Health Care Transformation in Canada

Physicians and Health Equity: Opportunities in Practice

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

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Physicians and health equity: Opportunities in practice

Executive summary

Health equity is created when individuals have the opportunity to achieve their full health potential. Health equity is undermined when social and economic conditions, the social determinants of health, prevent or constrain people from taking actions or making decisions that would promote health. While the majority of these determinants fall outside of the traditional health sector, the implications for health services in Canada are enormous. Most major diseases including heart disease and mental illness follow a social gradient with those in lowest socio-economic groups having the greatest burden of illness.

There remains, however, limited published material on opportunities for physicians to address these issues. This lack of literature does not denote a lack of action. Many physicians are engaged in innovative practices to help address the needs of the most vulnerable. Recognizing this, the Canadian Medical Association (CMA) interviewed a number of physicians across the country. It was hoped that their experiences would highlight work being done, and provide strategies and tools to physicians interested in opportunities to address health equity within their practices.

CMA developed an interview protocol in the fall of 2011 which was then pilot tested. In total, interviews were conducted with 32 physicians in 29 separate interviews. These physicians represented eight provinces and two territories and were drawn from family medicine, emergency medicine, pediatrics, psychiatry and public health. Once the interviews were completed, the content was reviewed and coded. General themes, keywords and responses were analyzed. An overview of the results is provided below. For more details please see the Results and Discussion sections of this report.

Physicians were asked to identify common areas of intervention for addressing health equity within practice. The most common answers in descending order were:

1. Linking patients with supportive community programs and services
2. Asking questions about a patient's social and economic circumstances
3. Integrating considerations of social and economic conditions into treatment planning (i.e. cost of medications)
4. Advocating for changes to support improvements in the social and economic circumstances of the community (i.e., advocating for reductions in child poverty)
5. Undertaking advocacy on behalf of individual patients (i.e., letters about the need for safer housing)
6. Adopting equitable practice design (i.e., flexible office hours, convenient practice location)
7. Providing practical support to patients to access the federal and provincial/territorial programs for which they qualify

Physicians did identify certain barriers to this work. The most common were:

1. Payment models (in particular 100% fee-for-service)
2. Attitudes that lead to stigmatized environments and prevent public action
3. Absence or lack of clinically-oriented information about the programs and services available for patients
4. Ability to find the time necessary to address these issues within practice
5. Lack of integration between health and community-based services

6. Lack of knowledge and skills to undertake this type of work
7. Practice design
8. Lack of services and supports in the community (in particular in rural and remote communities)
9. Lack of evidence and research on effective interventions for physicians
10. Personal attitudes that include powerlessness in the face of patients' social and economic barriers

Interviewees additionally highlighted facilitators to this work. The most common were:

1. Clinical training about how to do this type of work (i.e., service learning programs in medical school and residency)
2. Interdisciplinary team-based practice settings
3. A relationship with community services and programs
4. Clinically relevant resources about the programs and services that were available for patients
5. Supportive compensation models (i.e., salary, billing codes for complex patients)
6. Continued research that demonstrates efficacy in the clinical environment
7. Finding a like-minded community of practice

In the course of the interviews, participants suggested a number of areas for action. Interviewees saw a key role for CMA and other national medical groups in advocating for health equity issues. In addition, many felt that a national organization could take the lead in facilitating the development and dissemination of other key supports. They recommended actions in five main areas: clinical practice, education, compensation, research, and advocacy and communications. A list of suggested actions is provided in the table below. This is just a preliminary list and further refinement is required.

Area of interest	Potential action(s)
Clinical practice	• Development/refinement of health equity/social determinants of health assessment tool • Development/modification of clinical practice guidelines to integrate social and economic factors into medical care • Development of resources for physicians on programs and services for patients • Development of resources for physicians on accessing provincial/territorial and federal programs including forms and referral pathways, etc. • Development/consolidation and dissemination of plain language resources for patients on chronic disease management
Education	• Support and encouragement of the integration of the social determinants and health equity in medical schools • Support and encouragement of service learning in medical schools and residency training • Development of an accredited continuing medical education programs for practising physicians
Compensation	• Identification of effective compensation models for health equity practice in Canada • Development of these models for other jurisdictions and practice settings
Research	• Support of continued research on physician interventions in health equity • Help to assemble the evidence base and best practices and facilitate knowledge translation across Canada and internationally
Advocacy and communications	• Develop a national network of health equity physicians • Develop an advocacy strategy for health equity in Canada • Develop an advocacy map/tool for clinicians • Explore the development of health equity leadership and advocacy training resources for physicians

Improvements in the social and economic conditions of Canadians and greater equity within the health system are key strategies if population health is to be improved and the sustainability of the health sector ensured. Interviewees identified a series of opportunities for action by physicians across the country. It is hoped that these interventions will provide Canada's doctors with a toolbox to address challenges for their patients, which are often overlooked. Barriers will need to be addressed and facilitators capitalized upon. Leadership at the national level is necessary. Physicians are respected leaders in the health care system, within their communities, and at the provincial/territorial and federal levels. This research demonstrates that they possess the necessary skills to undertake greater leadership in speaking out and addressing the social factors that have such a profound impact on health. Action in the areas of clinical practice, education, research, and advocacy and communication will allow physicians to be active agents for change and play a significant role in ensuring health care transformation in Canada.

Background

Health equity is larger than the health care system itself. Recent evidence suggests that 15% of population health is determined by biology and genetics, 10% by physical environments, 25% by the actions of the health care system, with 50% being determined by our social and economic environment.[1] To optimize the health potential of individuals, and ensure greater health equity, preventable and avoidable systematic conditions which constrain life choices must be reduced or eliminated.[2] These conditions, known as the social determinants of health, are the circumstances in which people are born, develop, live and age,[3] and include: income and income distribution; early life; education; housing; food security; employment and working conditions; unemployment and job security; social safety net; social inclusion and exclusion; and health services.[4]

The majority of these determinants fall outside of the traditional health sector. However, the implications for health services in Canada are enormous. Most major diseases including heart disease and mental illness[5] follow a social gradient with those in lowest socio-economic groups having the greatest burden of illness. Those in the lowest socio-economic status are 1.4 times more likely to have a chronic disease, and 1.9 times more likely to be hospitalized for care of that disease.[6] Chronic diseases such as diabetes account for 67% of direct health care costs and 60% indirect costs.[7] According to a 2011 report, low income residents in Saskatoon consume an additional $179 million in health care costs than residents classified as middle income earners.[8] In Canada, data from the 2007 Community Health Survey described the Canadians who are most likely to report cost-related non-adherence to prescription medications as follows: those in poor health (2–4 times), lower household income (2–5 times), and those without drug insurance (3–6 times).[9] They estimate that one in 10 Canadians does not adhere to their prescription for reasons of cost.

Examining this data, it is hard to ignore the implications for Canada's physicians. The question is what can be done for areas that are largely outside of the health sector. Some literature has been published on the role for the health sector in addressing health inequities.[10] Additionally, reviews of specific interventions have been provided.[11] However, there remains limited published material on opportunities for physicians to address these issues. This lack of literature does not denote a lack of action. Many physicians are engaged in innovative practices to help address the needs of the most vulnerable. Recognizing this, CMA set out to undertake interviews with physicians who had been identified as health equity champions across Canada. It was hoped that their experiences would highlight the amount of work already undertaken by Canada's physicians, and provide strategies and tools to those physicians who were interested in more opportunities to address health equity within their practices.

Methodology

CMA developed an interview protocol in the fall of 2011. The complete protocol is found in Appendix I. In November 2011, this protocol was pilot tested with physicians from the Sandy Hill Community Health Centre in Ottawa. Once the protocol was approved staff set out to identify participants for the research. Potential participants were identified in a number of ways. Initial scanning was done using Google searches. Additionally, the web pages of Canadian medical schools were reviewed. Names were provided through provincial and territorial medical associations. Finally, additional participants were identified by other interviewees as the research was conducted.

In total 54 physicians were contacted with 37 (68.5%) agreeing to be interviewed, and 32 (59.3%) completing an interview. As some interviews involved more than one physician, 29 separate interview sessions took place. These physicians represented eight provinces and two territories and were drawn from family medicine, emergency medicine, pediatrics, psychiatry, and public health. A telephone interview was conducted with one individual with the remaining consultations being done face-to-face. The list of interviewees is provided in Appendix II.

Once the interviews were completed, the content was reviewed and coded. General themes, keywords and responses were analyzed. All themes that were mentioned in five or more interviews were included for discussion in the relevant section. The content of the paper and results were then verified with the interview participants. There was a great deal of consistency in responses to the areas reviewed. This suggests a high level of agreement on common interventions for physicians, and barriers and facilitators to this work. However, caution must be applied given the relatively small number of physicians interviewed. Further research with a larger sample size would be helpful in verifying these results.

Results

The physicians interviewed practised in a variety of clinical settings. Practice populations ranged from whole communities under the jurisdiction of public health departments, to 10,000–12,000 in large academic family health teams, to 500 in a First Nations community in rural Nova Scotia. Practice communities included urban and inner city, and rural and Northern practices. Specific subpopulations included child and youth, mental health, women, Aboriginal and immigrants. Even with this variety, there was consistency in responses.

Physicians were asked to identify common areas of intervention for addressing health equity within practice. They were asked to consider their own practice setting as well as what would be practical in a generic practice setting. The most common answers in descending order were:

1. Linking patients with supportive community programs and services
2. Asking questions about a patients social and economic circumstances
3. Integrating considerations of social and economic conditions into treatment planning (i.e., cost of medications)
4. Advocating for changes to support improvements in the social and economic circumstances of the community (i.e., advocating for reductions in child poverty)
5. Undertaking advocacy on behalf of individual patients (i.e., letters about the need for safer housing)
6. Adopting equitable practice design (i.e., flexible office hours, convenient practice location)
7. Providing practical support to patients to access the federal and provincial/territorial programs for which they qualify

The first two interventions were identified in almost every interview that took place. While the physicians interviewed have been successful in integrating some or all of these interventions into their practices, they did identify certain barriers to this work. The most common barriers included:

1. Payment models (in particular 100% fee-for-service)
2. Attitudes that lead to stigmatized environments and prevent public action
3. Absence or lack of clinically oriented information about the programs and services available for patients
4. Ability to find the time necessary to address these issues within practice
5. Lack of integration between health and community-based services
6. Lack of knowledge and skills to undertake this type of work
7. Practice design
8. Lack of services and supports in the community (in particular in rural and remote communities)
9. Lack of evidence and research on effective interventions for physicians
10. Personal attitudes that include powerlessness in the face of patients' social and economic barriers

While a significant number of barriers were identified, interviewees highlighted facilitators which enabled them to overcome some of these challenges. Additionally, they suggested some supports for physicians who were interested in getting started in this area of work. The most common facilitators included:

1. Clinical training about how to do this type of work (i.e., service learning programs in medical school and residency)
2. Interdisciplinary team-based practice settings
3. A relationship with community services and programs
4. Clinically relevant resources about the programs and services that were available for patients
5. Supportive compensation models (i.e., salary, billing codes for complex patients)
6. Continued research that demonstrates efficacy in the clinical environment
7. Finding a like-minded community of practice

Not surprisingly, many of the facilitators spoke directly to an identified barrier (i.e., education about addressing health equity within practice). In the discussion section below we will explore the innovative practices across Canada where these interventions are utilized as well as a further examination of the barriers and facilitators. It is important to recognize that many of these interventions are being undertaken by physicians across the country and not just by the physicians interviewed. Many regularly undertake actions to address the social and economic needs of their patients. It is hoped that the following sections will serve to enumerate these practices and provide support for physicians already undertaking this important work. It is further hoped that by identifying barriers and facilitators that targeted action can be taken. Finally, for physicians who have been interested in doing this work but who were not sure how to get started, the interventions can provide first steps and recommendations for action. The final section of this paper will examine areas for action at the national level as well as a possible role for CMA.

Discussion

Interventions

There has been a challenge within the health care system and among physicians in particular to become involved in the social determinants of health and health equity. This is certainly not because of a lack of compassion for patients, or ignorance of the issues, but because of a feeling that interventions were largely beyond their reach. As the interviews demonstrated, however, there are key interventions that can be undertaken by physicians at many levels.

> You still need to ask questions about the social determinants of health even if you aren't working in a disadvantaged population. Why not consider an annual social just like you do an annual physical.
>
> — *Dr. Ryan Meili*

While only the second most common intervention identified, it is important to begin with a discussion of the necessity of a social history as an intervention for physicians. It is a preliminary strategy because the information collected is necessary to support all of the other interventions.[12] There are a number of tools that can be used for such a consultation and more are in development.[13] Research by Dr. Vanessa Brcic at the University of British Columbia pilot tested a number of questions physicians could ask patients to identify poverty within their practice. The question "Do you (ever) have difficulty making ends meet at the end of the month?" was found to be a good predictor of poverty.[14] Physicians emphasized the need to ask these questions in all practice settings and not just disadvantaged areas. Consolidation of the best ideas into a tool that is suitable for the majority of health care settings is needed. The tool needs to organize information that reflects the realities of the patient and helps physicians consider the best options for care. Some suggested integrating such a tool into electronic medical records.

Interviewed physicians emphasized the need for community level data. Data within primary care practices could help to assemble community wide databases of health information, including information on the social determi-

nants of health.[15] This data is now regularly collected at the community level in Newfoundland and Labrador and Quebec. It can help physicians understand the needs of their practice and what interventions may or may not be helpful. It can be used to conduct equity assessments as well. Innovative programs within the Saskatoon Health Region and the Centre for Addiction and Mental Health in Toronto use data collected on health outcomes for various groups to find barriers and identify ways to ensure greater access and equity for all patients.

> When examining the patient profile it became clear that the vast majority of diabetic patients requiring dialysis were First Nations people. When the education program was examined, participation rates were quite low among this group. Clearly there was something about the education program which prevented these individuals from participating.
>
> — *Dr. Cory Neudorf*

Once the social as well as the medical needs of patients have been identified, physicians will need to integrate the information into planning about treatment decisions. This was the third most common intervention suggested by interviewed physicians. Physicians regularly take medical risk factors into account when planning treatment protocols. Interviewees suggested the same should be done for social and economic risk factors. In addition to risk factors, barriers to adherence needed to be identified when planning treatment. If patients would have difficulty accessing fresh and healthy food or getting exercise, it would be necessary to examine these barriers before making these recommendations. The cost of medications needed to be considered when determining treatment plans. Some interviewees discussed the use of samples for disadvantaged populations and ensuring medications would be covered under drug plans if applicable. They noted as well strategies for securing medications in the most affordable way for their patients.

> When someone has diabetes, we think about what that means clinically. Why don't we do that for social and economic data?
>
> — *Dr. Gary Bloch*

To address some of the barriers identified in the social assessment and to help with compliance with treatment plans, interviewees often linked patients with supportive programs within the community; the number one most common intervention identified by physicians interviewed. There were many examples of physicians linking patients to programs within the community. Some practice locations even had supportive programs in house. Physicians at the North End Community Health Centre in Halifax highlighted some of the programs that were available through the nutritionist on staff. Examples included local walking programs and programs designed to teach patients how to cook healthy meals on a budget. Similar programs were identified at community health centres across the country.

For those locations which did not have such supportive programs, they relied on services within the community. One Ontario initiative is aiming to make such referrals easier for physicians in practice. The Enhanced 18-Month Well-Baby Visit, is designed to utilize standardized tools to allow physicians to have a discussion with parents on child development, to identify at risk kids, and to link parents and their children with local community programs that will support early childhood development.[16]

Ontario's enhanced 18-month well-baby assessment

Based on recommendations from an expert panel comprised of the Ontario College of Family Physicians, the Ontario Children's Health Network, and the Ministry of Children and Youth Services, the standard 18-month well-baby assessment has been expanded from a well baby check to a more fulsome examination of child development. Using standardized tools for physicians and parents, this program is seen as offering enormous potential to identify issues before children reach school. Encouraging more attention to healthy development by all parents is a population health strategy that can be carried out in the primary care office. The program encourages the use of community resources for early child development. In collaboration with Ontario's Best Start Strategy, comprehensive databases of community resources are being developed. Physicians are compensated by the Ministry of Health for this work. More data about this program is available at www.18monthvisit.ca.

Further, physicians identified the need to get their patients access to all federal and provincial/territorial assistance programs which could offer support to their patients such as disability assistance or extra funding for food (7th most common intervention). The programs vary by community and province/territory, and include disability, nutritional supports and many others. Most if not all of these programs require physicians to complete a form in order for the individual to qualify. For some individuals, these programs make the difference for safe housing and healthy food. Researchers in Toronto have developed a clinical tool for poverty identifying the programs which patients can access including old age security and guaranteed income supplements, child benefits and special diet allowances, among others.[17] Similar guides would be helpful for physicians in other parts of the country.

> One of the amazing things about being a doctor is that we hear peoples' life stories along with their medical stories. We have the opportunity to retell and act upon these.
>
> — *Dr. Susan Phillips*

Interviewees suggested that there were opportunities for physicians to be more involved in advocating for improvements in the social and economic conditions within their communities (4th most common intervention). Interviewees highlighted the systemic barriers their patients faced in meeting the most basic needs. For example, the *annual* welfare income in Canada varies between $3,247 for a single person to $21,213 for a couple with two children. The 'best' of Canadian programs provides an income within only 80% of the poverty line. The lowest income is barely 30% of that needed to 'achieve' poverty.[18] Interviewees commented that physicians are in a unique position to advocate for these issues. As respected members of the community, their opinions add strength to these campaigns and can help to provide a voice for those who are often overlooked. Interviewees emphasized the duty of physicians to advocate for change at the policy level.

Physicians' role as health experts allowed them to speak to community leaders about the need for action in these areas. Participation on the boards of community services was seen as one place for such advocacy to take place. Membership in provincial/territorial and national medical organizations was another venue for such messages to be raised. While not all physicians will have the time or skills to become full-time advocates, identifying times and places where they can intervene would help to address the needs of their patients and their communities.

> I had a patient who had major surgery and was no longer able to do her laundry by hand like she had always done. I wrote a prescription for a washer and dryer and it was actually filled.
>
> — *Dr. John Haggie*

In addition to system level advocacy, interviewees identified the need to advocate for their patients on an individual level (5th). This is something that physicians regularly do for patients in terms of health service access. Physicians

Dr. Gilles Julien and Les centres de pédiatrie sociale

"We are an interface for the vulnerable children and the systems they access."

Disappointed with the lack of progress that he could make in regular practice, Dr. Gilles Julien set out to find a way that he could have a bigger impact on the needs of the children he was treating. With no funding and armed with only a bicycle he set out to develop a community social pediatric program for Montreal's most disadvantaged children. That program has now grown to 12 centres across Quebec, all located in the areas of greatest need. Dr. Julien and his team help children with the medical, legal, and social determinants. The facility has a staff of many trained health providers and provides children with a supportive environment where they can access services. The practice is completely interdisciplinary with all practitioners being involved in a child's care. When children come to the facility the whole health care team does an assessment of their needs. Clinical as well as legal staff develop an action plan for the child and their parents and work with the community to make sure it takes place. Regular community and home visits are part of the practice model. According to Dr. Julien, this program is 50% integrated services and 50% advocacy for children. The program is designed to address the health needs of its patients and protect the legal rights of the children involved. Further details about these programs can be found at:www.fondationdrjulien.org/

> The first thing to do about health equity is to think health equity and what the barriers are to people getting access. Think about times, women with children, disabled access. Think about how your older patients will be looked after.
>
> — *Dr. Kwame McKenzie*

commented that they were involved in advocating for the social and economic needs of their patients as well. Interviewees noted that they wrote letters to housing agencies for example, to help patients access more suitable housing. Some physicians utilized prescriptions for social issues. Additionally, physicians intervened on behalf of patients when they felt that children had been inappropriately taken from the home and placed in social services. Finally, physicians worked with schools and other community agencies to ensure that the best interests of patients were met. A practice which is very involved in this type of patient level advocacy for children and youth is community social pediatrics. Pediatricians and family physicians work closely with community organizations and systems to make sure that their patients' needs are met. The overview of Les centres de pédiatrie sociale provides more details about this innovative approach.

Building on the work of Dr. Julien, other centres have identified the benefits of the social pediatric approach. The Hospital for Sick Children in Toronto now has a Social Paediatrics program headed by Dr. Elizabeth Lee Ford Jones. Other programs are in development across Canada as well. Both Dr. Ford Jones and Dr. Julien are actively involved in developing medical education programs to support this kind of work in Canada.

Interviewees suggested that physicians could do a great deal for their patients by making sure that their practices were accessible and supportive to those most in need (6th). Examples included flexible office hours with many having hours outside of the traditional 9–5. Many highlighted the necessity of addressing health literacy for patients including information that was appropriate for all patients. Programs to support those who did not speak English were also necessary. Culturally safe care, especially when working with Canada's Aboriginal peoples, was a key support.

Offices needed to be located in areas that were convenient for patients. Some suggested locating clinics in areas where patients already were such as schools or early education centres. In some clinics, outreach workers went directly to the patients to ensure access. In rural Newfoundland and Labrador for example, a local physician identified the barrier that many women had in accessing cervical cancer screening. This lack of access is one of the reasons that Newfoundland and Labrador has the highest rate of cervical cancer in the country. During the summer months this physician utilizes a converted camper known as the "Papmobile," to access women who would not otherwise be screened.

Finally, setting up practices that integrated many services under one roof was seen as a key facilitator. One of the groups that faces the biggest barriers to health access are the homeless. They are also among the sickest in Canada. Being homeless is correlated with higher rates of both physical and mental illness.[19] In Canada, premature death is eight to ten times higher among the homeless.[20] Recognizing these needs many programs have been set up to try and reach this population; one of these is Ottawa Inner City Health.[21]

While not all practice locations will be able to facilitate the ease of access such as a program like Ottawa Inner City Health, all physicians can think of the barriers for access when planning their practice design. If barriers can be identified and eliminated, there is a greater chance for physicians to address not only the medical needs of their patients but to facilitate greater health equity.

Ottawa Inner City Health

Established in 2001, this program is a non-profit corporation in Ottawa that delivers primary health care, chronic and convalescent care, palliative care and addictions management to the chronically homeless. Partnerships with key community members, such as local shelters, the Salvation Army, and University of Ottawa ensure the program's continued success. All of the services and the layout of the clinic were designed with direct input from clients and patients. The goals of the program are to provide dignity and culturally appropriate care and to work to restore clients to mainstream society. This program was the first of its kind and has been used as a model for others across the country. Continued research on interventions and treatment are helping to establish the evidence base for future work. More information about the program can be found at: http://ottawainnercityhealth.ca/Home

Barriers

The interventions discussed above highlight some of the key steps that physicians can take in addressing the needs of their patients. However, these practices were not without barriers. The most common barrier was funding models for practice. Many commented on the difficulty in working with these complex patients if one was required to bill on a fee-for-service basis. In certain jurisdictions incentives for physicians were established in such a way that physicians would be encouraged to only treat healthy patients with more complex and vulnerable patients actually serving to punish physicians financially. Many felt that solo practice fee-for-service physicians would have a hard time undertaking this type of work in many jurisdictions.

> Assisting people to address the health inequities that they face requires time, and many financial models interfere with the effective delivery of adequate health care.
>
> — *Dr. Cathy Felderhof*

Financial disincentives were not the only reasons interviewees felt that solo practitioners might have difficulty in sustaining this type of practice. The fourth most common barrier was the additional time required to undertake this kind of work. Many underlined the time required to properly treat the needs of these patients and to link them with all of the necessary supports. Taking the time to write letters, fill out forms, and identify resources in the community could be difficult for already overburdened practitioners. It was the combination of time and financial barriers that led some physicians to comment that practice design could serve as a barrier to effective health equity work (7th). The absence or lack of clinically-oriented information about programs and services available for patients was another barrier (3rd). Many stressed that it had taken them a number of years to identify the community supports available. Further, these programs were often changing and it was difficult to keep up with what was going on in the community. A number commented that patients were often the ones that brought these programs to their attention. Many identified the need to have some sort of resource for physicians to allow them to keep current on these community supports.

> I try to spend time coordinating follow-up care with the shelters in the community. It is hit and miss though as being the only physician in the ER it is sometimes impossible to find the time necessary.
>
> — *Dr. Anna Reid*

In addition to barriers in identifying services, two other barriers related to community and social services and supports were discussed. First, a lack of integration between the health care sector and other social services was seen as a major barrier (5th). Key challenges included programs being organized in ways that were different from what the health sector would expect, differing bureaucracies, and having many different ways to access programs and services. Rather than having one way to refer patients to different community programs and services, there was often a multitude of different forms and information required which could cause a great deal of confusion. Physicians noted the need to streamline the process for patients to eliminate the difficulties they had in accessing needed supportive care. Distrust between community and social services and the health care sector was highlighted as another issue. The lack of integration also meant that information relevant to a physician's treatment planning was often not reported by the community organization or other social service, undermining the quality of patient care. There was a real need for social services and community organizations to become a more integrated part of the health care team.

> It would be helpful to patients for forms for welfare, etc., to be available in physicians' offices. Rather than having to send people to another location for a form that we ultimately have to fill out.
>
> — *Dr. Philip Berger*

Further, physicians commented that there was sometimes a lack of services in their communities to support the needs of their patients (8th). Mental health services were identified as a major gap by many of the physicians interviewed. Depending on the community, some patients had to be sent out of their province or territory in order to access the care that was necessary. A corollary to this is the limited capacity of some of the services available. Even if services were available locally, the wait times were often preventative due to patients' needs. This applied to medical services as well as community and social support services. The sheer scale of need in some communities could undermine the effectiveness of available resources.

The scale of the problem was identified as another challenge by the interviewees. Physicians could feel a sense of powerlessness in the face of the social and economic challenges that their patients faced (10th). The burden of poverty and disadvantage is so great in some areas that it could feel that no actions could truly address the need. It was suggested that some physicians would be unwilling to even ask their patients about these issues due to an ethical concern that they couldn't do anything to help if an issue was identified. Additionally, a lack of knowledge and skills to address these issues could serve as a barrier to some physicians (6th). In particular, social and economic considerations had not been part of medical training in the past. Working with community and social services was new and advocacy skills were lacking for many. Interviewees suggested further that physicians often felt reluctance to intervene in areas outside of their medical expertise even if the health consequences were clear.

> We had an elder who had been sent south for care. When she was ready to be discharged there were problems as the support services were not available locally. Her family took the initiative to work with the Department of Health to secure what was necessary. This collaboration, and the family's financial resources, was the only way that she was able to come home to be with her family.
>
> — *Dr. Sandy Macdonald*

This lack of knowledge was often identified in parallel with another barrier; the lack of evidence about effective interventions for physicians (9th). The medical model requires certain levels of evidence for physicians to utilize interventions within their practices. As there is limited published evidence on what physicians can do to address the social determinants and health equity, this could serve as a stumbling block for many.

> We have to overcome the judgments that people make about these populations. If they are there because it is their fault then they can be ignored. We have to move beyond the sense that it is someone else's problem.
>
> — *Dr. Jeff Turnbull*

Negative attitudes in the health care setting were seen as a barrier to health equity work. It was the second most common response by interviewees. More complicated patients could be labeled as difficult and faced stigmatization. Additionally, disadvantaged groups often had negative experiences with the health system making them defensive and further undermining any relationship with physicians. Discrimination and push back was identified as an issue, particularly when the challenges patients faced in complying with treatment instructions were not understood. These attitudes were found not only for the socially marginalized but for patients with complex medical needs. These attitudes could be translated into lack of access or suboptimal care; a real barrier to equitable health services. These negative attitudes were common in the general public as well. Action to reduce health inequities was hampered by a lack of interest by other Canadians who often blamed these individuals for their problems. Interviewees felt that the inability for most Canadians to understand what it truly meant to be disadvantaged or marginalized, led to discrimination and difficulties for their patients, including further social exclusion. This lack of interest by the public translated into a lack of action by politicians at all levels. Myths related to poverty and other areas of disadvantage were seen as the biggest barriers to getting people to take action to address the social and resulting health needs of these patients.

Facilitators

Although a number of barriers were identified, physicians suggested some key facilitators as well. The facilitator mentioned most often was education for physicians. A 2001, Health Canada report called for greater integration of the social determinants in medical curricula, and a greater emphasis on providing medical students with firsthand experiences in the community and with distinct populations.[22] Additionally, the CanMEDS Physician Competency Framework, identifies health advocate as a key role for physicians.[23] Teaching physicians about the CanMEDS competencies is a mandate of all Canadian medical schools.

Most if not all medical schools include information about the social determinants of health within their curriculum. Recognizing that this is sometimes difficult information to convey in a didactic setting, there is an increasing emphasis on programs which allow students to get first hand experiences working in the community and within disadvantaged populations. These programs, such as the Making the Links program at the University of

Saskatchewan, help students gain the skills to work with diverse populations.

Programs for medical residents are being implemented across the country. Interviewees highlighted programs at the University of Toronto, the University of Alberta and McGill University, which provide physicians with the opportunity to work in underserved and vulnerable communities. The McGill program uses community-oriented primary care as a model. Residents begin the program with a walking tour of the community, and community members make regular presentations. Additionally, residents make case presentations about the social and economic issues their patients encountered and the impact on medical outcomes. Residents in the Queen's University Family Medicine program can now use community advocacy as a genesis for their research projects.

Making the Links — University of Saskatchewan
Established in 2001, this program is a non-profit corporation in Making the Links places students as volunteers in a fully interdisciplinary student-run clinic in the inner city of Saskatoon, in Northern Saskatchewan communities, and in a small town in Mozambique. Students learn a model of social accountability developed by the University of Saskatchewan's College of Medicine known as CARE (clinical activity, advocacy, research, education and training). Through their experiences, they integrate the impact of the social determinants on population health into their learning, forge important relationships and convert theory into practice. More details about this program can be found at: www.medicine.usask.ca/leadership/social-accountability/initiatives/mtl1/index.html or www.makingthelinks.usask.ca

You need to make it easy for physicians to access services and connect their patients with supports.

— Dr. Len Moore

Interviewees identified the need for education for those physicians already in practice. Particular focus on the impact of the social determinants on medical outcomes and potential interventions were emphasized, as well as education about advocacy and community involvement. They noted that an accredited continuing medical education program would be helpful to reach interested physicians. Further, some suggested that practising physicians needed opportunities to go into the community to see some of the challenges faced by the most vulnerable first hand. The programs in medical school as well as in practice can help provide physicians with the tools to work within these communities and will go a long way in reducing the negative attitudes that are such a barrier.

In addition to education for physicians, some interviewees discussed the effectiveness of resource guides for physicians which identified community programs and services as well as provincial/territorial and federal patient support programs (4th). Many resource guides have been put together for physicians and other health providers. The Mobile Outreach Street Health program, which is affiliated with the North End Community Health Centre in Halifax, developed a guide for providers to let them know about programs and services such as shelters that were available for the street-involved and homeless. Programs at the University of Alberta and McGill University have developed pathways for various issues such as addictions that can be used by physicians when determining how to access services.[24]

While these guides were seen as helpful by some it was noted that they are often not kept as up to date as necessary. Having a person in the community that they could call that had this information at hand might be an additional option. A centralized website for physicians to use was suggested as well. Additionally, greater integration between primary care and the local public health departments might facilitate this kind of information sharing. Innovative programs in a couple of communities had public health services co-located in clinical practice.

Relationships with the community are hugely important and make physicians better at practising medicine.

— Dr. Jill Konkin

Some suggested that strong relationships with the community were a bigger facilitator to undertaking this type of work (3rd). They indicated that having a relationship and a point of contact made it easier for their patients to access services and helped them address the needs within their practices. These relationships also enabled greater advocacy

for patients, and allowed physicians to be aware of the providers, groups, and even businesses who would provide the most supportive environments for their patients. While many noted that it took time to establish these relationships, they underlined the necessity of these ties in ensuring that comprehensive care could be provided and health equity addressed.

Physicians interviewed identified a number of practice design facilitators that made this type of work possible. The first was interdisciplinary team-based practice (2nd). Many of the physicians interviewed worked in fully interdisciplinary models with a wide range of health providers. Many commented that this type of practice was the only way to ensure that their patients' needs were met. Further, team practice enabled greater information to be gathered about their patients. The College of Family Physicians of Canada has embraced a new model of primary care called the Patient's Medical Home. One of its tenets is the need for physicians and other health professionals to work in partnership. Greater collaboration is associated with improved health outcomes and increased patient satisfaction.[25]

> If you have a team then you become more powerful. You notice these issues in general practice but feel helpless to address them. Team practice makes it possible to address these issues more completely.
>
> — *Dr. Gilles Julien*

> There is a need to bring all the research together and create the evidence base. So much work is being done and we need to highlight what has been learned.
>
> — *Dr. Vanessa Brcic*

Interviewees emphasized the importance of supportive compensation models that allowed for this type of work (5th). In particular, salary models, or fee codes for complex or vulnerable patients were seen as key facilitators. For example, the genesis for the Inner City Health program in Toronto was a plan which allowed physicians to get paid on an hourly basis. This helped to overcome the barrier caused by the lack of health cards for many of Toronto's homeless. Equity measures for immunization are now part of pay-for-performance in Saskatoon. Additionally, interviewees mentioned that funding for physicians to hire social workers or community practice nurses could also facilitate this work. Similar funding resources for other jurisdictions and practices would greatly facilitate the uptake of this type of work by physicians across the country. Physicians identified the need to find a like-minded group of practitioners and supportive networks (7th). This type of work while rewarding, could be a challenge and could be isolating. A network of physicians and other practitioners could provide support as well as serve as a venue to share best practices and research.

Finally, the physicians emphasized the role of continued research in supporting health equity work (6th). As was identified, a lack of evidence is a barrier for physicians. Physicians interviewed highlighted work they were involved in as well as the work of other colleagues. Samples included research at the University of Alberta on improving services for homeless and street involved people; work in Saskatoon and Toronto to conduct health equity assessments and needs based planning; assessments of interventions such as the enhanced 18-month well-baby assessment, and the social paediatrics model; reviews of the impact on attitudes of medical students and residents who had participated in service learning programs, and ongoing research at the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto. As more of this research is published and shared, more work can be undertaken. The need for greater knowledge translation was highlighted by many of the physicians interviewed. It is hoped that this current study can contribute to the evidence necessary for physicians to capitalize on opportunities to address the social determinants of health and health equity.

Community Health Centre Model

Many of the physicians interviewed practised in community health centre models. These facilities integrate a number of health and social services in an interdisciplinary team setting. Physicians are generally paid a salary to allow greater flexibility in addressing patient needs. Providers work collaboratively to address the often complex needs of their patients and to identify the best course of action. Centres are usually located in areas of disadvantage and have flexible hours to accommodate patients who have faced barriers to access. This model incorporates all three of the practice design facilitators identified by interviewed physicians. More information on this model is available at: www.cachc.ca/

Areas for action

In the course of the interviews, participants identified a number of areas for action. Interviewees saw a key role for CMA and other national medical groups in advocating for health equity issues. They identified the need for a comprehensive and strategic approach. Some felt there was a need to frame the social and economic concerns of patients as a basic health campaign. In addition to this advocacy, many felt that a national organization could take the lead in facilitating the development and dissemination of other key supports. A preliminary list of potential actions is provided below.

These actions should not be seen as a complete list but merely suggestions that will require further refinement and discussion. Experts will need to be assembled to ensure that any interventions, tools or programs are as effective as possible. In addition to the interventions discussed above, these suggestions underline the sheer volume of work that can be done by physicians and physician organizations to address health equity in Canada.

Area of interest	Potential action(s)
Clinical practice	• Development/refinement of health equity/social determinants of health assessment tool • Development/modification of clinical practice guidelines to integrate social and economic factors into medical care • Development of resources for physicians on programs and services for patients • Development of resources for physicians on accessing provincial/territorial and federal programs including forms and referral pathways, etc. • Development/consolidation and dissemination of plain language resources for patients on chronic disease management
Education	• Support and encouragement of the integration of the social determinants and health equity in medical schools • Support and encouragement of service learning in medical schools and residency training • Development of an accredited continuing medical education programs for practising physicians
Compensation	• Identification of effective compensation models for health equity practice in Canada • Development of these models for other jurisdictions and practice settings
Research	• Support of continued research on physician interventions in health equity • Help to assemble the evidence base and best practices and facilitate knowledge translation across Canada and internationally
Advocacy and communications	• Develop a national network of health equity physicians • Develop an advocacy strategy for health equity in Canada • Develop an advocacy map/tool for clinicians • Explore the development of health equity leadership and advocacy training resources for physicians

Conclusion

Socio-economic factors play a larger role in creating (or damaging) health than either biological factors or the health care system. Improvements in the social and economic conditions of Canadians and greater equity within the health system are key strategies if population health is to be improved and the sustainability of the health sector is to be ensured. The physicians interviewed for this study have identified a series of opportunities for action by physicians across the country, both in practice and through continued advocacy. It is hoped that these interventions will provide Canada's doctors with a toolbox to address challenges for their patients that are often overlooked. Barriers identified will need to be addressed, and successful facilitators will need to be expanded and shared across the health sector. Leadership at the national level is necessary to promote change and provide a sharing of knowledge among all stakeholders. Physicians have long been respected leaders in the health care system in their communities and at the provincial/territorial and federal levels. This research demonstrates that they possess the necessary skills to undertake greater leadership in speaking out and addressing the social factors that have such a profound health impact. Action in areas of clinical practice, education, compensation, research, and advocacy and communication will allow Canada's physicians to be active agents for change and will help them provide a voice to those who are often powerless to speak for themselves. These initiatives will allow physicians to play a significant role in ensuring health care transformation in Canada.

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Appendix I: Interview protocol

Clinic name _____

Address _____

Principle contact _____

Contact phone number _____

Thank you for agreeing to speak with me. The focus of this interview is on the practical actions that physicians can take to help address the health inequalities that arise from disparities in the social determinants of health/socio-economic status within their practice and their communities. We would like to collect success stories and examples of innovations, programs or practice policies that we hope can be translated to other physicians for use in their practices.

There are sixteen open-ended questions. There are no right or wrong answers – I am collecting descriptions and experiences in order to prepare a background paper that we will provide to the Board and General Council of the Canadian Medical Association regarding the potential for Canadian physicians to create greater health equality in their practices.

Documents provided to the General Council may be seen by members of the public and the press. The names of individuals will not be used. Please indicate if you prefer that the clinic is anonymized in any written report.

In the event that we would like to identify your practice or practice location, we will provide you with a copy of the draft documents so that you may review the content, and we will seek specific permission before publication to a larger audience.

Before beginning, I would like to clarify one definitional issue. In several of the questions I have used the phrase "practice population." I would define this as the number of patients for whom you have an active chart (i.e., they come in to see you at least once in the last two years). If you are in group practice, you can answer either about

- ❑ Your own roster of patients or
- ❑ The entire group practice of patients, whichever you prefer

Demographics

Goal of Questions — We need information to help us describe the type of practice in which the intervention is used. We need to know the composition/type of the practice, as well as get a sense of the patient population served, e.g., under-serviced populations, visible minorities or special risk populations, neighborhood vs. client chosen site.

1. Is this clinic a particular category of clinic? [e.g., Community Centre, Family Health Team, etc.]
2. How many physicians (FTE) work in this clinic setting?
3. How many and what type of other professionals work in this clinic setting?
4. Roughly how large is your practice population?

5. Describe the population served by your practice (e.g., under-serviced populations, visible minorities or special risk populations, neighborhood vs. self-referral).What would you consider to be some of the determinants of their level of health?
6. Are you able to readily determine this from some form of database (e.g., electronic medical record)?

Opportunities for intervention

Goal of Questions — to describe the intervention used to address health inequality AND the essential facilitators of the interventions.

7. What opportunities would you say that you as a primary care physician have to address these determinants of health and the resulting health inequalities? Can you provide any specific examples?
8. Did you work with other academic or health services to develop the intervention or was it initiated internally? Was there a formal process for implementation? Evaluation? Has the intervention been published?
9. What are the facilitators and barriers for carrying out this work?
10. Are there other physicians or groups that you think we should speak to?
11. If the Canadian Medical Association were to create a network of health equity physicians, would you be interested in participating?

Linkages to other sectors

Goal of questions — We need to know about linkages to other sectors because part of our underlying theory is that interventions for health equality will include agencies from outside of the health care sector. We need to know how they 'grew' the linkages so that we can provide 'tips' to other clinicians who may wish to adopt the intervention.

12. Which health and social service agencies provide support to your practice population?
13. Do you have any links or referral mechanisms with these agencies or is it more of an informal relationship?
14. What were the facilitators in establishing linkages with health and social service agencies?
15. What were (or are) the barriers that limit your ability to work well with health and social service agencies?

Recommendations for other physicians

16. What recommendations would you make to other physicians who are interested in taking a more active role in addressing the social determinants and health inequalities in their practices?

Appendix II: Interview participants

Dr. David Allison	Public health — medical officer of health, Eastern Health	Mount Pearl, NL
Dr. Anne Andermann	Family physician — public health — chair, Community Oriented Primary Care Committee, Family Medicine Centre, St. Mary's Hospital; assistant professor, Department of Family Medicine, Faculty of Medicine, McGill University; regional medical officer, First Nations and Inuit Health Branch, Health Canada, Quebec Region; public health physician, Regional Public Health Department, Cree Health Board (CBHSSJB)	Montreal
Dr. Philip Berger	Family physician — St. Michael's Family Health Team; medical director, St. Michael's Inner City Health program; chief, St. Michael's Hospital, Department of Family and Community Medicine	Toronto
Dr. Gary Bloch	Family physician — St. Michael's Family Health Team; St. Michael's Inner City Health program; assistant professor, Department of Family and Community Medicine; University of Toronto, Health Providers Against Poverty	Toronto
Dr. Rob Bourrier	Family physician — Sandy Hill Community Health Centre	Ottawa
Dr. Vanessa Brcic	Family physician — Clinician Scholar Program, Department of Family Practice; Clinical Assistant Professor, University of British Columbia; locum in rural and urban interdisciplinary practices	Vancouver
Dr. Margaret Casey	Family physician — The North End Community Health Centre (worked at the clinic for 25 years, former director, retired)	Halifax
Dr. Jean Clinton	Psychiatrist — associate clinical professor, Department of Psychiatry and Behavioural Neuroscience, McMaster University, division of Child Psychiatry; staff, McMaster Children's Hospital; associate, Department of Family Medicine at McMaster; associate, Department of Child Psychiatry, University of Toronto and Sick Children's Hospital; associate member, Offord Centre for Child Studies.	Hamilton
Dr. Stephen Darcy	Family physician — Shea Heights Community Health Centre — Academic CHC	St. John's
Dr. Kathryn Dong	FRCP emergency medicine — Royal Alexandra Hospital; faculty, Department of Emergency Medicine; faculty, Medicine and Dentistry, University of Alberta; co-director, Edmonton Inner City Health Research and Education Network; founder and mentor of inner city health elective, residency program at Faculty of Medicine and Dentistry, University of Alberta	Edmonton
Dr. Norah Duggan	Family physician — Shea Heights Community Health Centre — Academic CHC, assistant professor, Faculty of Medicine, Memorial University	St. John's
Dr. Anne Durcan	Family physician — Mount Carmel Clinic (CHC), Inuit Health Program of the J.A. Hildes Northern Medical Unit, University of Manitoba	Winnipeg
Dr. Cathy Felderhof	Family physician — Pictou Landing First Nation Health Centre, Canso Medical Centre, Eastern Memorial Hospital, Canso	New Glasgow, NS & Canso, NS
Dr. Elizabeth Lee Ford Jones	Pediatrician — infectious diseases specialist and clinical researcher, The Hospital for Sick Children, Department of Pediatrics; professor, Pediatrics, University of Toronto; head, Social Pediatrics, The Hospital for Sick Children, Toronto	Toronto
Dr. John Haggie	General surgeon, chief of staff, James Paton Memorial Hospital CMA past president	Gander
Dr. Trevor Hancock	Public health — professor and senior scholar, School of Public Health and Social Policy, University of Victoria; former public health consultant, BC Ministry of Health	Victoria
Dr. Anne Houstoun	Family physician–obstetrics — The North End Community Health Centre	Halifax

Dr. Gilles Julien	Pediatrician — Centres de pédiatrie sociale (one of the founders of social pediatrics in Canada), Department of Pediatrics, McGill University	Montreal
Dr. Jill Konkin	Family physician — associate dean, Community Engagement (responsible for indigenous, inner city, global and rural health); Faculty of Medicine and Dentistry, University of Alberta; rural Alberta practice for 16 years and continues to do rural locums	Edmonton
Dr. Sandy MacDonald	Family physician and anesthetist — Qikiqtani General Hospital; director, Medical Affairs, Department of Health and Social Services, Government of Nunavut	Iqaluit
Dr. Kwame McKenzie	Psychiatrist — senior scientist, Social Equity and Health Research section; deputy director, Continuing and Community Care Schizophrenia Program, Centre for Addictions & Mental Health; professor, Department of Psychiatry, University of Toronto	Toronto
Dr. Ryan Meili	Family physician — Westside Community Clinic; head, Division of Social Accountability, College of Medicine, University of Saskatchewan; co-founder, Student Wellness Initiative Toward Community Health (SWITCH) — student run health centre — and Making the Links program for medical students	Saskatoon
Dr. Len Moore	Family physician — Sandy Hill Community Health Centre	Ottawa
Dr. Cory Neudorf	Public health — chief medical health officer, Saskatoon Health Region; assistant professor, College of Medicine — Department of Community Health and Epidemiology, University of Saskatchewan	Saskatoon
Dr. Susan Phillips	Family physician — Queen's Family Health Team; faculty, Department of Family Medicine, Queen's University; member CFPC Equity and Diversity Committee	Kingston
Dr. Jane Philpott	Family physician — Health for All (Family Health Team); Markham Family Medicine Teaching Unit, University of Toronto Department of Family and Community Medicine; founder of "Give a Day to World AIDS" movement	Markham
Dr. Andrew Pinto	Family physician — PH — St. Michael's Family Health Team; family physician and public health and preventive medicine specialist,St. Michael's Hospital; research fellow at the Centre for Research on Inner City Health; Health Providers Against Poverty	Toronto
Dr. Brian Postl	dean of medicine, University of Manitoba	Winnipeg
Dr. Anna Reid	ER — emergency physician, Stanton Territorial Hospital, Yellowknife; CMA President	Yellowknife
Dr. Todd Sakakibara	Family physician — Three Bridges Community Health Centre; associate director, Division of Inner City Medicine, University of British Columbia, Department of Family Practice; mentor, Community Health Initiative by University Students	Vancouver
Dr. Konia Trouton	Family physician — Vancouver Island Woman's Clinic; member, College of Family Physicians of Canada Equity and Diversity Committee	Victoria
Dr. Jeff Turnbull	Internal medicine — founder and medical director, Ottawa's Inner City Health Project, Chief of Staff, Ottawa Hospital, former CMA president	Ottawa