Addressing health inequities

A case for implementing primary health care

Carmel M. Martin MB BS MSc PhD MRCGP **Terry Kaufman** LLB

The year 2008 is the 30th anniversary of the World Health Organization's 1978 Declaration of Alma-Ata on primary health care.[1] This declaration draws our attention to the global burden of health inequities not only in poor underdeveloped countries but also in rich developed countries; these health inequities constitute a considerable barrier to improving the health status of the overall population. The literature demonstrates that addressing health inequities has the potential to contain escalating health costs as well as to develop a healthy and peaceful civil society.[2] Specifically, Marmot, in a consensus statement based on international research findings with the Commission on Social Determinants of Health, asserts the following:

> Strengthening health equity—globally and within countries—means going beyond contemporary concentration on the immediate causes of disease .... The time for action is now, not just because better health makes economic sense, but because it is right and just.[2]

Reduced focus

Primary care is a patient's first point of entry into the health system. Traditionally, it is organized around family practices and family physicians, but it is being practised increasingly by nurses and other health care providers.[3] Family physicians provide first-contact treatment in offices and also deliver services in the home and in long-term care facilities—as well as a substantial amount of secondary and tertiary care, particularly in rural and remote settings.[4] *Primary health care*, a term derived from the 1978 Alma-Ata declaration,[1] is the strategy most likely to address the social determinants of health and health inequalities in health systems internationally. The declaration integrated the strategy of primary care as a level of first-contact health care services into a broader strategy for equitable health development for all.

Key policy makers have advocated system redesign for primary health care with a multidisciplinary work force.[5,6] Since 2000, federal, provincial, and territorial governments have substantially invested in a Primary Health Care Transition Fund.[7] Internationally, ongoing reforms to primary care services have brought improvements, including better management of some common diseases, some shorter wait times, and faster electronic communication.[8] However, these reforms in countries such as the United Kingdom have had unintended outcomes (eg, generating little or no effect on widening health disparities) and have been associated with undesired shifts in care for some chronic conditions.[9,10] Yet renewed interest and debate about the primary health care transition have focused on expanding the breadth of primary care and increasing health care accountability, with little attention to addressing health inequalities and social determinants of health.[11]

Canada has been a world leader in research related to the social determinants of health. According to the Canadian Population Health Initiative of the Canadian Institute for Health Information, however, "Canada has fallen behind countries, such as the United Kingdom and Sweden and even some jurisdictions in the United States, in applying the population health knowledge base that has been largely developed in Canada."[12] In the United Kingdom, there have long been aspirations to address the determinants of health and health inequities.[13] However, emerging evidence reveals that the reform strategies focusing on implementing primary care, such as pay-for-performance based on selected performance indicators, are not necessarily addressing health inequities.[14]

Reasons to consider

A range of compelling evidence from Canada and other countries indicates that the social and economic circumstances of individuals and groups influence their health status and mortality as much as or more than health care. These circumstances affect the success rate of interventions to change personal health behaviour, such as smoking and diet,[12,15,16] or of improved outcomes of chronic disease management.[17] Addressing health inequities is strongly associated with the improvement of health care outcomes.[17]

Social determinants of health have a direct effect on the health of individuals and populations, are the best predictors of individual and population health, structure lifestyle choices, and work interactively to produce health.[16] In terms of the health of populations, it is well known that disparities—the size of the gap of inequality

CFPlus GO La traduction en français de cet article se trouve à **www.cfp.ca**. Allez au texte intégral (full text) de cet article en ligne, puis cliquez sur **CFPlus** dans le menu en haut, à droite de la page.

in social and economic status between groups within a given population—greatly affect the health status of the whole: the larger the gap, the lower the health status of the overall population.[18]

Health has been defined as "the extent to which an individual, family or community is able to realize aspirations and satisfy needs to cope with their environment."[1] Health inequities or disparities of health are the "systematic differences (potentially remediable) in one or more aspects of health across population groups defined socially, economically, demographically, or geographically."[19,20]

Social determinants of health include the following: income and social status; social support networks; education and literacy; employment and working conditions; and social and physical environments. Other health determinants include personal health practices and coping skills, healthy child development, biology and genetic endowment, and gender and culture. The presence and quality of health services are also recognized as determinants of health.[21]

The evidence for the value of primary health care to address the social, economic, and political determinants of poor health has emerged during the 20th century[22,23]; in more recent times, relevant analyses by many—including Starfield et al and De Maeseneer et al, culminating in a synthesis paper by the Health Knowledge Network of the World Health Organization, repeatedly demonstrated better health outcomes.[24-26] In 2005, Canada and the other government members of the Pan American Health Organization affirmed their commitment to new orientations for primary health care by signing the Declaration of Montevideo.[20]

Taking part

We propose a local primary health care approach, derived from the Pan American Health Organization's declaration,[20] that builds on the care currently provided by individual practitioners and community health centres and moves toward addressing health inequities. At the core of the system is an understanding of local population health determinants and inequities of health outcomes, as well as local primary care demands for services. With the developments in information technology, the horizontal interconnecting of local providers is realistic and feasible; such interconnecting is essential to collectively address local needs, rather than, as at present, individuals and groups working in local organizational silos. This networking would build on existing and successful collective enterprises to deliver after-hours care, improve quality and safety of individual disease management, and link with public health initiatives to extend toward implementing strategies that address the factors contributing to the genesis and evolution of disease and health outcomes.[25]

The following are ways in which family physicians in partnerships within adaptive networks of primary health care providers can take a broader role in other aspects of primary health care:

- Lead and participate in community partnerships to identify health disparities in local populations, and prioritize and address these disparities.
- Ensure each primary health care system explicitly addresses local public health problems related to nonmedical determinants of health (eg, lifestyle factors) and, where feasible, secondary and tertiary health care disparities.
- Develop and support interconnected programs to explicitly address social and economic barriers to adherence to common chronic disease treatment and self-management (eg, diabetes, arthritis, chronic obstructive pulmonary disease, congestive heart failure, mental illness) outside of the practice, which address the determinants of health.
- Develop and support programs that explicitly address barriers to access and health care adherence for "hard to reach" populations.
- Ensure undergraduates, residents, and practising physicians have resources to develop the appropriate skills and competencies to reduce gaps in health disparities in partnership with other agencies.
- Stimulate and participate in the intersectorial arrangements and programs in each primary health care system to address the needs of each of the disadvantaged groups (eg, homeless, recent immigrants, drug addicts, adolescents with legal and educational problems), according to local context and priorities.
- Participate in and collaborate on community partnerships, identifying and solving health-related problems with vertical integration in relation to the community's social environment (eg, violence, lack of day care) and physical environment (eg, personal security, housing, nonmedical social determinants).

The lack of an articulated pan-Canadian framework for primary health care leaves serious potential gaps in any future transition to an effective primary health care system. In order to address the publicly stated goals of improving health, attention needs to be paid to the principles of equity, access, empowerment, community self-determination, and vertical and horizontal integration within the system. The unintended consequences of resources being directed to improving the average quality of primary care ultimately leads to widening health inequities.

By taking up the challenge of the new orientations of primary health care, which have already been agreed upon by the government of Canada through its international commitments, family physicians can take a leading role in addressing health inequities.

Dr Martin is an Associate Professor of Family Medicine in the Clinical Sciences Division at the Northern Ontario School of Medicine in Ottawa, Ont. **Mr Kaufman** is a member of the Board of Directors of Canadian Alliance of Community Health Centre Associations.

Competing interests
None declared

Correspondence
Dr Carmel Martin, Northern Ontario School of Medicine, Clinical Sciences Division, 238 Bruyère St, Ottawa, ON K1N 5E3; telephone 613 878-7372; fax 613 482-4609; e-mail **cmartin@NorMed.ca**

References

1. World Health Organization. *Primary health care. Report of the International Conference on primary health care, Alma-Ata, USSR, 6-12; September 1978.* Geneva, Switz: World Health Organization; 1978.
2. Marmot M, Commission on Social Determinants of Health. Achieving health equity: from root causes to fair outcomes. *Lancet* 2007;370(9593):1153-63.
3. Keleher H. Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. *Aust J Prim Health* 2001;7(2):57-61.
4. College of Family Physicians of Canada. *Primary care and family medicine in Canada. A prescription for renewal*. Mississauga, ON: The College of Family Physicians of Canada; 2000. Available from: **www.cfpc.ca/English/cfpc/communications/health%20policy/primary%20care%20and%20family%20medicine/default.asp?s=1**. Accessed 2008 Sep 17.
5. The Standing Senate Committee on Social Affairs. *The health of Canadians—the federal role. Final report. Volume six. Recommendations for reform*. Ottawa, ON: Government of Canada; 2002. Available from: **www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/rep-e/repoct02vol6-e.htm**. Accessed 2008 Sep 17.
6. Romanow RJ. *Building on values. The future of health care in Canada. Final report.* 2002. Ottawa, ON: Commission on the Future of Health Care in Canada; 2002. Available from: **www.cbc.ca/healthcare/final_report.pdf**. Accessed 2008 Sep 17.
7. Health Canada. *Primary Health Care Transition Fund. Funded initiatives*. Ottawa, ON: Health Canada; 2007. Available from: **www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index-eng.php**. Accessed 2008 Sep 17.
8. British Medical Association. *Quality and outcomes framework, 2006*. London, Engl: British Medical Association; 2006. Available from: **www.bma.org.uk/ap.nsf/Content/focusqoffeb06**. Accessed 2008 Sep 17.
9. Ashworth M, Armstrong D. The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework, 2004-5. *BMC Fam Pract* 2006;7(1):68.
10. Gulliford MC, Ashworth M, Robotham D, Mohiddin A. Achievement of metabolic targets for diabetes by English primary care practices under a new system of incentives. *Diabet Med* 2007;24(5):505-11. Epub 2007 Mar 22.
11. Ballem P. Guaranteeing accountability for quality care. *Healthc Pap* 2007;7(4):61-5.
12. Raphael D. Social determinants of health: an overview of concepts and issues. In: Raphael D, Bryant T, Rioux M, editors. *Staying alive. Critical perspectives on health, illness, and health care*. Toronto, ON: Canadian Scholars' Press; 2006. p. 115-38.
13. Smeeth L, Heath I. Why inequalities in health matter to primary care. *Br J Gen Pract* 2001;51(467):436-7.
14. McLean G, Guthrie B, Sutton M. Differences in the quality of primary medical care for CVD and diabetes across the NHS: evidence from the quality and outcomes framework. *BMC Health Serv Res* 2007;7:74.
15. Bartley M, Plewis I. Accumulated labour market disadvantage and limiting long-term illness: data from the 1971-1991 Office for National Statistics' Longitudinal Study. *Int J Epidemiol* 2002;31(2):336–41.
16. Raphael D. Social determinants of health: present status, unanswered questions, and future directions. *Int J Health Serv* 2006;36(4):651-77.
17. Bottle A, Gnani S, Saxena S, Aylin P, Mainous AG 3rd, Majeed A. Association between quality of primary care and hospitalization for coronary heart disease in England: national cross-sectional study. *J Gen Intern Med* 2008;23(2):135-41. Epub 2007 Oct 9.
18. Marmot M. Social determinants of health inequalities. *Lancet* 2005;365(9464):1099-104.
19. International Society for Equity in Health [website]. Guatemala, Guatemala: International Society for Equity in Health; 2005. Available from: **www.iseqh.org**. Accessed 2008 Sep 24.
20. Pan American Health Organization, World Health Organization. *Regional declaration on the new orientations for primary health care.* (Declaration of Montevideo). September 26-30 2005. Available from: **www.paho.org/English/GOV/CD/cd46-decl-e.pdf**. Accessed 2008 Sep 17.
21. Public Health Agency of Canada. *Determinants of health*. Ottawa, ON: Public Health Agency of Canada; 2007. Available from: **www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php**. Accessed 2008 Oct 8.
22. Tarimo E, Webster EG. *Primary health care concepts and challenges in a changing world: Alma-Ata revisited*. Geneva, Switz: World Health Organization; 1994.
23. Sanders D. Twenty-five years of primary health care lessons learned and proposals for revitalization. *Health for the Millions* 2004;30(4-5):15-21.
24. Starfield B, Shi L, Macinko J. Contribution of primary health care to health systems and health. *Milbank Q* 2005;83(3):457-502.
25. De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M. *Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Knowledge Network*. Witwatersrand, South Africa: Health Systems Knowledge Network; 2007. Available from: **www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf**. Accessed 2008 Sep 17.
26. Gilson L, Doherty J, Loewenson R, Francis V; WHO Commission on the Social Determinants of Health. *Challenging inequity through health systems. Final report knowledge network. June 2007*. Geneva, Switz: World Health Organization; 2007. Available from: **www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf**. Accessed 2008 Oct 8.