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COMMENTARY



Community health workers in Canada and the US: working from the margins to address health equity

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ABSTRACT

In this commentary, we address community health workers' (CHWs) marginalized social location within the health care systems of Canada and the US. This marginalization is due, in part, to their being a workforce shaped by socio-structural factors, such as gender discrimination, racism, and poor socio-economic conditions. This marginalization challenges their ability to address health equity. We propose system-level and workforce-level policy changes that build toward an empowerment path for CHWs to realize their full potential to address health equity. Regarding the work they do and the populations they serve, system-level changes would allow CHWs to strengthen their intimate connection with, and commitment to, advancing health and well-being in their marginalized communities. Workforce-level changes would target their peripheral status by addressing multiple structural factors and altering organizational arrangements to remove their marginalization as a workforce. Together these system-level and workforce-level changes would greatly enhance the health and social services systems.

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Introduction

A recent surge in interest has emerged in the US, Canada and other high-income countries to examine the role of community health workers (CHWs) in achieving health equity (Forrest, Neuwelt, Gotty, & Crengle, 2011; Pérez & Martinez, 2008; Torres, Labonté, Spitzer, Andrew, & Amaratunga, 2014), defined as 'the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups' (International Society for Equity in Health 2000, cited in Starfield, 2006, p. 13).

For Canada and the US, CHWs' social location – specifically, their marginalization as a health human resources workforce – affects their ability to address health equity (Balcázar et al., 2011; Rosenthal, Wiggins, Ingram, Mayfield-Johnson, & De Zapien, 2011; Torres, 2013). Based on our knowledge and involvement in the field, in this commentary, we explore CHWs' social location and the policy development implications of diminishing the related marginalization many CHWs face. As such, we deepen the scholarship on CHWs as a workforce that, while working from the margins, enhances the health and social services systems and often is an agent of change (Colvin & Swartz, 2015; Torres, 2013).

Community health workers' social location in Canada and the US: challenges in addressing health equity

CHWs link either the highly regulated and market-driven health and human service system (in the US) or the universal health care system and other social services (in Canada) to their own communities (e.g. immigrants and refugees, people living with disabilities, people with low socioeconomic status, Aboriginals). In both countries, CHWs' social location places them on the margins (or at the periphery) of the health system and the health human resources workforce. Regarding the work they do and the populations they serve, this social location at the margins is an asset because it entails an intimate connection with and commitment to advancing the health and well-being of their communities. However, their power as workforce is negatively affected by this peripheral status. This status stems, as discussed below, from multiple structural, social, and organizational social factors:

(1) Structural social factors

CHWs generally occupy less economically powerful positions given their peripheral social location in the public health workforce (Torres, 2013). CHW positions are often defined as low-skilled (Armstrong & Armstrong, 2010). They are traditionally women, drawn from ethno-specific communities in geographically diverse areas or communities of affiliation where they have strong familiarity (Torres, Spitzer, Labonté, Amaratunga, & Andrew, 2013). Both CHWs and their clients tend to be poor and face barriers such as, racism, gender inequalities, and discrimination based on poor socioeconomic status (Jennissen & Lundy, 2011; Spitzer, 2011).

CHWs, as a workforce, may at times be invisible and therefore undervalued (Torres, 2013). CHWs' invisibility results in systematic differences (inequity in health) 'across socially, demographically, or geographically defined populations or population subgroups' (Starfield, 2006), which hinders their ability to address health equity.

(2) Organizational social factors

CHWs' legitimacy and work roles are based on their intimate connection and linkages with the communities they serve. Often CHWs working in organizations that are 'arm's-length' from the formal health system, have less stable funding and may experience struggles associated with that instability (Torres et al., 2013). CHWs who are staff within the 'formal' health system have more stable funding and are often part of public health delivery teams, but their responsiveness to community concerns may at times be restrained by the bureaucracy, which may stifle or delay new initiatives (Brownstein, Hirsch, Rosenthal, & Rush, 2011). The effectiveness of within-system CHWs as advocates for their own communities is, however, overlooked (Pérez & Martinez, 2008).

New organizational models for CHWs featuring hybrid models that combine 'arm's-length' and 'formal' health system arrangements have been proposed (Findley & Matos, 2015). Identifying emerging needs of populations is a significant strength that CHWs bring to their work notwithstanding the setting or model (US or Canada) being used (Page-Reeves et al., 2016). However, the presence of systemic barriers that undervalue CHWs' contributions limits their potential to address health equity.

Community health workers: the Canadian experience

CHWs in Canada first became formalized with the establishment of Community Health Representatives (CHRs) in 1962. CHRs often facilitate access to health services of Aboriginal populations living in rural areas or on remote reserves for whom the provision of health care is a federal government responsibility (Dedam-Montour, 2010, personal communication; National Indian & Inuit Community Health Representatives Organization, 2006). In 1972, Canada extended Medicare (single payer, publicly insured medical care) across all provinces and territories, a system pioneered in the province of Saskatchewan a decade earlier. In 1984 the federal *Canada Health Act* identified principles that form the cornerstone of the Canadian health care system – including values of equity, fairness and solidarity (Romanow, 2002).

Most health services organized and administered by Canada's ten provinces and three territories are funded through taxation and are free at the point of service (Canadian Institute for Health Information [CIHI], 2005). Several models for public payment of physicians and other primary care services exist (salary, capitation, fee-for-service) (Hogg et al., 2009). About 30% of health spending remains privately insured or out-of-pocket. This amount has risen slightly in recent years as government health services seek to constrain public spending (CIHI, 2005).

The universality of Canada's health care system is fundamental for CHW work, since clients typically do not have to pay for most health services. In addition, Canada's health system has given considerable attention to disease prevention through programs targeting health behaviors, community empowerment and what are now referred to as social determinants of health (Public Health Agency of Canada, 2011).

Despite the ostensible universality of Canada's health care system, CHWs confront persistent barriers in facilitating access to services for different population groups, such as immigrants and refugees. Barriers include, but are not limited to, language, racism, low socioeconomic status, and sexism (Stewart et al., 2011). Although there is a lack of data on the size and distribution of the CHW workforce in Canada, emerging research suggests that CHW models span a continuum, ranging from workers incorporated within formal health system institutions to workers situated in independent community-based organizations (Torres et al., 2013).

Over the past 20 years, CHWs in Canada have generally been deployed to reach out to underserved populations, but are not yet seen as part of the public health workforce (South Riverdale Community Health Centre, Mount Sinai Hospital, & Toronto Public Health, 2010; Torres et al., 2014). Factors contributing to their marginality are: (1) the health system focuses on the medical work doctors and nurses do, but not the support work that CHWs provide (Armstrong & Armstrong, 2010); (2) the CHW workforce is not formally organized (Torres et al., 2013); and (3) the populations that CHWs serve are invisible and marginalized (Spitzer, 2011; Torres, 2013).

Community health workers: the US experience

Formalization of the role of CHWs in the US started in the 1950s, when CHWs began working with migrant and tribal communities (Rosenthal, 2009). The prominence of CHWs grew in the 1960s with the *Federal Migrant Health Act* (1962) and the *Economic Opportunity Act* (1964), which built on the community health center movement that integrated CHWs into their community outreach and education activities (Geiger, 2002). Around the same time, the Indian Health Service began tribal CHW programs throughout the US. The US health care system underwent a major reformation in this era with establishment of Medicaid (for the poor) and Medicare (for the elderly) in 1965 (Ramirez-Valles, 1998). Today these two programs represent over one third of overall US health care expenditures (Kaiser Family Foundation, 2014). The organization of the delivery of health care began to shift from a fee-for-service payment system towards one dominated by managed care with enactment of the *Health Maintenance Organization Act* by Congress in 1973.

These changes in US health care financing and structure helped to shape how CHW programs and services evolved, i.e. primarily with short term funding from grants and contracts. Increasingly, CHWs themselves were able to play a crucial role in improving individual and community health and access to care owing to their powerful identification and networks with communities in need (Eng & Young, 1992). Recognizing the CHW effectiveness while at the same time observing the lack of sustainable investment in and recognition of CHWs (Rosenthal et al., 2011), a US-wide movement in the 1970s linked to the American Public Health Association re-emerged in the early 1990s to support their growth and development (Community Health Worker Section, 2014). As a result, CHW networks developed and continue to play a critical role in fostering CHWs in the US. Reflecting this increased recognition, the Bureau of Labor established a definition for CHWs, first utilized in the 2010 census (Balcazar et al., 2011).

In this context of federal regulations, opportunities for community transformation with CHWs began to emerge including a new system of health care financing and delivery due to the passage of the

US *Patient Protection and Affordable Care Act* (ACA). In 2014, a change to federal Medicaid regulations allowed states to pay for clinical preventive services provided by ‘unlicensed individuals,’ including, but not limited to, those offered by CHWs (Rush, 2012). Despite this greater recognition, CHWs continue to be on the margins of the US health human resources workforce (Behforouz, 2014). The US health care system remains highly fragmented and driven by economic incentives based on disease-focused management (Balcazar et al., 2011). CHWs’ roles often remain constrained and rigid, given the continued reliance on the medical model. Issues of power, inequality, and the complexity of CHWs’ services and interventions frequently remain on the backburner (Rosenthal et al., 2011).

Marginalization and motivation of community health workers: debate cuts across continents

A key question, which countries like the US and Canada have not yet resolved, is balancing the gains CHWs are attempting to make as a viable workforce within transforming health systems and the need to examine CHWs’ intrinsic and extrinsic motivations for undertaking CHW work (Swartz & Colvin, 2015). While this commentary focuses on the US and Canada, Swartz and Colvin’s (2015) research in South Africa illuminates the similarities and challenges CHWs face across continents: CHWs seek to serve their communities but face structural barriers owing to their work in contexts of economic deprivation. As Swartz and Colvin illustrate, CHW work should not be seen in a reductionist or simplistic way, but needs to be analyzed as a more complex, competing, and overlapping narrative recognizing their work context, and their motivations (Swartz & Colvin, 2015).

Moving toward an empowerment model: policy implications

The principle behind policy change is to advance an agenda that connects social justice and transformation of health care systems, including making CHWs a visible workforce. Our research, knowledge, and long-term involvement in the field in both countries lead us to propose adoption of policy changes on two levels in order for CHWs to effectively address health equity for marginalized populations.

- (1) Structural social factors- Systems-level policies would include actions to address health equity issues directly and strengthen the knowledge and strategic connection CHWs have with the communities they serve:
 - facilitate access to health and social services of underserved populations by removing barriers based on sexism and racism (Jennissen & Lundy, 2011),
 - target the social determinants, for example, poor housing, affecting the health and well-being of underserved populations (Pérez & Martinez, 2008);
 - support CHWs’ focus on breaking the isolation and marginalization that some populations face by creating new social programs (Ramirez-Valles, 1998);
 - support of CHWs’ lobby and advocacy efforts to give voice to people they work with who otherwise have no voice (Torres, 2013).

- (2) Organizational social factors –Workforce-level policies would include actions to address CHWs peripheral social location as an unlicensed profession:
 - diversified and stable systems’ funding of CHWs and competitive wages with other health and professional workers to support CHWs in bringing a similarly sophisticated skill set to their roles (Rush, 2012);
 - recognition and acceptance of CHWs by other professionals in public health, primary care, and social services systems as well as willingness to grant CHWs co-equal or at least non-marginal status (Rosenthal et al., 2011);

- enhancement of CHWs' work to build community capacity and to forge collaboration between communities and local systems (Torres et al., 2014).

In Table 1 we outline key areas of CHW practice and propose, a path to recognizing CHWs as vital partners in the health and human resources workforce. The first column is the empowering path. It illustrates the

Table 1. Examining factors facilitating or hindering CHWs' workforce empowerment.

CHW Workforce	Empowering the CHW workforce	Hindering the CHW workforce
<i>(1) Individual policy level components:</i>		
Recognition	A clear strategy is in place to recognize and promote CHWs in many settings and models as a viable and sustainable workforce	No clear strategy in place to promote and sustain the CHW workforce in varied settings
Credentialing	A holistic definition of credentialing for CHWs is established. CHWs lead or are meaningfully involved in defining the parameters for credentialing. Their role as unlicensed public health workers is recognized	There is no consensus on or available credentialing. Credentialing initiatives are undertaken with minimum or no input from CHWs
Training and supervision	Multiple training levels are developed with appropriate guidelines embracing adult education principles. CHW supervision, geared to support and fulfill this role, is the norm. CHWs are trained to be supervisors	Little or no investment in training with lack of systematic approaches to supervision. Poor quality control or interest in supervision is the norm. Few CHWs become supervisors
Scope of practice	This is set by National CHW Networks to build CHW practice that has a range of prevention activities to address social determinants of health and promote health and health care access	CHWs practice is seen in clinical terms only, that is, providing health service linkages without community action wherein CHWs help to maintain the status quo
Career paths and workforce development	CHWs varied career paths are supported (in) formal health and social services systems, in a mixed-model setting, or with a community-based setting in a mixed model setting or community-based setting	CHWs are not formally recognized by the health and social services systems, so there is no career path; only episodic opportunities are available for CHW work
<i>(2) Workforce policy level components:</i>		
Financing	Funding supports a CHW Scope of Practice that is being recognized by many national, regional and local CHW networks. CHWs funding is stable and wages are competitive with other health and professional workers	Narrow CHW Scope of Practice funded. CHW work is based on episodic funding for marginalized populations and health issues. Wages are poor; benefits are limited or non-existent
Occupational regulation	CHWs have an occupational category based on the holistic work they do	CHWs do not have an occupational category, or if one exists, it is based on a medical model
Parameters of evaluation	Qualitative and quantitative methods of assessment highlight equity and measure varied aspects of success, including holistic health measures	Rigid and unrealistic evaluation and assessment protocols that have biased success, defining it as Return on Investment and only fiscal measures
<i>(3) System level integration components:</i>		
Strengthen community action	A system of wide community penetration for an empowered CHW workforce serves at many levels of the social-ecological model embracing health equity and social justice	CHWs workforce is marginalized and unable to respond to opportunities for transformation of health care system or other systems
Effecting systems' change for health equity	A public health approach empowerment model creates health equity, ameliorates population health disparities and integrates many health care and non-health care systems to embrace the CHW workforce	CHW workforce is peripheral to public health action and the system adheres to narrow views of the biomedical model to address illness and disease with no investment in prevention and wellness

elements that foster and empower the CHW workforce advancing health equity. The implementation of these elements will contribute to privileging a holistic and equitable system as well as an ecological public health model of prevention. The second column shows the elements that are currently challenges to the CHW workforce's efforts towards this goal. The lack of attention to these elements perpetuates the continued marginalization of CHWs as intermittent auxiliaries to a primary clinical model of health, which alone is not enough to address health equity for marginalized populations.

The empowerment path that we propose recognizes CHWs' social location at the margins is an asset because this leads to an intimate connection and commitment to advancing the health and well-being of their communities. However, their peripheral status as a workforce must be addressed. We acknowledge that standardization and regulation of professional status must not compromise the independence of their work with communities. In other words, the recognition and visibility of CHWs as a workforce must not be at the expense of limiting their role as agents of change (Colvin & Swartz, 2015; Jennissen & Lundy, 2011; Torres, 2013).

At this stage of development of the CHW workforce, a well-defined policy agenda and evaluation framework ought to be a key feature in both countries. The field of CHWs needs to be transformed with policies that improve the feasibility and desirability of their work in communities, specifically health equity work. Although there is some indication that this marginalization has lessened (notably through CHW recognition in the US), CHWs and communities continue to experience marginalization in both countries.

At the workforce level, we have further identified several hypothesized policy categories, divided into the three levels of components identified in Table 1.

- (1) Recognition, credentialing, training and supervision, scope of practice, career paths, and workforce development

Policies established with input from CHWs that enhance the social currency, legitimacy, and sustainability of the CHW workforce as a viable and respected profession.

- (2) Financing, occupational regulation, and parameters of evaluation

Policies that facilitate financial and regulatory mechanisms promoting meaningful employment of CHWs as part of formal and informal health and social services structures, and thus address the social isolation/marginalization that currently exists.

Policies that provide fair and comprehensive guidelines to measure processes and impact of the CHWs as a human resources workforce promoting health equity.

- (3) Strengthen community action and effective system change for health equity

Policies valuing the ability to assess and address social and behavioral determinants (and the ability to tailor interventions to include the life experience and cultural preferences of the service user) that privilege CHWs' unique domain of expertise.

Policies that place greater stress on the social determinants of health and thus raise the intrinsic merit of CHW contributions. Such policies would facilitate improvement of health equity by valuing CHW 'experience-based expertise', that is, to successfully identify and highlight how social determinants of health affect the health and wellbeing of communities.

Conclusion

In this commentary, we addressed CHWs' marginalized social location within the health care systems of Canada and the US. We proposed system-level and workforce-level policy changes that build toward an empowerment path for CHWs to realize their full potential to address health equity. This empowerment path addresses, in part, the marginalization CHWs face as a workforce shaped by socio-structural factors, such as gender discrimination, racism, and poor socioeconomic conditions. Targeting both system-level and workforce-level changes in how CHWs are treated would greatly enhance the health and social services systems.

A challenging task awaits Canada and the US: undertaking a comprehensive and multi-level discussion seeking a systematic approach to health equity in which the CHW workforce plays a vital role. It is time each country undertook a clear and well-instrumented policy direction. This commentary provides a starting point for embarking on that new direction.

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