the delivery of primary care services, but is necessary for policy makers, practitioners, and researchers to analyze and assess the equity of healthcare services provided to patients.

Health Care Organization in Ontario

We now turn our attention once again to health care in Ontario, particularly with regards to the level of equity in its organization and delivery. The system is divided into 36 areas of the

Province called health units, each with a board of health. These boards vary as 22 are autonomous county/district health units, 6 are regional or upper tier health departments (York, Durham, Peel, Halton, Niagara, Waterloo), 4 are single tier health departments (Haldimand-Norfolk, Hamilton, Ottawa, Oxford), and the remaining 4 are autonomous boards that are integrated into municipal structures (Chatham-Kent, Huron, Lambton, Toronto) ([Pasut, 2007](#)).

Ontario's health care system offers 10 different types of care centres for citizens:

1. Walk-in/After Hours Clinic - Reason to visit: Provides care in non-emergency situations.
2. Urgent Care Centre - Reason to visit: Treatment for illnesses and injuries that are urgent but not life threatening.
3. Community Health Centre - Reason to visit: Provides non-emergency health care and health promotion programs to individuals, families and those who are not covered by OHIP.
4. Family Health Team - Reason to visit: A diverse health care team that provides ongoing care to their roster of patients, promoting healthy living.
5. Public Health Unit - Reason to visit: Provides health promotion information and disease prevention programs.
6. Nurse Practitioner-Led Clinic - Reason to visit: Provides ongoing care, promotes disease prevention and healthy living.
7. Family Health Care Provider - Reason to visit: Provides ongoing health care and familiarity with patient history.
8. Emergency Room - Reason to visit: Provides care in emergency and life-threatening situations.
9. Breast Screening Centre - Reason to visit: To help enable early detection and treatment of breast cancer.
10. Diabetes Education Program - Reason to visit: Provides education to help individuals and their family members manage diabetes ([Ministry of Health and Long-Term Care, 2011](#)).

These care centres were developed through the primary care reform movement in Ontario during the 2000s, which initially concentrated on providing more health human resources to provide greater access to primary care. The number of medical school placements and family medicine training positions has increased as a result of the introduction of "new physician compensation models, non-physician delivery models including midwives, inter-professional care models such as Family Health Teams, Nurse Practitioner-Led Clinics, intra-professional care models such as Shared-Care and Collaborative Care Models between family doctors and consulting specialists, in addition to specialized or alternative models to address unique circumstances such as rural or northern primary care. In addition, an increased number of Community Health Centres have been established in hard to serve communities." ([Working on Group Primary Care Governance, 2011](#)). Although primary care reform has been a strong focus

for the Ontario government over the past decade, policy makers at the service and provincial levels agree that Ontario lacks a coordinated and sustainable approach to collect, analyze and report on the performance of the primary care system ([Health Quality Ontario, 2014](#)). This assessment was also supported by researchers [Hutchison, Levesque, Strumpf, & Coyle \(2011\)](#), [Pauly, MacKinnon, and Varcoe \(2009\)](#), [Asanin and Wilson \(2008\)](#), [Asada and Kephart \(2007\)](#), [Allin \(2008\)](#), and [Haggerty et al. \(2007\)](#).

Without this ability to adequately assess system performance, it is difficult to determine whether policy changes and investments of the reform movement are having the desired effect. In response to this need, Health Quality Ontario (HQO) and the Canadian Institute for Health Information (CIHI), in collaboration with the MOHLTC, eHealth Ontario, Cancer Care Ontario, the Local Health Integration Networks, the Institute for Clinical Evaluative Sciences, and C-CHANGE established a Steering Committee to prioritize aspects of primary care performance that would be valuable to measure on a regular basis to inform decision-making at the service and/or system (community, regional, or provincial) levels.

The Proceedings Report by this Steering Committee provides us with an equity lens-based examination of the organization and delivery of health care in Ontario. The HQO's Nine Attributes of a High Performing Healthcare System Framework was used to examine Ontario's primary care performance and they are as follows: Accessible; Patient-Centered; Integrated; Efficient; Effective; Focused on Population Health; Safe; Equitable; and Appropriately Resourced. Accessible ("People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes"), patient-centered ("Healthcare providers should offer services in a manner that is sensitive to an individual's needs and preferences"); effective ("People should receive care that works and is based on the best available scientific information"); and integrated ("All parts of the health system should be organized, connected, and work with one another to provide high quality care")([Health Quality Ontario, 2013](#)) are the four we will be focusing on as they correlate to Starfield's four key attributes of primary health care: first contact care, longitudinality (person-focused or patient-focused care), comprehensiveness of services, and coordination of care. The assessment was scored out of 50 and has been summarized into the following chart ([Health Quality Ontario, 2014](#)):

Table 1. Provincial (Ontario) Primary Care Performance Scorecard

Attributes	Measurement Priorities	Score
Accessible / First contact care	Timely access to care	44
	Access to care by telephone/email	28
	Access to after-hours care	20
	Access to an inter-professional primary care team	19
	Access to a regular primary care provider	18
	Access to home visits	15
	Use of Emergency Department services	15
Patient-centered / Longitudinality	Shared clinical decision making between patients and providers	40
	Patient experience	37
	Coordination of care	31
	Support for patient self-management	31
	Respect for patients' values and expressed needs	22
	Socio-cultural competency	22
	Symptom management	21
	Access to a regular primary care provider	18
Privacy & confidentiality	7	
Effective / Comprehensiveness	Screening and management of risk factors for CVD and other chronic conditions	44
	Management of multiple chronic conditions (multi-morbidity)	43
	Management of mental disorders	27
	Support for patient self-management	25
	Management of CVD/stroke	20
	Palliative care	20
	Management of diabetes/CKD 19	19
	Management of asthma & COPD	19
	Shared clinical decision making	18
Management of cancer	12	
Integrated / Coordination	Information sharing across the continuum of care	38
	Continuity of care and coordination with other health care providers	38
	Hospital admissions and readmissions	20
	Time to referred appointment with a specialist	17
	Use of Emergency Department services	10
	Time to referred diagnostic test (e.g., CAT scan, MRI)	8

Given that the above chart is far more red than it is green, or in other words the scores selected for the measurement priorities are largely below the midway point of 25/50, it is reasonable to suggest that primary health care in Ontario has a long way to go before meeting

the standards of equity as set out by Starfield. Out of the four key attributes, the provincial health care system fared the best in longitudinality, also known as being patient-centered.

Accessible / First Contact Care

In regards to accessibility, timely access to care and access to care by telephone and/or email received the highest marks. However, access to after-hours care, inter-professional primary care team, home visits, Emergency Department services, and most importantly a regular primary care provider all fared quite poorly ([Health Quality Ontario, 2014](#)). While Ontarians are now much more likely than other Canadians to have a regular primary care provider ([Kralj & Kantarevic, 2012](#)) nevertheless, the MOHLTC notes that there are still around 850,000 Ontarians ([Working Group on Primary Care, 2011](#)) who still do not have a regular primary care provider, and finding a family doctor who has room to accept new patients remains a challenge. In a 2014 Progress Report, the MOHLTC states that the system has been working to increase accessibility. In comparison to 2003, 2.1 million Ontarians now have access to a family doctor and that 23 new hospitals have been built over the course of the last decade or now are underway ([Government of Ontario, 2014](#)). Despite this, data from the Primary Care Access Survey shows that fewer than half of Ontarians are able to see their family doctor when they are sick or they require care. After hours primary care coverage and advanced access options are also far from reaching the level of availability which would be beneficial to the public and meet evidence-based standards of access to primary care. As such, although most Ontarians live within 1 hour travel time of their primary care providers, timely and continuous access remain key issues, with patients often turning to walk-in clinics and far more than what is considered "optimal" by MOHLTC ([Working Group on Primary Care, 2011](#)).

There is some controversy over whether immigrants have the same level of access to primary health care as Canadian-born individuals do. A 2012 cross-sectional study that collected information from patients and providers in 137 primary care practices across Ontario found that immigrants, both recent and old, reported equal access to primary care services as compared with Canadian-born citizens. ([Muggah, Dahrouge, & Hogg, 2012](#)). However, [Asanin and Wilson \(2008\)](#) found that immigrants, particularly recent immigrants, faced substantial geographic, economic, and socio-cultural barriers when attempting to access primary health care services in their community and strongly advocated for changes to be made by all levels of government to address and remove these barriers. On the whole, other studies and articles appear to back up the claims made by [Asanin and Wilson \(2008\)](#) in regards to immigrants facing significant barriers to primary health care access. ([Van Doorslaer, Masseria, & Koolman, 2006](#)) ([Lasser, Himmelstein, & Woolhandler, 2008](#)) ([Pollock, Newbold, Lafrenière, & Edge, 2011](#)). The latter article found that lack of accessibility was the number one answer given by immigrant newcomers and refugees

when asked where they had experienced interpersonal discrimination in Ontario's health care services.

Whether it is in regards to health care or social services, accessibility is crucial for survivors of interpersonal violence. With the former, according to the WHO, women who have been subjected to violence seek health care more often than non-abused women, even if they do not disclose the associated violence. Moreover, survivors also view health-care providers as the professionals they could most trust with disclosure of abuse. However, given that of those injured by a current or ex-partner "13% required medical attention and 2% were hospitalised" ([Mason, Schwartz, Burgess, & Irwin, 2010](#)) inaccessibility jeopardizes these already low numbers. By appearing inaccessible, survivors lose out on an essential resource and risk not only their immediate physical health and wellbeing, but avoiding the system can instigate health complications in the future. As such, primary care providers should work to reduce the amount of barriers survivors face when accessing the health care system. In addition, extra attention should be given to immigrant and racialized survivors as these vulnerable populations need easy access to support and resources when seeking help for violence as barriers to service access and delivery are exacerbated when survivors of violence fall outside of the white, middle-to-upper class, English-speaking, female population ([Hyman, Forte, Mont, Romans, & Cohen, 2006](#)). As such, researchers strongly recommend the development of partnerships between mainstream and ethno-specific services; "health professionals must collaborate with social workers and settlement workers to address structural barriers that limit women's access to and use of formal social support." ([Guruge & Humphreys, 2009](#)).

Patient-Centered / Longitudinality

This key attribute is where the Ontario health care system scored the highest equity rates in. There is a culture of clinical decision-making being shared between patients and doctors. Patients report generally positive experiences with the health care system and feel supported in self-management. Also, there is adequate coordination of care because information is shared with other health care providers to ensure a continuum of care. Patients report that they are satisfied with the screening and management process of risk factors for chronic illness and the management of mental disorders. ([Health Quality Ontario, 2014](#)).

Where the system appears to fail is in regards to health care providers respecting patients. The scores for giving respect to patients' values, expressed needs, and privacy from doctors, particularly from a socio-cultural perspective, were quite low. Symptom management also fared poorly. The WHO strongly advocates that health care providers need to be trained to better respond to the needs and situations of survivors of violence. If a survivor of violence feels as

though they are being disrespected or belittled by their primary care provider, the desire to continue to stay within the sectors of health care and/or social services is diminished and the likelihood of attempting to access these services again in the future is greatly reduced. Cross-sectoral training between health care and social services providers would be instrumental in the development of this [\(WHO, 2013\)](#). This would not only benefit health care providers, but professionals from social services as well because they would become more knowledgeable about resources and help make them available for survivors of violence from the health care sector. Therefore, these professionals would be able to make better referrals, thus increasing the likelihood of survivors not only staying within the systems, but receiving the care and services that they need.

Providers being socio-culturally incompetent ties into the aforementioned discrimination issue that immigrants face within the Ontario health care system. Aside from lack of accessibility language discrimination, cultural discrimination and insensitivity; discrimination based on country of origin; and religious discrimination were also listed as way immigrants experienced discrimination through the Ontario health care system. Those who felt they had experienced discrimination noted that it occurred in forms of exclusion, dismissal, or being treated rudely and they argued that the system needs to take into consideration the differential needs of immigrant newcomers and refugees [\(Pollock, Newbold, Lafrenière, & Edge, 2011\)](#) [\(Edge & Newbold, 2013\)](#) [\(Simich, 2010\)](#) [\(Rootman & Gordon-El-Bihbety, 2008\)](#). These barriers naturally extend to and hamper racialized and immigrant survivors of violence. Interpersonal violence experienced by women from immigrant and racialized populations are rendered less visible, often overlooked, and can even be excused for cultural reasons. There is a lack of appropriate services and intervention strategies as well as culturally and linguistically appropriate services for immigrant women [\(Guruge & Humphreys, 2009\)](#).

A systematic review of the Canadian literature on racialization and health inequalities found that research on racialization and health inequalities in Canada is in its infancy [\(Hyman & Wray, 2013\)](#). Hyman and Wray's review concluded that although racialization has not consistently been associated with poorer self-rated health than non-racialized groups, however the same cannot be said in regards to chronic illness. Racialized groups have higher rates of high blood pressure and diabetes [\(Hyman & Wray, 2013\)](#). As such, it is essential that racialized groups have equitable access to primary health care to begin the process of reducing these rates. Nevertheless, according to Toronto Public Health "racialized group members were more likely than non-racialized group members to report having experienced all six measures of racial discrimination." [\(Levy, Ansara & Stover, 2013\)](#). These six are being treated with less respect, poorer service, perception of others' fear, being viewed as inferior, and being threatened and/or harassed [\(Levy, Ansara, & Stover, 2013\)](#). This extends to the primary health care system as Toronto Public Health

also found that primary health care providers may have "conscious or unconscious bias against members of racialized groups. [...] Health care providers may take histories, interpret symptoms, and assess risks and benefits of treatment differently in encounters with members of racialized groups versus non-racialized groups." ([Levy, Ansara & Stover, 2013](#)). Inevitably, this can negatively affect the care provided to members of racialized groups.

The Ontario Medical Association agrees with this assessment. Ontario's current primary care system remains a predominantly physician-focused system. In order to achieve their goal of creating a patient-centered system, one where patients can move freely along a care pathway, are treated with respect and dignity, and their individual needs are considered, they have to address the following issues: (a) increased integration of care across the system, (b) moving to match the demand to capacity and doing so with minimal delay, (c) different funding models, and (d) transforming the system from one that focuses on acute care to one that includes a focus on chronic disease management. Although the WHO titles their recommendations as 'women-centered care' their suggestions can be easily expanded to include all individuals who have experienced interpersonal violence and therefore be considered as 'patient-centered care.' The WHO Guidelines state that anyone who discloses any form of interpersonal violence should be offered immediate, first-line support from health care providers. First-line support entails: (a) being non-judgemental and supportive; (b) providing practical care and support that responds to concerns, but does not intrude; (c) asking about their history of violence, listening carefully, but not pressuring; (d) helping the individual access information about resources; (e) assisting with increasing safety where needed; and (f) providing or mobilizing social support ([WHO, 2013](#)). Moving to a more patient-oriented system is essential for increasing accessibility and for providing better, stronger care for individuals who have experienced interpersonal violence.

Effective / Comprehensiveness

While there is no definition of comprehensive primary care in Canada, there is a general observation that it is a "long-term relationship between a provider and a patient in which medical services, support for self-care and care coordination are the foundation." ([Southey & Heydon, 2014](#)). The Proceedings Report scored the Ontario health care system high on screening and management of risk factors for chronic illnesses, multi-morbidity, and mental disorders, but low on the actual management of chronic illness including but not limited to cardiovascular diseases, cancer, and diabetes. The system also fared poorly in palliative care and shared clinical decision making in regards to chronic illnesses ([Health Quality Ontario, 2014](#)). The majority of the measurement priorities being negative are not surprising, as the term comprehensiveness does not appear in Ontario's Action Plan for Healthcare. Comprehensiveness of service means that all services should be provided within primary care except those services

that are done so rarely that primary care providers would not be able to maintain their skills ([Starfield, Shi, & Macinko, 2005](#)).

As such, given that there is a strong association between comprehensive primary care and system efficiency, this oversight needs to be addressed in order to make Ontario's health care not only more equitable, but a better resource for survivors of interpersonal violence. The first part of providing more comprehensive care for survivors is better training for health care providers on the whole so that these professionals can respond adequately to survivors of violence and meet their needs which are often unique from more typical patients who access primary care services. More education is especially needed for emergency medical service workers, who although they have frequent contact with survivors of interpersonal violence, possess little education about their issues and needs ([Mason et al., 2012](#)). This not only reduces the level of effectiveness of health care services for survivors, but negatively affects accessibility as well. On a positive note, the Sunnybrook-Osler Centre for Prehospital Care in Toronto, Canada has received funding from the government of Ontario to develop a curriculum on domestic violence specific to EMS practice ([Mason, Schwartz, Burgess, & Irwin, 2010](#)).

Integrated / Coordination

According to the Proceedings Report, Ontario's system does well at sharing information across the continuum of care and in continuity of care and coordination with other health care providers, which are the cornerstones of Starfield's concept of coordination in primary health care. However, the system has room to improve when it comes to hospital admissions and readmissions, the time to referred appointment with specialists, the use of Emergency Department services, and especially the time to referred diagnostic tests ([Health Quality Ontario, 2014](#)).

The Ontario Medical Association (OMA) paints a different picture of coordination and the Ontario health care system. In an October 2013 report, the OMA stressed that physicians must "collaborate with other primary care providers to establish clear primary care focussed care pathways" ([Ontario Medical Association, 2013](#)) and that "integrating the clinical and community care record can remove barriers to collaborative care and network all providers with the patient." ([Ontario Medical Association, 2013](#)). OMA believes that by overcoming these administrative and system barriers primary health care will become more integrated as patients will be able to move seamlessly between providers and care locations. This is crucial because active integration at the community level and between practice sites leads to more efficient patient care, improved capacity, and greater all-around satisfaction with services ([Increasing Efficiency in the Family Practice Setting, 2011](#)).

A seamless continuum of services is essential for meeting the needs of survivors of interpersonal violence. Without it, survivors are forced to navigate the confusing system of resources available to them alone. Given the high level of gaps, barriers, and fragmentation, survivors can become frustrated and leave the system and therefore not receive the care that they need. Cross-sectoral collaboration between health care and social services would work to reduce the confusing nature of resources available for survivors of violence. Moreover, cross-sectoral collaboration will enable primary care providers to provide first-line support as if they are unable to, they would be able to ensure that someone else within their range of resources is easily accessible and immediately available to do so.

Coordination with Social Services

Primary health care services are not effectively coordinated with social services to make them accessible and of better quality to survivors of violence and vulnerable populations. This statement is backed up by a large amount of literature ([Government of Ontario, 2011](#)) ([Kasperski, Power, & VanderBent, 2005](#)) ([Guruge & Humphreys, 2009](#)) to name a few. Given that comprehensive care for patients is based on coordinated communication and care planning, health care and social services are undoubtedly connected. "Health and social supports are crucial to enable clients to age in place, sustain family configurations, reduce client transitions resulting from caregiver fatigue and minimize transition points for clients through the health care continuum." ([Kasperski, Power & VanderBent, 2005](#)). Moreover, social services are uniquely equipped to meet needs "as an adjunct to the physician, assisting in developing comprehensive networks, care coordination for both health and social issues, and links to other providers and sectors within a family and community oriented practice model." ([Kasperski, Power & VanderBent, 2005](#)). In addition, increasing coordination between the two sectors will "contribute to overall health system cost reduction related to hospital re-admissions, emergency department presentations, frequency of physician visits, and crisis placements in long term care." ([Kasperski, Power & VanderBent, 2005](#)). As such, increased coordination and collaboration between the primary health care system and the social services sector is crucial.

To facilitate increased cross-sectoral collaboration, studies show that professionals from the two sectors must work to overcome the lack of experience and knowledge of other system. As such, this is a major incentive for service coordination, as only through collaboration via formal partnerships and cross-sectoral training, can these issues be remedied. Collaboration accelerates the development of cross-agency referral systems, makes additional professionals and resources available to survivors, routine screening procedures and policies, formal service linkage agreements, and creates an environment which allows for more effective working partnerships ([Macy & Goodbourn, 2012](#)).

Furthermore, stronger coordination is necessary to not only strengthen the response to all clients for both fields, but is absolutely fundamental in the path towards reducing the amount of gaps and barriers that survivors of interpersonal violence face when they enter both systems. This need has been recognized by government, health care, and social service policy makers. Timely access to health and social services is required to meet the needs of survivors of interpersonal violence because services that lack integration increase the level of difficult people have in accessing the right amount of support that they need ([Government of Ontario, 2011](#)). Also, the lack of coordination between health care and social services jeopardizes the safety of individuals who are currently experiencing interpersonal violence. Low integration decreases accessibility and forces survivors to have to navigate the separate system not only alone, but multiple times, which places them at an elevated risk of harm from their current partners. Furthermore, studies have found that being unable to have all of their concerns addressed in one location is particularly frustrating for survivors of violence. This is especially truly for racialized and/or immigrant survivors who may have unequal access to socio-economic resources such as little about services and locations, face language barriers, are constrained financially, or have limited access to transportation ([Guruge & Humphreys, 2009](#)).

Past Successful, Equitable Organizational Models

This literature review has chosen to look at two examples of equitable organizational models that effectively integrate health care and social services, the Chronic Care Model and the Integrated Services Delivery Model.

The Chronic Care Model (CCM)

Developed by Dr. Edward H. Wagner in 1999, CCM is widely recognized in the United States and across the world for its ability to guide health care teams in providing care for patients suffering from chronic illnesses. Studies show that redesigning care using CCM leads to stronger patient care, proactive patient behavior change, and improved health outcomes ([Coleman, Austin, Brach & Wagner, 2009](#)) ([Oprea, Braunack-Mayer, Rogers, & Stocks, 2010](#)) ([Hung et al., 2008](#)). Improved health and clinical outcomes are the result of "productive interactions between informed, activated patients and the prepared, proactive practice team of clinicians and healthcare professionals." ([Barr et al., 2004](#)). The CCM integrates community resources and policies with health system organization by developing partnerships with social services to support patients' needs comprehensively.

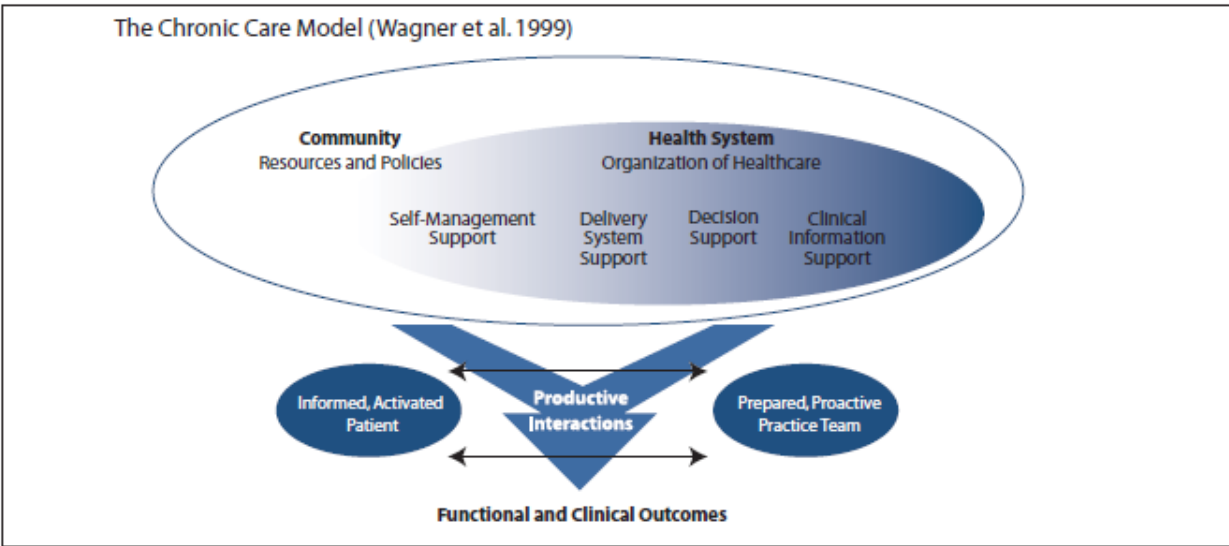


Figure 2: The Chronic Care Model. Source: [\(Barr et al., 2004\)](#)

Integrated Services Delivery Model (ISDM)

Developed by the Department of Health and Social Services and the Health and Social Services Authorities in the Northwest Territories (NWT) in 2004, the ISDM is a patient-focused approach to organizing and providing health care and social services that focuses on health promotion and disease prevention to increase the capacity of public health, rehabilitation services, and family counseling services [\(Northwest Territories Health and Social services, 2004\)](#). At the heart of ISDM is integration and collaboration as it combines three elements, (1) Uses a primary community care approach; (2) Ensures all caregivers and their organizations are connected and work together; and (3) Describes and strengthens core services (Northwest Territories Health and Social services, 2004). There are 6 core service areas: (1) Diagnostic and Curative Services; (2) Rehabilitation Services; (3) Protection Services; (4) Continuing Care Services; (5) Promotion and Prevention Services; and (6) Mental Health and Addictions Services [\(Northwest Territories Health and Social services, 2004\)](#). This integration of health care and social services into an organizational model has proven successful in the NWT [\(Health Council of Canada, 2013\)](#).



Figure 3: Integrated Services Delivery Model. Source: ([Northwest Territories Health and Social services, 2004](#)).

Conclusion

For this report, the questions of what is known about community coordination and inter-agency collaboration of services for survivors of violence, what contributes to and limits improved coordination of services, benefits to survivors, examples of successful models of service coordination and collaboration, conditions that promote and enable strong collaborative relationships, and the implications of service coordination on violence prevention were explored. As previously mentioned, this literature review was divided into two sections: (1) an overview of the health care system and chronic illness prevention in Ontario; and (2) an equity-lens based analysis of Ontario's primary health care services and delivery organization and exploration of other successful, integrated organizational models. For the first section, by exploring what health care looks like in Ontario and how the province is addressing chronic illness, we showed that the experience of interpersonal violence not only increases the likelihood of chronic illness, but that the issue of violence is total absent from MOHLTC's plans to address and reduce the prevalence of chronic illness. This is a major oversight by both health care and government policy makers alike. Studies have demonstrated that survivors of violence have an elevated risk of developing one of the four most prevalent chronic illnesses. Given that the experience of interpersonal

violence increases risk behaviors for chronic illness, if the government really wants to decrease the rates of cardiovascular disease, cancer, chronic respiratory illness, and/or diabetes, the issue of violence must be included in future government action plans to target chronic illness.

In the second section of the literature review, by assessing the organization and delivery of health care in Ontario on the grounds of whether it is: (a) equitable from a Barbara Starfield perspective and (b) effectively coordinated with social services to make them more accessible and of better quality to survivors of violence and vulnerable populations, we came to a number of conclusions. First of all, Ontario's health care is a long way to go before meeting the requirements of truly equitable primary care. Our system falls short in all four of the key attributes of equitable primary care as defined by Starfield. This has a tremendous effect on survivors of interpersonal violence, increased accessibility, patient-centered care, comprehensive care, and coordination with social services is essential to providing survivors with the level of care that they need and in meeting their needs that are unique from other patients of chronic illness. The lack of accessibility, physician-centered care, ineffective services, and the absence of a seamless continuum of services negatively impacts the short-term and long-term health of survivors of interpersonal violence as well as their overall well-being and sets up systematic difficulties for future survivors. This does not always have to be the case though as there have been past examples of coordination between health care and social services including the Chronic Care Model (CCM) and Integrated Services Delivery Model (ISDM), which have been successful in integrating care. Ultimately, this literature review hopes to not only further the efforts already in place by the Government of Ontario to better the prevention and management of chronic illnesses, but to improve services for survivors of interpersonal violence.

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