

MEDICAL REFORM GROUP

**BUILDING A CULTURE
OF PATIENT-CENTERED
CARE**

Working Group

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To:

Canadian Medical Association

Working Group on “Building a Culture of Patient-Centred Care”

CMA Blueprint for Health Care Transformation

On behalf of the Medical Reform Group, we congratulate the Canadian Medical Association on your work towards a blueprint for health care transformation. In particular, we applaud your commitment to a focus on innovations in patient-centred care. We believe that putting in place a patient quality charter that will facilitate the implementation of appropriately patient-centred care is extremely valuable. In this submission, we will share our perspective on the vision, and the specific contents of such a charter.

Equity as an international, and a Canadian value

In 1966, the United Nations General Assembly proposed the “Covenant on Economic, Social and Cultural Rights”, which Canada ratified in 1976, that affirms “The right of everyone to the enjoyment of the highest attainable standards of physical and mental health... through the conditions which would assure to all medical services and medical attention in the event of sickness.”²⁵ The World Health Organization’s Commission on the Social Determinants of Health recently issued its final report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, which recognized that health care was one of many social determinants of health that are important for advancing health equity, alongside social and political factors, and that health equity was fundamental to achieving social justice.⁹

The right to health represents a deeply held belief among most Canadians. As ethicist Nuala Kenny has pointed out, what may have been dry policy initiatives of the Canada Health Act in fact captured the Canadian imagination, and have taken on strong symbolic value for Canadians. Communitarian values, and a notion that individual good of others represents a social good from which we all benefit, underlie the value of equity in health care. The notion that health has a special value, and that therefore health care represents a service fundamentally different from other services, represents an essential ethical standard.¹⁸

Despite economic tensions, Canadians continue to place a high value on equity in health care delivery. In 2002, the Romanow *Commission on the Future of Health Care in Canada* investigated the values of Canadians in regard to our health care system and determined that Canadians place a high value in equity. Indeed, Canadians assigned the highest priority to universal access based on need. In the report, Romanow stated: “Almost all Canadians I have heard from to date want to ensure that the poorest in our society have access to health care.”²⁵

When equity is not given a high value, consequences are dire

The experience of the United States, which continued to maintain a largely privatized health care system after Canada turned to Medicare in the 1970s, has shown how a private system is not only inefficient but, most importantly, results in inequitable health and health care.

Two studies have been published in prominent public health journals in recent months linking increased mortality with the insurance status of Americans. In the first study, investigators analyzed records of 23 million children that found an excess relative mortality of 37.8% in the uninsured.¹ The second study presented data suggesting 45,000 deaths annually are associated with a lack of health insurance in the U.S.³⁰ Previous investigations have established that those without insurance are more likely to die prematurely from conditions such as breast, cervical, colorectal, prostate cancer and melanoma. They also have significantly worse outcomes in chronic diseases such as diabetes, cardiovascular disease, HIV infection, end-stage renal disease and mental illness.⁷

Not only have the uninsured had difficulty with health care in the U.S. but so have those who were insured. Harvard University investigators found that 46% of personal bankruptcies in the U.S. in 2001 and 62% in 2007 were due to medical bills. The majority of these bankruptcies were filed by those with middle-class incomes and three quarters of them were actually insured.¹⁵

A study that directly compared the difference between equity of outcomes in Canada versus the U.S. looked at the survival rates of breast cancer in Ontario in comparison to California. The study showed that breast cancer survival was linked to income in the United States with a significantly lower survival rate for those in the lower socioeconomic group. The investigators found no such gradient in Canada, and attributed this to the Canadian universal health care system.¹⁴

The needs of vulnerable Canadians demand a commitment to equity

Recognition of the health status of vulnerable populations, and the role of physicians in addressing their needs are necessary to maximize the impact of a patient-centered charter. While all patients deserve patient-centered care, it is for members of vulnerable groups that patient-centered interactions and health planning can have the greatest health impact. This charter should make a commitment to use resources to reduce health disparities and provide targeted, quality health care for vulnerable groups.

High quality evidence indicates that those who are part of vulnerable or marginalized groups in Canada suffer from significantly worse health outcomes.^{5, 22} People who live in poverty have poorer health in major indicators such as life expectancy, low birth weight and infant mortality; and higher incidence of, and morbidity from, chronic physical and mental health conditions.^{23, 28, 29} Children who grow up in poverty have worse short-term health and social outcomes, and suffer the health effects of that poverty throughout their lives, even if their family income subsequently rises from the poverty level.¹⁰ Single parent-led families and people with disabilities are at significantly higher risk of living in poverty than the general population.^{6, 24}

While poverty is a common landing point for vulnerable groups, certain specific groups warrant targeted attention to address inequitable disparities in health.

- Aboriginal people continue to suffer from dramatically worse access to care and poor quality of care compared to other Canadians.^{13, 17} First Nations people experience markedly lower life expectancy, higher infant mortality, and higher rates of injuries, suicide, and diabetes.²
- Immigrants, especially those with low income, have much lower rates of screening and preventive health services.^{20, 26} There is a growing trend toward a racialization of poverty, especially in major cities, and health interventions must recognize race-based disparities.²¹
- People without health insurance are at high risk of poor outcomes due to lack of access to health care. This group includes recently arrived refugees; new immigrants to Canada who face a three-month waiting period in Ontario, B.C., Quebec and New Brunswick before they are eligible to apply for insurance; and people who have no or are awaiting immigration status.⁸
- People without secure housing are at particularly increased risk of having unmet health care needs.¹⁹ Homeless individuals have far higher rates of chronic and acute mental and physical illness, lower life expectancy, and higher health care use, than the general population.^{12, 16}

Physicians Have an Important role in Health Inequity

The medical community has a strong role to play in alleviating the health impacts experienced by these vulnerable groups. Investment in services for low-income, vulnerable populations is associated with decreased health disparities.¹¹ Policy analyses have shown that tailored models of care are necessary to ensure adequate access to care for this highly marginalized population.²⁷ Physicians have multiple direct roles to play in reducing health disparities, through targeted lobbying of policymakers, specific restructuring of their practices, and through direct

knowledge of interventions with vulnerable individual clients that will decrease the health effects of their marginalization.^{3,4}

The Charter should recognize three types of equity as crucial to patient-centred care

A patient-centered charter should explicitly recognize the health needs of these populations, and commit to specific interventions to decrease the inequities in health experienced by these groups. This will ensure the patients who need care the most receive it, and that the maximum potential health impact of the charter is realized.

Given the values of Canadians, the ethical imperative of equitable health care, and the special needs of vulnerable populations, a health care charter should explicitly commit to three types of equity.

Equity in opportunity refers to individuals having equal chance to obtain health care if they so choose without financial barriers. To a large extent, our publicly funded health care system provides this for physician and hospital services, although there are some groups who remain uninsured and some barriers to care such as block fees. As the CMA has recognized, we do not have equality in opportunity for other services, including drugs, dental care, and home care, and this is problematic. Equity in opportunity is the fundamental aspect of equity to which the charter should commit.

Equitable access refers to barriers that may present themselves to use of health care such as transportation, stigma and language. These are frequently issues for marginalized populations. Physicians should recognize, and commit to help ameliorate, barriers to equitable access through considering how they operate their practices and working with administrators to address structural barriers to accessing health care.

Equity of outcomes refers to an equal standard of health. To truly have equity, we should not only provide opportunity and access, but take measures to ensure equal health outcomes at the end of the day. This may mean directing resources preferentially to groups known to have worse access or outcomes. In the CMA's vision and blueprint for health care transformation, we strongly encourage commitment to strive for equity of health outcomes.

Conclusions

Reports, polls, and focus groups consistently reveal that Canadians demand that equity be a core principle of our health care system. Ethical principles, and recognition of the poorer health status and greater health needs of vulnerable

populations further mandates equity as a core principle of any charter developed of patient-centred care. Enshrining equity into the charter for patient-centred care will place the Canadian Medical Association at the forefront of working towards a health care system that provides patient-centred care for all Canadians.

The Medical Reform Group would be greatly interested in working alongside the Canadian Medical Association to develop strategies as to how best we can improve patient-centred care. We would also greatly appreciate the opportunity to aid in creating a patient charter that truly embodies the values and needs of all Canadians.

Sincerely,

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On behalf of the Medical Reform Group

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