ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

CMA POLICY

CMA POSITION STATEMENT
ENSURING EQUITABLE ACCESS TO CARE: STRATEGIES FOR GOVERNMENTS, HEALTH SYSTEM PLANNERS, AND THE MEDICAL PROFESSION

Executive Summary:

Ensuring equitable access to effective and appropriate health care services is one strategy which can help to mitigate health inequities resulting from differences in the social and economic conditions of Canadians.

Equitable access can be defined as the opportunity of patients to obtain appropriate health care services based on their perceived need for care. This necessitates consideration of not only availability of services but quality of care as well.[1]

There is far ranging evidence indicating that access to care is not equitable in Canada. Those with higher socio-economic status have increased access for almost every health service available, despite having a generally higher health status and therefore a decreased need for health care. This includes insured services (such as surgery), as well as un-insured services such as pharmaceuticals and long-term care.

Those from disadvantaged groups are less likely to receive appropriate health care even if access to the system is available. They are more likely to report trouble getting appointments, less testing and monitoring of chronic health conditions, and more hospitalizations for conditions that could be avoided with appropriate primary care. There is a financial cost to this disparity in equitable care. Reducing the differences in avoidable hospitalizations alone could save the system millions of dollars.
Barriers to equitable access occur on both the patient and health care system or supply side. Common barriers include:

Demand Side or Patient Barriers
Health literacy
Cultural beliefs and norms
Language
Cost of transportation
Time off work for appointments
Access to child care
Payment for medications or other medical devices/treatments
Immobility- due to physical disabilities, and/or mental health barriers
Cognitive issues, ie. Dementia, that adversely affect ability to access and comply with care

Supply Side or System Barriers
Services not located in areas of need
Patients lack family physicians
Lack of management of chronic disease
Long waits for service
Payment models which don't account for complexity of patients
Coordination between primary care and speciality care and between health care and community services
Standardization of referral and access to specialists and social services
Lack of needs based planning to ensure that population has necessary services
Attitudes of health care workers

To tackle barriers on the patient side there is a need to reduce barriers such as transportation and the prohibitive cost of some medically necessary services. Further, there is a need to increase the health literacy of patients and their families/caregivers as well as providing support to health care providers to ensure that all patients are able to be active participants in the management of their care.

On the system side the strategies for action fall into four main categories: patient-centred primary care which focuses on chronic disease management; better care coordination and access to necessary medical services along the continuum of care; quality improvement initiatives which incorporate considerations of equity as part of their mandate; and health system planning and assessment which prioritizes equitable access to care. Recommendations are provided for CMA and national level initiatives; health care planners; and physicians in practice.

Despite a commitment to equal access to health care for all Canadians there are differences in access and quality of care for many groups. By removing barriers on both the patient and system side it is hoped that greater access to appropriate care will follow.

Introduction:

In Canada as in many countries around the world there are major inequities in health status across the population. Those lower on the socio-economic scale face higher burdens of disease, greater disability and even shorter life expectancies.[2] Many of these disparities are caused by differences in social and economic factors such as income and education known as the social determinants of

health.[3],1 While many of these factors are outside of the direct control of the health care system, ensuring equitable access to effective and appropriate health care services can help to mitigate some of these disparities. The alternative can also be true. In health systems where access to care and appropriateness are unequal and skewed in favour of those of higher socio-economic status, the health system itself can create further inequities and add greater burden to those already at an increased risk of poor health. Physicians as leaders in the health care system can play a role in ensuring equitable access to care for all Canadians.

Equitable Access to Health Care in Canada:

Equitable access can be defined as the opportunity for patients to obtain appropriate health care services based on their perceived need for care. This necessitates consideration of not only availability of services but quality of care as well.[4]

Due to burden of disease and therefore need, those with lower socio-economic status should be utilizing more services along the continuum.[5] That, however, is not the case. Individuals living in lower income neighbourhoods, younger adults and men are less likely to have primary care physicians than their counterparts.[6]

Primary care physicians deliver the majority of mental illness treatment and they are the main source of referrals to psychiatrists or other specialists. However, much of the care for people with mental illnesses, especially on the lower socio-economic end of the scale, is delivered in emergency rooms, which is both costly and episodic. This is due not only to a lack of primary care access but to a lack of community mental health services.[7]

Those with higher socio-economic status are much more likely to have access to and utilize specialist services.[8] Examples include greater likelihood of catheterization and shorter waits for angiography for patients with myocardial infarction[9]; and greater access to in-hospital physiotherapy, occupational therapy, and speech language therapy for those hospitalized with acute stroke[10]. Low income men and women with diabetes were just as likely to visit a specialist for treatment as high income individuals despite a significantly greater need for care.[11]

There is a correlation between higher income and access to day surgery.[12] A Toronto study found that inpatient surgery patients were of much higher income than medical inpatients.[13] Additionally, utilization of diagnostic imaging services is greater among those in higher socio-economic groups.[14] Access to preventive and screening programs such as pap smears and mammography are lower among disadvantaged groups.[15]

Geography can cause barriers to access. In general rural Canadians have higher health care needs

1 This paper represents a focus on equitable access to care. For a more general policy statement on the role of physicians in addressing the social determinants of health please see: Canadian Medical Association. Health Equity and the Social Determinants of Health: A Role for the Medical Profession. Ottawa, ON; 2012. Available: http://policybase.cma.ca/dbtw-wpd/Policypdf/PD13-03.pdf

but less access to care.[16] People in northern and rural communities typically have to travel great distances to obtain health services as many, especially specialist services, cannot be obtained in their home community.[17] Those living in the most rural communities in Canada are the least likely to have a regular family doctor, or to have had a specialist physician visit.[18] According to data from the Society of Rural Physicians of Canada, 21% of the Canadian population is rural while only 9.4% of family physicians and 3% of specialists are considered rural.[19] This lack of access to specialists and other medically necessary services can lead to delays in treatment and harm to health including unnecessary pain and permanent disability.[20] Further, travel for necessary treatment often comes with a significant financial cost.[21]

It is not just access to insured services that is a problem in Canada. Many Canadians do not have access to needed pharmaceuticals. Researchers have reported that those in the lowest income groups are three times less likely to fill prescriptions, and 60% less able to get needed tests because of cost.[22] The use of appropriate diabetes preventative services, medication, and blood glucose testing, has been shown to be dependent on out of pocket expenditures.[23]

Rehabilitation services are difficult for some Canadians to access as well. Services such as physiotherapy and occupational therapy are often not covered unless they are provided in-hospital or to people on certain disability support programs. This leads to long wait times for services that are covered or no access at all.[24] Adding to these inequities is the fact that different programs are covered in different provinces and territories.[25]

Access to mental health services is a major challenge for Canadians. According to data from Statistics Canada, more than half a million Canadians who had a perceived need for mental health care services, reported that their needs were unmet. Access to counselling services was the most frequent unmet need reported.[26] A number of important mental health professionals – notably psychologists and counsellors - are not funded through provincial health budgets, or are funded only on a very limited basis. Access to psychologists is largely limited to people who can pay for them, through private insurance or out of their own pockets.[27],[2]

Access to subsidized residential care, long-term care, home care and end-of-life care is problematic as well. Those with means can access high quality long-term care services within their community, while those with inadequate resources are placed in lower quality facilities sometimes hours away from family and friends.[28] Even with expansions promised by governments, home care will not be able to meet the needs of underserved groups such as those living in rural and remote areas.[29] Finally, only a fraction of patients have access to or receive palliative and end-of-life care. Those living in rural or remote areas or living with disabilities have severely limited access to formal palliative care.[30]

Difficulties in access are particularly acute for Canada's Aboriginal peoples. Many live in communities with limited access to health care services, sometimes having to travel hundreds of

2 The Canadian Medical Association is currently developing a policy paper on access to mental health services in Canada. It is anticipated that this policy statement will be completed in 2014.

miles to access care.[31] Additionally, there are jurisdictional challenges; many fall through the cracks between the provincial and federal health systems. While geography is a significant barrier for Aboriginal peoples, it is not the only one. Aboriginals living in Canada's urban centres also face difficulties. Poverty, social exclusion and discrimination can be barriers to needed health care. Of all federal spending on Aboriginal programs and services only 10% is allocated to urban Aboriginals. This means that Aboriginals living in urban areas are unable to access programs such as Aboriginal head start, or alcohol and drug services, which would be available if they were living on reserve.[32] Further, even when care is available it may not be culturally appropriate. Finally, Canada's Aboriginal peoples tend to be over-represented in populations most at risk and with the greatest need for care, making the lack of access a much greater issue for their health status.[33]

However, these examples are only part of the story as accessing care which is inappropriate cannot be considered equitable access.[34] Those of lower socio-economic status are more likely to use inpatient services; show an increased use of family physician services once initial contact is made;[35] and have consistently higher hospitalization rates; [36] This could be due to the higher burden of need or could demonstrate that the services that are received are not addressing the health care needs of those lower on the socio-economic scale.[37]

Women and men from low-income neighbourhoods are more likely to report difficulties making appointments with their family doctors for urgent non-emergent health problems. They were also more likely to report unmet health care needs.[38] In terms of hospitalizations, people with lower socio-economic status were much more likely to be hospitalized for ambulatory care sensitive conditions (ACSC) and mental health[39]; admissions which could potentially be avoided with appropriate primary care.[40] They were also found to have on average longer lengths of stay.[41] According to a study of hospitals in the Toronto Central Local Health Integration Network, patients considered to be Alternate Level of Care were more likely to have a low-income profile.[42]

Further, people with ACSC in low-income groups, those living in rural areas, or those with multiple chronic conditions were twice as likely to report the use of emergency department services for care that could have been provided by a primary care provider.[43]

There is a financial cost to this disparity. According to a 2011 report, low-income residents in Saskatoon alone consume an additional $179 million in health care costs than middle income earners.[44] A 2010 study by CIHI found increased costs for avoidable hospitalizations for ambulatory care sensitive conditions were $89 million for males and $71 million for females with an additional $248 million in extra costs related to excess hospitalizations for mental health reasons.[45]

Areas for Action:

As the background suggests, equitable access is about more than just utilization of services. There are patient characteristics as well as complex factors within the health system which determine whether equitable access is achieved. Recent work has categorized access as having considerations on the supply of services and demand of patients for care. On the demand or patient side we must consider: ability to perceive; ability to seek, ability to reach, ability to pay, and ability to engage. On

the supply side or health system considerations include: approachability; acceptability, availability and accommodation, affordability, and appropriateness. [46] The following table highlights some of the current barriers to equitable access.

Demand Side or Patient Barriers	Supply Side or System Barriers
Health literacy	Services not located in areas of need
Cultural beliefs and norms	Patients lack family physicians
Language	Lack of management of chronic disease
Cost of transportation	Long waits for service
Time off work for appointments	Payment models which don't account for complexity of patients
Access to child care	Coordination between primary care and speciality care and between health care and community services
Payment for medications or other medical devices/treatments	Standardization of referral and access to specialists and social services
Immobility- due to physical disabilities, and/or mental health barriers	Lack of needs based planning to ensure that population has necessary services
Cognitive issues, ie. Dementia, that adversely affect ability to access and comply with care	Attitudes of health care workers

Patient based actions for improving equitable access:

Low health literacy can lead to difficulties for some Canadians in perceiving a need for care.[47] Evidence suggests that more than half of Canadian adults (60%), lack the capacity to obtain, understand and act upon health information and services in order to make health decisions on their own.[48] Many physicians are undertaking strategies to minimize this lack of health literacy among their patients. Examples include plain language resources as well as teach-back exercises which allow physicians to determine whether patients have fully understood the information provided.[49] These efforts should continue to be supported.

Understanding how the health system works and where to access services can be a problem for some individuals.[50] Beliefs about the need and value for certain services can also undermine the ability of patients in seeking care.[51] Work needs to be done to ensure that disadvantaged groups are aware of the services that are available to them and the benefits of taking preventative steps in their health.

Low-income Canadians are ten times more likely to report unmet needs of health care due to the cost of transportation.[52] Other barriers include a lack of child care, and ability to get time off work to attend necessary health appointments.[53] Strategies that provide patients with transportation to appointments or subsidies for such travel have seen some success. Extended office hours and evening appointments can increase access for those unable to take time off work. Additionally, programs that provide patients with home visits from health care providers can help to eliminate this barrier. Further support and expansion of these programs should be explored.

There is also the inability to pay for services not covered by provincial plans such as pharmaceuticals, physiotherapy and other rehabilitation services.[54] According to a 2005 report on diabetes in Canada, affordability and access to medical supplies was the biggest challenge for those Canadians living with diabetes.[55] Access to services such as mental health counselling, subsidized residential care, and long-term care are also hindered by the inability to pay.

Even if patients are able to obtain care they may not be able to fully engage. Language difficulties, low health literacy, cognitive challenges (ie. Dementia), cultural mores and norms, and discrimination or insensitivity of health care workers, may all act as barriers to full participation in care.[56] Efforts should be made to develop teaching methods to improve engagement of patients and their families/caregivers from disadvantaged groups.[57] Strategies to remove or minimize the barriers created by a lack of health literacy should be developed and shared with physicians and other health care providers. Further, programs which facilitate access to services including interpretation and translation of key health information should be supported.[58]

Finally, an understanding of a patient's cultural and social context is important. The Royal College of Physicians and Surgeons of Canada and the Association of Faculties of Medicine of Canada have developed training modules for physicians who will be working with Canada's Aboriginal peoples.[59] Similar programs have been developed by the Canadian Paediatric Society, and the Society of Obstetricians and Gynaecologists of Canada. More of this training is needed and should focus on groups who are likely to experience disadvantage in health care access and appropriateness.

Recommendations for action:

CMA and National Level Initiatives

The CMA recommends that:

1. Governments develop a national strategy for improving the health literacy of Canadians which takes into account the special needs of different cultures.

2. Governments provide accessible and affordable transportation options for patients requiring medical services when such services are unavailable locally.

3. Governments, in consultation with the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

4. Governments examine methods to ensure that low-income and other disadvantaged Canadians have greater access to needed medical interventions such as rehabilitation services, mental health, home care, and end-of-life care.

5. Governments explore options to provide funding for long-term care services for all Canadians.

6. Governments ensure that necessary interpretation and translation services are provided at all points of care.

Physicians in Practice

The CMA recommends that

7. Physicians be supported in addressing the health literacy of their patients and their families/caregivers.

8. Physician education programs continue to emphasize the important cultural and social contexts in which their patients live.

System based actions for improving equitable access:

On the system side there are two main areas that need to be addressed: making sure that people can access the services that they need (approachability, availability and accommodation, and affordability); and ensuring that once they have accessed the system that services are appropriate for their health needs (acceptability and appropriateness). Strategies for action include: patient-centred primary care which focuses on chronic disease management; better care coordination and greater access to necessary medical services along the continuum; quality improvement initiatives which incorporate equity as part of their mandate; and health system planning and assessment which prioritizes equitable access to care.

1. Patient-centred primary care which focuses on chronic disease management and which includes programs to increase access to those most at need.

Comprehensive primary care offers the biggest possibility for increasing equitable access and reducing health disparities. Data from a large population study in Ontario indicates that inequities in access to primary care and appropriate chronic disease management are much larger than inequities in the treatment of acute conditions.[60]

Currently many primary care services are located outside of the neighbourhoods with the greatest need for care. While some are accessible through public transportation, there is still a need for more convenient access for these communities. Community health centres (CHC) offer a good model for addressing this challenge through location in disadvantaged neighbourhoods and the provision of culturally appropriate care.[61] Additionally, CHCs offer a number of different health, and sometimes social services, under one roof making access to many different types of care more convenient for patients.

More work needs to be done to to reduce barriers in access to Canadians living in rural and remote

communities. Telemedicine is one strategy that has increased access for rural Canadians. The Ontario Telemedicine Network is one example of this innovative approach. Patients in rural communities can have access to specialists in urban centres through their local health providers. Examples include cardiac rehab follow-up, tele-homecare to support lifestyle changes, and psychiatric or mental health consultations.[62]

Programs which encourage recruitment and training of health professionals from rural and disadvantaged populations have been found to increase access as these individuals are more likely to return to their home communities to practice.[63]

Medical schools have been attempting to increase the diversity in their schools for a number of years. However, work still needs to be done. Data from the 2012 student component of the National Physician Survey shows that 278 of the 2000 students who responded to the survey (13.9%) come from families considered to be in the top 1% of earners in Canada. This is compared to only 46 (2.3%) of students whose family incomes place them in the bottom quintile of earners. [64]
One of the suggested strategies for increasing diversity in medical schools is increasing the knowledge about the medical profession among rural and disadvantaged young people. An innovative program in Alberta called Mini Docs allows children between the ages of six and 12 to learn about being a doctor and how to stay healthy. The children get to wear medical scrubs for the day and use harmless medical tools such as stethoscopes and bandages. The day long program is run by medical students.[65]

Strategies to remove financial barriers to access, such as scholarships, should be expanded. Further, there is a need to modify the admissions process to recognize the differences in access to programs such as MCAT preps and overseas volunteer experiences based on the availability of financial resources as well as the necessity of employment for some students while in medical school. This necessary employment may limit the time available for volunteer and community service.[66]
Another strategy that can be effective in increasing access is programs that seek to link primary care providers with unattached and underserved patients. Programs such as Health Care Connect in Ontario and the GP and Me program in British Columbia actively seek to link sometimes hard to serve patients to appropriate primary care.

The College of Family Physicians of Canada has developed a blueprint for comprehensive primary care for Canadians. The concept, a 'patient's medical home' seeks to link Canadians with a comprehensive health care team led by a family physician. These medical homes will take many forms but will be designed to increase both access and the patient-centredness of care.[67]
Another barrier to access is timeliness of service. Many patients are forced to use walk in clinics or emergency departments as they cannot receive the required care from their primary care providers. Use of walk-in clinics or emergency departments for primary care may lead to lost opportunities for prevention and health promotion.[68] Advanced access programs can help to improve equitable access to care by facilitating timely appointments for all patients.[69] The AIM (Access improvement measures) program in Alberta uses a system designed by the Institute for Healthcare Improvement to redesign practice to focus on same day appointments and elimination of unnecessary delays.[70]
Primary care which prioritizes chronic disease management offers the greatest potential for

increasing appropriateness of care and reducing system costs. Those most likely to have chronic diseases are also those who face the biggest barriers to equitable access.[71] Currently many people with ACSC do not receive the appropriate tests to monitor their conditions, management of their medications, or supports to self-manage their disease.[72] Some programs do exist to encourage more effective management of chronic disease. The Champlain Local Health Integration Network (LHIN) in Ontario has developed a cardiovascular disease prevention network to improve care through the use of evidence based practices and better integration between all areas of the health care continuum.[73] Primary Care networks in Alberta have similar goals designed to connect multiple physicians, clinics and regions together to support the health needs of the population.[74]

Further work is necessary to expand these types of programs and to provide appropriate compensation models for complex patients. Payment models in some jurisdictions undermine access by failing to take morbidity and co-morbidity into consideration in designing rates such as equal capitation.[75]

Finally, there is a need to encourage greater self-management of disease. Practice support programs in British Columbia are providing training to support physicians in increasing patient self-management and health literacy.[76] Additional programs of this nature are necessary in all jurisdictions.

2. Better care coordination and greater access to necessary medical services along the continuum of care.

Patient-centred care which integrates care across the continuum and which includes community services will be necessary to ensure not only greater access but greater acceptability of care.[77] Innovative programs focused on increasing the coordination in terms of transition from hospital to home have shown some success in preventing readmissions particularly when vulnerable populations are targeted.[78] Health Links in Ontario aims to reduce costs, based on the assumption that much of the utilization of high cost services, such as emergency department visits, could be prevented with better coordinated care. One of the pilot sites in Guelph aims to assign one person in primary care, likely a doctor or a nurse, to be the primary contact for patients deemed high need and to intervene on behalf of these patients to ensure better care coordination.[79]

Further work is needed to ensure greater coordination in speciality care. As the evidence demonstrates, access to specialist services are skewed in favour of high-income patients. To reduce this inequity it may be necessary to standardize the referral process and facilitate the coordination of care from the primary care providers' perspective.[80] A new program in British Columbia is designed to reduce some of these barriers by providing funding and support to rapid access programs which allow family physicians to access specialist care through a designated hotline. If no specialist is available immediately there is a commitment that the call will be returned within two hours. Specialists available through this program include cardiology, endocrinology, nephrology, psychiatry, and internal medicine among others.[81] Similar programs in other jurisdictions could help to increase coordination between primary and speciality care.

Care coordination is only part of the problem, however. There is also a need to increase the access to services that are medically necessary across the care continuum. These include a lifetime prevention schedule[82], diagnostic testing, specialty services, and access to appropriate rehabilitation services, mental health, long-term care and end of life care.

3. Quality improvement initiatives which incorporate considerations of equity as part of their mandate.

Equity has become a key component of many quality improvement initiatives around the world. The Health Quality Council Ontario identified nine attributes of a high-performing health system: safe, effective, patient-centred, accessible, efficient, equitable, integrated, appropriately resourced, and focused on population health.[83]

The POWER study, a large study of Ontario residents found that where there were targeted programs for quality improvement fewer inequities were observed. In particular they referred to the actions of Cancer Care Ontario and the Ontario Stroke Network. Both of these groups had undergone large quality improvement initiatives to standardize care and increase coordination of services through evidence-based guidelines and ongoing performance measurement. Considerations of accessibility and equity were specifically included. As a result of these efforts, the POWER study found that acute cancer and stroke care in Ontario were quite equitable.[84]

Similar efforts are underway in other jurisdictions. The Towards Optimized Practice initiative in Alberta supports efforts in medical offices to increase the use of clinical practice guidelines for care as well as quality improvement initiatives.[85] Encouraging more health services and programs to undertake such quality improvement initiatives could help to reduce the inequities in access for all Canadians.

4. Health system planning and assessment which prioritizes equitable access to care

Considerations of equity must be built specifically into all planning considerations. Too often services are designed without adequate consideration of the specific needs of disadvantaged groups. Planners need to do a better job of understanding their practice populations and tailoring programs to those most in need of care.[86] This planning should be done in consultation with other sectors that play a role in influencing the health of their practice populations.

Further, assessments of the equity and use of services is also needed. Some services may be designed in a way that is more appropriate for some than others, resulting in higher utilization among some groups and a lack of access for others.[87] Innovative work is taking place in the Saskatoon Health Region to try and understand these barriers. Health care services are undergoing specific health equity assessments to ensure that all services meet the needs of diverse populations. This includes looking at the full spectrum of services from preventative care and education programs to tertiary level care such as dialysis. In Ontario, the local health integration networks (LHIN) have now been tasked with developing equity plans for their services. Clear goals and performance measurements are part of this work.[88]

One of the tools available to support this work is a health equity impact assessment tool developed by the Ontario Ministry of Health and Long-Term Care. This tool is intended for use by organizations within the health system as well as those outside the system who will impact on the health of Ontarians. The main focus of the tool is to reduce inequities that result from barriers in access to quality health services. Additionally, it is designed to identify unintended health impacts, both positive and negative, before a program or policy is implemented.[89] Further work is needed to ensure that equity is included in the deliverables and performance management of health care organizations and provider groups across the country.[90]

To support these planning programs appropriate data will need to be collected. This data needs to be comprehensive for all services and needs to include specific data points which will allow planners as well as providers to understand the composition of their populations as well as measure and report on considerations of equity.[91]

Recommendations for action:

CMA and National Level Initiatives

The CMA recommends that:

9. Governments continue efforts to ensure that all Canadians have access to a family physician.

10. Appropriate compensation and incentive programs be established in all jurisdictions to support better management of chronic disease for all Canadians.

11. Governments provide funding and support to programs which facilitate greater integration between primary and speciality care.

12. With support from government, national medical organizations develop programs to increase standardization of care and the use of appropriate clinical practice guidelines.

13. Appropriate data collection and performance measurement systems be put in place to monitor equitable distribution of health services and greater appropriateness of care.

Health System Planners

The CMA recommends that:

14. Needs based planning be mandated for all health regions and health system planning. Equity impact assessment should be part of this planning to ensure that services meet the needs of all Canadians.

15. Chronic disease management and other supportive strategies for vulnerable patients at risk of frequent readmission to the acute care system be prioritized in all health systems.

16. Quality improvement initiatives be mandated in all care programs. These programs should include a specific focus on standardization of care and continuous quality improvement and should include equity of access as part of their mandate.

Physicians in Practice

The CMA recommends that:

17. Physicians be supported in efforts to offer timely access in primary care settings.

18. Physicians be supported in continued efforts to include all patients in decisions about their care and management of their illnesses.

19. Physicians be supported in continued efforts to standardize care and utilize evidence based clinical practice guidelines with a particular emphasis on the management of chronic disease.

20. Physicians be encouraged and adequately supported to participate in community-based interventions that target the social determinants of health.

Conclusion:

Despite a commitment to equal access to health care for all Canadians there are differences in access and quality of care for many groups. For those that are most vulnerable, this lack of access can serve to further exacerbate their already increased burden of illness and disease. The strategies discussed above offer some opportunities for the health sector and the medical profession to intervene and mitigate this inequity. By removing barriers on both the patient and system side it is hoped that greater access to appropriate care will follow. While these strategies offer some hope, these actions alone will not be sufficient to increase the overall health of the Canadian population. Action is still required to tackle the underlying social and economic factors which lead to the disparities in the health of Canadians.

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