UNDER-SERVED

HEALTH DETERMINANTS OF INDIGENOUS,
INNER-CITY, AND MIGRANT POPULATIONS
IN CANADA

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CHAPTER 26

Reforming Health Systems to Promote Equity and Improve the Health of Under-Served Populations

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LEARNING OBJECTIVES

After reading this chapter, you should be able to:

1. Understand the role of structural factors and systems in creating marginalization.
2. Appreciate the complexity involved and jurisdictional ambiguities in addressing challenges relating to disadvantaged and under-served populations.
3. Identify pathways for creating structural changes to promote more inclusive, equitable, and healthier societies.

BACKGROUND

Improving the health of marginalized populations requires action on the social determinants of health, which is not something that can be achieved through the efforts of the health sector alone (Commission on the Social Determinants of Health 2008). Indeed, the health sector is but a single component in a much larger web of health determinants including education, employment, and housing (Mahamoud et al. 2013). However, either the health sector can be part of the solution by promoting health equity within the health system and beyond, or it can contribute to the regressive structural factors that maintain and widen health gaps from generation to generation.

This chapter will outline some of the ways in which health systems may contribute to health inequities—even if inadvertently—as well as ways in which health systems can become more pro-equity in the future.

THE GOALS OF THE HEALTH SYSTEM

According to the *World Health Report 2000*, "health systems have a responsibility not just to improve people's health but to protect them against the financial cost of illness—and to treat them with dignity" (Musgrove et al. 2000, 8). Multiple objectives are therefore involved, including improving the overall health of the population while at the same time reducing gaps in health outcomes between individuals and groups, preventing catastrophic health expenditure and poverty due to out-of-pocket spending during illness, and treating patients in a way that considers the whole person and promotes their agency and involvement in decisions that affect their current and future well-being.

Improving Overall Population Health

Life expectancy in Canada increased by 24.6 years between the years 1921 and 2011 (Decady and Greenberg 2014). Much of this improvement in health outcomes results from reductions in infant and child mortality, particularly in the first half of the twentieth century, as well as further reductions in mortality in more recent decades due to fewer premature heart disease deaths among younger adults. Moreover, while mortality is now occurring in later age groups (predominantly among persons 75 to 89 years of age), functional health and quality of life continue for longer, with more severe disability occurring after 77 years of age on average. Thus, in Canada, as in many other countries around the world, there have been significant improvements in overall population health in recent generations.

Reducing Health Inequities between Groups

While Canadians are much healthier on the whole than they were a century ago, not all groups fare as well. For instance, homeless persons in Canada have a life expectancy that is almost 40 years less than the population average (Hwang et al. 2009; Condon and McDermid 2014). Babies born to Inuit mothers today have infant mortality rates not much lower than the Canadian rates in the 1920s, which is two to three times higher than current rates in the general population (18.7 infant deaths per 1,000 live births among Inuit babies as compared to 4.9 infant deaths per 1,000 live births among non-Aboriginal babies) (Gilbert, Auger, and Tjepkema 2015). These are simply a few examples, but the list of marginalized groups with worse health outcomes as compared to the general population is vast, including immigrants and refugees, young single mothers, persons who are institutionalized or incarcerated, persons with mental health problems and addictions, persons with disabilities, children living in poverty, and isolated seniors, all of whom not only have greater health needs but tend to "fall through the cracks" of traditional health systems.

Preventing Catastrophic Health Expenditure

Despite health care services in Canada being largely publicly funded via the ten provincial and three territorial health systems that make up our Canadian health system, this is mostly true for services delivered in hospitals or through doctors' offices (Maioni 2014). However, with changing medical practice over the years, as well as the demographic transition resulting in greater chronic disease care required later in life, there is more and more that is often left uncovered by public health insurance, and users therefore must bear the additional costs themselves unless they can afford and access private health insurance. This is true even in Canada, and is particularly challenging for marginalized patients who have difficulties accessing mainstream care and thus take a "double hit"—reduced access to care at a greater cost. For instance, "most vulnerable elderly do not have a coordinated care system they can rely on; instead, they are dependent on office visits, hospital and emergency room care, a family caregiver (for those who have access), or an assisted living situation (for those who can afford it)" (Maioni 2014, 38).

Treating All Patients with Dignity and Respect

The health system is part of the larger society in which it is embedded, and as a result, certain prejudices and structural forms of racism and violence can also be present—overtly or not—within these systems. Despite health professionals learning about person-centred care during their training, there are nonetheless examples, in Canada and beyond, of patients not receiving the attention and care that they deserve; and when they do receive care, it is not always provided in a respectful and dignified way. A recent and disturbing example of this are the findings of a report entitled *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada* (Allan and Smylie 2015). In this report, the authors explain that "stereotypes of Aboriginal people impact the care they receive … being denied treatment or access to hospital care based on assumptions that they were drunk or that they were 'troublemakers' … [and] how the anticipation or experience of being blamed for one's own health problems prevented some from even trying to access hospital care at all" (27). There is even increasing concern about the way in which power differentials within the doctor-patient relationship can lead to criminal abuses including sexual misconduct (Collège des médecins du Québec 2018). Important needs exist, then, to create safe spaces within health care settings, clarify boundaries, and provide trauma-informed care that considers the whole person, since health workers have more power to promote social accountability than they may realize, starting at the patient level (Goel et al. 2016).

HEALTH SYSTEMS—PART OF THE PROBLEM?

Even though by definition, "health systems consist of all the people and actions whose primary purpose is to improve health" (Musgrove et al. 2000, 1), there are times when these actions are intentionally or inadvertently counterproductive.

The Inverse-Care Law

It has long been recognized that those with the greatest health needs are often less likely to be able to access quality health care, particularly when market forces are at play (Tudor Hart 1971). The inverse-care law can also be found when local conditions are so dire that it is difficult to attract health workers to provide services in areas where people are most in need—for instance, in conflict and post-conflict areas, or in areas with extreme poverty and few resources (Moosa et al. 2013). This also applies to northern, rural, and remote areas of Canada, where health workers are often transient, and recruitment and retention are difficult. Even in heavily populated inner-city settings, there are relatively sparse outreach services to meet the needs of those out in the community who, for various health or social reasons, are less able to navigate often complex and siloed hospital-centric health and social systems.

The Health Care Imperative

Health systems are often focused on acute health care issues, dealing with day-to-day problems and "putting out fires" through diagnosing health conditions and providing patients with treatment and rehabilitation. However, there is generally less time and fewer resources dedicated to preventing disease in the first place and promoting health more broadly using the strategies laid out in the *Ottawa Charter for Health Promotion* (WHO 1986). Often, the focus on prevention only enters the public discourse after some breakdown has occurred and people are looking to understand what went wrong—for instance, after the Walkerton crisis or the SARS outbreak. Only then do people appreciate that neglected and anemic public health systems need to be better funded and strengthened (Naylor et al. 2004), rather than dismantled in the name of greater efficiency and cost-savings, as is the current trend (Guyon et al. 2017). Indeed, more emphasis on prevention can lead to a greater return on investment for each health dollar spent, and prevention provides better value for money; yet all too often, this aspect gets overlooked in favour of acute care services that are often more expensive in the long run than it would be to get the root of the problem and prevent disease and human suffering in the first place (Young and Olsen 2010).

HEALTH SYSTEM REFORM TO INCREASE HEALTH EQUITY

In order to make progress in reducing disparities in health outcomes, health equity needs to be clearly articulated and at the core of every health system, every health worker mandate, and every health action.

Primary Health Care as the Cornerstone of the Health System

A key mechanism through which health systems can contribute to improving health equity, social justice, and the end of exclusion is to move towards universal health coverage and social health protection by making health care services available to all, and to transform

conventional health care into primary health care by putting patients at the centre of care and bringing care closer to the people (WHO 2008). At the global level, there is still a long way to go, as 100 million people fall into extreme poverty each year due to health expenses, and 800 million spend more than 10 percent of their annual income on out-of-pocket health expenses (WHO and World Bank 2017).

Indeed, beyond preventing poverty, having a "patient medical home" can also make a major impact on improving health outcomes, especially for marginalized patients (Sugarman et al. 2014). The patient medical home assures that every individual has timely access to a family physician or other primary health care professionals, including nurses, midwives, or community health workers, depending on the context, all working within a patient-centred primary health care team, with coordination and continuity of care, close to where patients live (College of Family Physicians of Canada 2009).

Reorienting Health Systems

In addition to addressing the under-service of marginalized populations in terms of di-agnosis and treatment, there is a need for greater "upstream" focus on disease and injury prevention, health promotion, and addressing the social determinants of health (see Meili and Piggott, Chapter 25 in this volume). It is important to ensure that the entire con-tinuum of these strategies is being used to improve health (Andermann 2013).

Even when a new program or service intended to improve health is developed, such as a cancer screening program or a sexual health education curriculum in schools, the con-sideration of equity is critical, so that those who have the greatest education and ability to navigate the system don't end up as the sole beneficiaries. Even a well-intentioned program can lead to increased inequities if those who are more marginalized are less able to benefit; ongoing vigilance and monitoring are required to ensure that certain population subgroups are not being left behind (Morère et al. 2018).

For instance, a school-based program may not reach students who have already dropped out of school and are even more vulnerable. Thus, it is necessary to always think ahead of ways to increase access for those most in need (e.g., through outreach), as well as ways of evaluating whether marginalized groups are accessing care and benefitting from it.

Supporting a Pro-equity Lens within the Health Workforce

Front-line health workers can make a difference in reducing health inequities, particularly when they attempt to address the root causes of morbidity and mortality, in addition to treating illness (Gilbert, Auger, and Tjepkema 2015). First, health workers can play a key role in improving outcomes for marginalized patients in the way that they organize their clinical practice to make it more accessible (e.g., close proximity to where marginalized patients live, welcoming look and feel, extended open hours after regular working hours and on weekends, no hidden fees, etc.).

Case Study: The CLEAR Toolkit

Established in 2010, an international collaboration of researchers and policy-makers joined together with the goal of creating an evidence-based clinical decision aid to help front-line health workers contribute to raising awareness and tackle the social determinants of health, particularly in low- and middle-income countries. The CLEAR toolkit (available at http://www.mcgill.ca/clear) was developed based on 1) a realist review of the literature on what health workers can do to address the social determinants of health; 2) primary research with vulnerable patients, their health care workers, and community members to determine what patients would find helpful and what health workers have found effective in practice; 3) feedback from key informants and international experts in social determinants and primary health care; and 4) pilot studies in a wide variety of health care settings, ranging from remote Aboriginal communities and inner-city neighbourhoods with a high prevalence of immigrants and refugees in high-income countries, to urban slums and rural areas in low- and middle-income countries. The resulting toolkit is therefore a practical and clinical practice–oriented way of enabling primary health care workers to provide much needed support to disadvantaged patients, as well as to galvanize community mobilization, intersectoral partnerships, and policy change at multiple levels. In particular, the toolkit guides front-line health workers in a) treating the immediate health problem, b) asking about underlying social problems, c) referring to local social support resources, and d) advocating for more supportive environments for health. The toolkit has been translated into over a dozen languages including Arabic, Russian, Chinese, Urdu, French, Spanish, and Portuguese.

In addition, health workers can also ask about and support patients in dealing with complex health and social issues through taking a social history and referring to social support services (Andermann 2011). Health care workers can be made more aware of the issues that marginalized patients face, and of their own background and preconceived notions, to provide more culturally safe care (Macaulay 2009).

There are also numerous opportunities for increased advocacy by health care professionals who come into regular contact with the health effects and human suffering caused by these inequities while working on the front lines (British Medical Association 2011). The role of health care providers engaging in advocacy around issues related to the health of under-served populations will be discussed further in the following chapter.

Promoting Community Development through Intersectoral Action

Improving the health of populations requires intersectoral action and sustainable community development (WHO 2012). Indeed, there are long-standing models of how

front-line health workers can help to galvanize intersectoral action and impact social determinants at a grassroots level.

The concept of community-oriented primary care (COPC; discussed at length in Chapter 15 by Guenter, Oudshoorn, and Mancini in this volume) was developed by two family doctors, Sidney and Emily Kark, while they were working in a poor rural community in South Africa in the 1940s. Rather than treating each health problem that presented at their doorstep, the Karks wondered what more could be done to prevent these problems, which were so common in the community. COPC is thus "a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services" (Mullan and Epstein 2002, 1750); it is an important approach that should receive greater emphasis in undergraduate and postgraduate medical training programs to enable future health workers to incorporate COPC in their day-to-day clinical practice.

Partnering with Local Government and Community Groups

While health workers can be important catalysts in the process of community development, many other local partners, including municipal government and community groups, are needed to make this happen. However, the notion of intersectoral action and collaboration towards reducing health inequities may be a rather novel concept in certain spheres. While recreational programming and affordable housing are considered within the remit of local governments in taking action on the social determinants of health, insufficient federal and provincial funding is often perceived to be the biggest constraint on municipal action, raising concerns about "inter-governmental downloading of responsibilities, and behaviour-based assumptions of disease etiology" (Collins and Hayes 2013, e304). Yet, supportive guidance and coaching can help civil servants, managers, and municipal councillors in adopting a "Health in All Policies" approach with the aim of improving health and social outcomes for the community (Steenbakkers et al. 2012).

THE CANADIAN HEALTH POLICY CONTEXT AS IT RELATES TO UNDER-SERVED POPULATIONS

When considering the Canadian health policy context as it pertains to under-served populations, one must necessarily identify the jurisdictional responsibilities in this regard. For instance, in relation to the issue of homeless persons with mental health conditions, who is responsible for creating the social safety net and ensuring adequate and appropriate access to care? There is no simple answer to such complex questions. Addressing these issues often involves "shared responsibility" across multiple government departments and levels of jurisdiction, and as a result, things tend to "fall between the cracks." Health care services clearly fall within provincial and territorial jurisdiction in Canada, and on the whole, the federal government is not involved in social housing

(except on reserves and in certain military bases), which is left to provincial and municipal authorities (Munn-Rivard 2014).

This challenge of jurisdictional ambiguity is also a major issue pertaining to Indigenous health. Even within the federal government, there are multiple departments supporting various aspects—for instance, until recently, Indigenous and Northern Affairs Canada dealt with infrastructure for housing and water, Health Canada's First Nations and Inuit Health Branch with health care services on reserve, and the Public Health Agency of Canada with urban Indigenous populations; and then there is the provincial health care system and public health authorities who also provide services and care to varying degrees across the country (National Collaborating Centre for Aboriginal Health, 2011). To overcome this complexity and address the challenges of "shared responsibility," mechanisms are needed whereby Indigenous partners and all levels of government come together to see the big picture, define shared goals, and identify who does what to make things work "on the ground" from a person-centred perspective. This requires consultation and a strong voice from those who are most affected by the decisions being made, thus allowing greater self-determination in co-creating the systems that are more responsive to the needs of specific groups, which can in and of itself lead to improved health outcomes (Chandler et al. 2003).

INFLUENCING POLICY TO CREATE SUPPORTIVE ENVIRONMENTS FOR HEALTH

According to theories on influencing policy (Nutbeam, Harris, and Wise 2010), health workers need to better understand who makes policy (e.g., government officials, school boards, etc.), who else is influencing policy (e.g., stakeholders, media, the public), what can be influenced (e.g., the content of policy and the speed at which it is adopted), and how to influence policy change to improve community health (e.g., understanding the context, recognizing who is most influential, determining what different stakeholders stand to win or lose, identifying where they may be willing to compromise). Increasing one's power in influencing policy requires understanding the process, monitoring interests, acting strategically, and building alliances. According to the prominent policy theorist Kingdon (2011), the first step is to ensure that the issue is identified as an important problem and makes it onto the policy agenda. Next, one can influence the various policy options that may be available to address the issue. Finally, one must understand the political forces determining the adoption of policy. Experience has shown that "policy entrepreneurs or champions" (i.e., leaders from professional, political, or interest groups who effectively advocate policy) have played key roles in policy reforms (Brownson, Chriqui, and Stamatakis 2009). While there is some debate about the extent to which health workers should be involved in political activism as opposed to advocating for patient needs in a clinical context (Dobson, Voyer, and Regehr 2012), health workers who are often highly respected members of communities and who have access to privileged information about the health needs of the

population are well-placed to encourage local action and to advocate, along with other key stakeholders, for more supportive environments for health.

CONCLUSION

Structural factors, whether intentional or inadvertent, create the emergence and perpetuation of disadvantaged and marginalized populations. Therefore, the key is not only increasing access to care for these under-served groups but also reducing the marginalization itself by creating more transparent, inclusive, and equitable structures. These structures are developed and modified over time, in planned and unplanned ways, and can often be bureaucratic and slow to change, but people can intervene to turn these structures into engines for equity. Within the health system, there are many ways that front-line health workers can become catalysts for such wider change, starting at the patient level, the practice level, and the community level (Andermann 2016). Over a century ago, Virchow remarked that "physicians [and other allied health workers] surely are the natural advocates of the poor and the social problem largely falls within their scope" (quoted in Rather 1985, 4). Understanding how to create structural change, then, is an important lever for creating a more inclusive, equitable, and ultimately healthier society.

CRITICAL THINKING QUESTIONS

1. How can a health worker at the front lines begin to tackle complex and widespread social challenges such as homelessness, poverty, and racism?
2. Who are the key decision-makers involved, and who would be natural partners within your local community that you could join up with to try to create wider social change?
3. Why are inequities perpetuated, and what can be done to undo long-standing social exclusion and discrimination rooted in historical events that no longer reflect today's reality?

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