OMSA AÉMO
Ontario Medical Students Association
Association des étudiant·e·s de médecine de l'Ontario

POLICY PAPER

Equitable and Inclusive Health Care for South Asians

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SUMMARY

Summarized Background

South Asians, composing 7.1% of the population of Canada, face disproportionately high rates of diabetes and cardiovascular disease. They are 2.3 times more likely to develop diabetes than White Canadians, contributing to the overall 9.5% prevalence of diabetes in Canada (2021-2022). The elevated risk in South Asians is due to genetic factors, increased visceral fat, and insulin resistance, and is compounded by social factors such as limited healthcare access, financial constraints, and cultural differences. Cardiovascular disease is another major issue, with South Asians accounting for over 50% of cardiovascular deaths globally, while presenting with cardiovascular diseases at younger ages.

These challenges underscore the need for culturally competent healthcare approaches, including routine screenings, personalized care plans, and targeted educational interventions. Integrating South Asian-specific health objectives into medical curricula to educate future physicians, and fostering collaborations between medical student organizations and South Asian health organizations, are crucial steps toward improving culturally competent care for these populations. These efforts will help bridge the gap in healthcare access and improve the management of chronic diseases within the South Asian community, ultimately leading to better health outcomes across Canada.

Summarized Recommendations

- Learning objectives specific to South Asian health should be implemented in Ontario medical school curricula.
- The Canadian health guidelines should better reflect the needs of the South Asian demographic.
- Public health and patient care resources should be created in a culturally inclusive and language-accessible manner for South Asians.
- OMSA should collaborate with existing South Asian health organizations to achieve the above recommendations.

INTRODUCTION

South Asians, encompassing individuals from Sri Lanka, India, Pakistan, Nepal and Bangladesh, are the largest racialized group in Canada, composing 7.1% of the population in 2022.[1] They are disproportionately impacted by chronic diseases such as diabetes and cardiovascular disease.

In Canada, South Asians are 2.3 times more likely to be diagnosed with diabetes than their White counterparts.[2] Diabetes is a chronic, multifaceted condition that causes significant morbidity and mortality worldwide, affecting at least 9.5% of the Canadian population,[3] and costing the Canadian healthcare system $3.1 billion in 2020.[4] About 90% of diabetes cases are Type 2.[5] The disproportionate burden of diabetes among this demographic is due to biological and social factors.[6] Biological factors include genetics, increased visceral adiposity, insulin resistance, and β-cell dysfunction. Social factors include urbanization and migration, leading to reduced physical activity, increased intake of processed foods, and increased stress levels. Amplification of stress, in turn, causes worsening abdominal obesity and increased insulin resistance. Furthermore, when diagnosed with Type 2 Diabetes (T2D), South Asians have greater microvascular and macrovascular complications, and heightened mortality, compared to their European counterparts.[6]

Diabetes is closely associated with cardiovascular diseases, which is another health issue that disproportionately affects South Asians,[7] with South Asians representing over 50% of cardiovascular deaths worldwide.[8] The international INTERHEART study found that South Asians had a mean age of presentation for a first myocardial infarction approximately 10 years earlier than in Caucasians and Chinese individuals.[9.] A recent Canadian study also found that the South Asian population had higher rates of coronary artery disease and were younger at presentation than their East Asian and White counterparts.[10] Many studies have found a higher prevalence of cardiac risk factors (e.g., hyperlipidemia, hypertension, diabetes) in South Asians, which may explain the findings that the South Asian population is at higher risk of developing acute myocardial infarction and dying from cardiovascular causes compared to the general population.[10,11]

Not only does the South Asian demographic have a heightened predisposition to T2D and cardiovascular disease, they also experience significant social barriers when managing these chronic conditions, which increases their vulnerability to complications. Healthcare services may be inaccessible to this population due to immigration status, inability to take time off work, difficulty traveling to healthcare facilities, and lack of child care services.[12, 13] Chronic disease management is also adversely affected by financial challenges which may preclude patients from purchasing needed medications. Additionally, South Asians encounter obstacles when attempting to follow dietary and fitness suggestions, including a lack of culturally suitable food choices available at food banks.[12] Cultural and communication differences also impact the accessibility of healthcare for South Asians in high-income Western countries.[13] For example, some individuals believe that attending regular healthcare services are not helpful for monitoring their chronic conditions. Furthermore, the language barrier has a significant impact on the communication between healthcare providers and patients, as interpreter services are often limited in clinics. There is a need to train additional healthcare providers who share this cultural background, more training to develop South Asian-specific cultural competence, and increased involvement of South Asian migrants in the management of their own healthcare.

Given the staggering rate of diabetes and cardiovascular disease among South Asians, increased adverse health outcomes among patients diagnosed with these chronic illnesses, and the social barriers hindering management, physicians should adopt a proactive and culturally competent approach for their South Asian patients. This includes prioritizing routine screenings for diabetes and cardiovascular disease among South Asian patients and implementing personalized care plans that account for biological, social, and cultural determinants of health.

Most medical curricula focus on generalized healthcare, which often overlooks the specific needs of diverse populations, including South Asians. The medical school curriculum should be targeted towards understanding the cultural, social, and biological factors that influence health outcomes in South Asian patients outlined previously (e.g. through expert-taught lectures, incorporating stories on the South Asian patient experience, etc.). By equipping future healthcare providers with this knowledge, we can move towards more personalized and effective care for South Asian patients, ultimately improving health outcomes within this community.

In order to further bridge this gap, it would be beneficial for medical student organizations such as the OMSA to actively collaborate with existing organizations that have deep roots in the South Asian community. For example, joint efforts to organize culturally appropriate health promotion events or community-based screening programs on a province-wide scale can offer valuable learning opportunities for future physicians while also directly benefiting the community.

Another issue faced by South Asians in Canada is that they often face barriers to understanding and utilizing health services due to language differences, cultural norms, and varying levels of health literacy. Many South Asians in Canada may not be fluent in English or French, and they may rely on their native languages such as Punjabi, Hindi, Urdu, Tamil, or Bengali for communication. Without resources available in these languages, critical health information may be inaccessible to a large segment of this population. Moreover, cultural beliefs and practices can influence health behaviors, including diet, exercise, and perceptions of illness, which must be considered when designing health interventions. For example, dietary advice that does not incorporate traditional South Asian foods and ingredients may not be practical and well-received.

One study that demonstrates the importance of culturally competent care for South Asians found that even though South Asians have increased rates of cardiovascular disease, they participate in cardiac rehabilitation at lower rates due to cultural factors.[14] This study also suggests several tips to help improve the participation of South Asians in cardiac rehabilitation. For example, families should be included in patient educational sessions, and there should be a focus on creating community as South Asians are more likely to participate in cardiac rehabilitation if other people they know also participate. South Asian culture regards physicians as a source of trust and authority, so physicians should encourage patients to participate in cardiac rehabilitation programs. Moreover, knowledge of coronary heart disease is often not optimal especially amongst women, South Asians, and those with low economic status.[15] Another example of tailored care is directing South Asian Muslim women to physical activity programs in the mosque, which have been found to be effective.[16]

To address these challenges, public health and patient care resources should be tailored to the cultural and linguistic needs of the South Asian community. This includes translating materials into relevant languages, using culturally appropriate imagery and examples. Customized educational interventions in a culturally sensitive manner are crucial to bridging this knowledge gap and ultimately improving the health outcomes of South Asians in Canada.

PRINCIPLES

The Ontario Medical Students Association makes its recommendations using the following guiding principles:

1. Principle 1. OMSA supports patient access to social justice and equity, defined as a society that is free of discrimination and that accepts and promotes principles of inclusivity in all personal, professional, social and educational environments.

2. Principle 2. Undergraduate medical education that incorporates high quality, current evidence-based practices that reflect the principles of social justice and patient safety.

3. Principle 3. OMSA supports patient access to food, defined as access to healthy, affordable food options regardless of area of residence or socioeconomic status.

4. Principle 4. OMSA supports patient access to income, defined as a livable wage relative to the cost of living.

5. Principle 5. Accessibility, in that no financial, geographic, or physical barriers may exist that impede reasonable or timely access to medically necessary services.

6. Principle 6. OMSA advocates for the engagement of these communities in setting and implementing advocacy priorities.

7. Principle 7. Support short-term and long-term improvements in public services, states, and societies.

8. Principle 8. Increase medical students' exposure to population-based approaches to healthcare.

From the document *OMSA Advocacy Values and Guiding Principles*, the principle of social justice and equity most significantly aligns with this paper. South Asians should have access to equitable health care that is culturally sensitive, meets their unique needs, and addresses the social determinants of health pertinent to this population. Furthermore, the principle of social justice is closely tied to several other related issues raised in this paper. For example, South Asians should have better access to healthy and affordable foods to reduce the risk of developing chronic illnesses. Medical students should be better informed about the health disparities experienced by South Asian communities, so that when they are practicing medicine in the community, they can help connect South Asians to appropriate resources and provide the necessary education to their patients to improve health outcomes.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

1. **Learning objectives specific to South Asian health should be implemented in Ontario medical school curricula.**

Currently, medical education is lacking in this regard. For example, one of the authors observed that in Western's medical undergraduate diabetes curriculum, "South Asian" was only mentioned once, in a single slide listing ethnic groups at a higher risk for diabetes. Students should be required to receive culturally sensitive and holistic knowledge to better prepare them to diagnose and treat South Asian patients, and thus improve patient health. This requirement should be embedded in the *Medical Council of Canada* medical expert objectives for diabetes and cardiovascular disease, as currently it is lacking in this regard.[17] These objectives should cover evidence-based diagnostic and treatment considerations for South Asian patients. To deliver these learning objectives, healthcare providers serving a significant South Asian patient population in Canada should share their experiences through educational events and

panels at medical schools. This will deepen the understanding of the unique barriers and challenges that South Asian patients face in accessing and receiving appropriate healthcare.

2. **That the Canadian health guidelines should better reflect the needs of the South Asian demographic.**

For example, current guidelines from *Diabetes Canada* do not adequately reflect the unique needs of South Asians. While their guidelines do mention that patients of certain ethnicities, including South Asian, are at higher risks of developing diabetes, and should be screened earlier and more frequently, a concrete number is not provided, leaving room for interpretation.[18] Research indicates that South Asians in Canada develop diabetes on average ten years earlier than their White counterparts, and at lower BMIs.[19] However, it is imperative to consider the diversity within the South Asian diaspora. For example, in Ontario, Sri Lankans have higher rates of diabetes (26.8%) when compared to individuals from other South Asian backgrounds, like Bengalis (22.2%), Pakistanis (19.6%), Indians (18.3%) and Nepalese (11.6%).[20] Tamil-speaking individuals have unique experiences that contribute to this heightened rate, as most were refugees escaping violence in their home country. Current guidelines recommend starting diabetes screening in the general public at age 40.[18] Given that South Asians develop diabetes at an earlier age than their counterparts, more research is warranted to elucidate the optimal ages to begin screening each South Asian subgroup for diabetes, and this should be communicated through objective guidelines. These measures will lead to improved patient care by facilitating earlier identification of diabetes among South Asian patients.

3. **That public health and patient care resources should be created in a culturally inclusive and language-accessible manner for South Asians.**

One barrier that manySouth Asian immigrants face is differences in language and English reading comprehension. Health resources written in English are not accessible to individuals less familiar with this language. Therefore, health resources should be offered in multiple languages, such as Urdu, Hindi, Bengali, Tamil, and Nepalese. These resources should also be sensitive to South Asian culture. For example, the *Canadian Food Guide* projects the Western diet, but to be more effective for South Asians, it should also incorporate healthy food guidelines that align with the traditional South Asian diet.

4. **That OMSA should collaborate with existing South Asian health organizations to achieve the above recommendations.**

Some Canadian non-profit organizations that OMSA can work with include *South Asian Canadian Health and Social Services*, *South Asian Health Network*, *South Asian Health Institute*, and *South Asian Women's Health Association*.

Implementation Strategy

The first recommendation is on creating and implementing medical school learning objectives about South Asian health, and the second recommendation is advocating for holistic health guidelines for South Asians. These recommendations first require evidence-based research to inform learning objectives and guideline changes. A research subcommittee can be created or partnered with, that will conduct a literature review on specific South Asians health concerns. Given the enormity of medical diseases, it is realistic and most practical to first focus these literature reviews on only some of the most significant diseases faced by the community, which are cardiovascular diseases and diabetes. The research should focus on the unique needs of this community, and the gaps in care that currently exist.

These literature reviews can then be used to suggest changes to present-day health guidelines, to create learning objectives for medical students, and to recommend future research objectives to address gaps. The literature reviews and recommendations can be compiled in a report which can be published on OMSA's website, and promoted on OMSA's social media accounts. OMSA can use the report to initiate discussions with the *Medical Council of Canada* about integrating the proposed curriculum objectives, and with organizations such as *Diabetes Canada* to revise existing health guidelines to be more inclusive.

The third recommendation in this position paper is to create culturally tailored and language accessible health resources for South Asians. OMSA can do this by providing funding to medical student groups who are interested in pursuing this initiative, or by overseeing the creation of such a committee. The created resources can be posted on the OMSA website, or a new website, for providers and patients to benefit from.

The final recommendation encourages OMSA to partner with existing organizations that advocate for South Asian health. These partnerships will aid in the achievement of the other recommendations. The Advocacy Partnerships committee of the OMSA Advocacy portfolio is well positioned to foster such connections.

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