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Authors

O'Neill, Braden
Ferrer, Robert
O'Brien, Patricia
[et al.](#)

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Improving Equity Through Primary Care: Proceedings of the 2019 Toronto International Conference on Quality in Primary Care

Braden O'Neill, MD, DPhil, CCFP

Robert Ferrer, MD, MPH

Patricia O'Brien, RN, MScCH

Grabam Watt, MD

Laura Gottlieb, MD, MPH

Andrew Pinto, MD, MSc, CCFP

Sara Willems, MPH, PhD, MHS

Jody Currie

Dawnmarie Harriott

Jonathan Leitch, MPH & TM

Alexander Zsager

Michael Kidd, MD

Tara Kiran, MD, MSc, CCFP

ABSTRACT

Health equity allows people to reach their full health potential and receive high-quality care that is appropriate for them and their needs, no matter where they live, what they have, or who they are. It is a core element of quality in health care. Around the world, there are many efforts to improve equity through primary care. In order to advance these efforts, it is important to share successes and challenges. Building on our work with international stakeholders to identify key primary care research priorities, we organized the Toronto International Conference on Quality in Primary Care that was held on November 16, 2019. Participants from 8 countries took part. Key recommendations included leveraging the continuous relationships between providers and patients over time, developing partnerships between the health and social sectors, and advocating for resources that are proportional to patient need. Solutions must be generated using team-based approaches that explicitly include people with who have experienced discrimination. Progress will require confronting structural determinants including racism, capitalism, and colonialism. Conference participants suggested practical solutions, such as developing a public transportation program for rural residents to improve community building and the ability to attend medical appointments, and identifying patients who have recently missed clinic visits that may benefit from additional care. These approaches will need to be evaluated through high-quality research and quality improvement, with a knowledge translation that facilitates sustainability and expansion across settings.

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INTRODUCTION

Achieving the triple aim of improved population health and better patient care at reduced cost will require us to tackle unfair disparities in health and health care. Twenty years ago, the Institute of Medicine identified equity as the sixth dimension of health care quality but until recently, it was often forgotten in the pursuit of safety, timeliness, and other areas requiring improvement.^{1,2} It has long been known that systems with strong primary care generally have better outcomes, lower costs, and better equity, where everyone has the fair and just opportunity to be as healthy as possible.^{3,4} In measurable terms, that means an absence of systemic disparities among populations with different levels of social advantage. Yet it is unclear how primary care can more fully advance equity in low-, middle-, and high-income countries.

Social determinants of health have gone mainstream, focusing conversations in settings as diverse as ghettos, hospital hallways, and philanthropic boardrooms. There is increasing alignment on the urgent need to address adverse social determinants of health, but less certainty about the path forward. While an overdue sense that solutions must transcend health care is emerging, front line care delivery may provide meaningful opportunities to intervene and may be more immediately responsive than upstream societal institutions such as built environments, tax codes,

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CORRESPONDING AUTHOR

Braden O'Neill, MD, DPhil, CCFP
Family Medicine Teaching Unit
North York General Hospital
4001 Leslie Street
Toronto, Ontario, Canada M5K1E1
braden.oneill@nygh.on.ca

educational systems, and the entrenched exclusionary workings of race and class. A gathering sense of *all hands on deck* recognizes that solutions must span the gamut from daily family life to enduring institutions. While primary care can offer only a partial response to the challenges of social adversity, its wide community reach means it is well-positioned to lend its eyes, ears, voice, and hands to the cause.

On November 16, 2019, we convened the second Toronto International Conference on Quality in Primary Care with a focus on health equity. The first conference was held in April 2018. We brought together clinicians, patients, health administrators, educators, and researchers to help us begin to answer the question identified, by international stakeholders, as the number 1 primary care research priority: "How can primary care best address the social determinants of health and promote health equity?"⁵ Participants came from Australia, Belgium, Brazil, Canada, Japan, New Zealand, Nigeria, United Kingdom, and the United States. Speakers from several countries shared their work and insights and the audience engaged in discussion through plenary sessions and small group interactions. This article summarizes key discussions and insights from the conference.

The conference started with a ceremony led by Indigenous Elder Cat Criger, including an acknowledgment that the conference was being held in Toronto, Canada, the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples. This territory is now home to many diverse First Nations, Inuit, and Métis peoples. In her opening statement, conference co-chair Dr Tara Kiran noted the stark disparities in health outcomes among Indigenous people compared with the total population in Canada, including a life expectancy gap of 11 years between Inuit men and the total male population in Canada.⁶

The 5 A's of Advancing Equity (USA)

Laura Gottlieb, MD from the University of California San Francisco, described a 5-part framework of health care sector strategies to strengthen social care from a recent National Academies of Science, Engineering, and Medicine report *Integrating Social Care into the Delivery of Health Care*.⁷ The framework first highlights the importance of *awareness* activities to identify the social risks and assets of defined patients and populations. For people with diabetes, this might include asking patients about the availability of nutritious, medically tailored food. The second component refers to *adjustment* activities, which involve changing clinical care based on social risk factors. For instance, clinicians might reduce

insulin doses near the end of the month when a person's food benefits often run out. *Assistance* strategies include activities that bridge patients to social services and other resources, such as government food benefits or financial assistance programs. *Alignment* activities aim to improve the health care sector's understanding of existing social care assets in the community by organizing them to facilitate synergies, and investing in and deploying them to positively affect health outcomes. This might involve health care systems working with local workforce training organizations to establish training programs that improve employment possibilities. Finally, *advocacy* activities include the ways health care organizations partner with social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs. This might involve working with local government advocates for larger food benefit packages. Within this framework, Dr Gottlieb reminded the audience about the value of focusing on patient priorities when working to lessen the impacts of social adversity on health care and health outcomes (Table 1).

Healing Our Indigenous Roots (Australia)

Jody Currie and Jonathan Leitch from Brisbane, Australia described the Aboriginal and Torres Strait Islander Community Health Service,⁸ a health service run by Indigenous people for Indigenous people. They grounded their presentation with the history of colonialism and systemic discrimination faced by Indigenous people in Australia. The resulting inequities in health outcomes include life expectancy lowered by 8 years, infant mortality increased more than 2 times, intentional injuries (suicide and self-harm) increased almost 5 times, and an increased burden of chronic disease. Their organization has been successful in improving outcomes among its Indigenous clients because it was built on a foundation of trusted relationships

Table 1. Examples of the 5 A's From Conference Presentations

Awareness	Julian Tudor Hart's understanding of social deprivation among his patients (Graham Watt)
Adjustment	Use of equity-informed language such as <i>resilient</i> rather than <i>vulnerable</i> in clinical care (Dawnmarie Harriott)
Assistance	Enhancing access to cooking education and food through the Deadly Choices program (Jody Currie and Jonathan Leitch)
Alignment	Breaking down silos between different social service organizations (Alex Zsager)
Advocacy	Encouraging resource allocation toward improved government-subsidized housing (Sara Willems)

5 A's = awareness, adjustment, assistance, alignment, advocacy.

with the community. Currie and Leitch work to build resilience and capacity in the community and actively improve their services in response to feedback. They take a holistic approach to care across the lifecycle by integrating primary care with other components such as home care, dental care, and early childhood interventions within the organization.

One of their exemplar primary care initiatives is the *Deadly Choices* program, a social marketing campaign linked with health promotion including annual health checks at the primary care clinic.⁹ The campaign reflects Aboriginal culture, using the term *deadly* which means *great* in Aboriginal slang and tying in Aboriginal people's love of sports by offering custom-made sports jerseys as an incentive for the annual health check. The annual health check takes a *no wrong door* approach, trying to connect clients to the right services whatever their need. It improves equity in access by connecting with people who have traditionally not accessed care.

Over the past 8 years, the community health services have seen a 340% increase in patients served and a 530% increase in chronic disease management plans being established with patients. But, as Currie and Leitch said, "Equity in process is not enough." This community- and data-driven approach has resulted in substantive improvements in chronic disease outcomes such as glycemic control among patients with diabetes.

Learning From the Resilient (Canada)

Conference attendees heard from 2 patient partners with experience of poverty, homelessness, and other social factors detrimental to health. Alex Zsager, a research team member, advisor/consultant, and board member of many organizations, described his journey to unemployment, poverty, and eventual homelessness. He noted that when you rely on social services, you are relying on "systems designed to fail." Zsager expressed surprise from his own experience of navigating the health and social care systems that "no one seems to know what anyone else is doing, they only know what their own organization offers" and challenged those in attendance to go back and address the silos in their own work and community.

Dawnmarie Harriott, the coordinator of Toronto's Voices From the Street/Relief Worker Training program,¹⁰ described the existing social safety net as a "web" that you "really get stuck in if you end up in it." She outlined the importance of looking at people's "lives" rather than their "ailments" and reminded the attendees that things that happen to you are not always your fault, but current social service systems often treat them as such and that it can be traumatic to try to access these systems. Harriott noted the importance

of language in inadvertently promulgating stigma, pointing out that describing someone as "vulnerable" puts blame on them for a system that has failed them. Instead, she suggested people use the word "resilient."

The Potential of General Practice (United Kingdom)

Graham Watt, MD described the work of general practitioners (GPs) at The Scottish Deep End Project that he founded in 2009. The Deep End GPs serve the 100 most-deprived populations in Scotland. Over the last decade, these GPs have come together to share experience and better support each other in caring for the patients they serve. Research from the group confirmed the high rates of multimorbidity among those living in deprived communities. Yet, resources in general practice did not match the need—an example of the inverse care law.¹¹ As a result, GPs serving deprived communities were struggling with high patient need but too few resources.

Based on a series of more than 30 reports on specific issues, the Deep End manifesto argues for longer consultations, especially for patients with complex multimorbidity; better use of serial encounters to build patient's knowledge, confidence, and self-agency; the development of local health systems around GP hubs, with their intrinsic features of contact, continuity, coverage, flexibility, and trust; better connections and collegiality between practices to share learning and develop new norms; better support of front line practices from central organizations, and GP leadership, especially at the practice and community levels.¹² Deep End GPs have also taken on an advocacy role, commenting on social factors and policies with adverse effects on patients and arguing that if health care is not best where it is needed most, health inequalities will widen. The Scottish Deep End project has been followed by similar projects in Ireland, England (Yorkshire and Humber, Greater Manchester, Plymouth), and Australia (Canberra).¹³

Dr Watt provided an example for how a general practitioner could influence health equity, describing the work of GP Julian Tudor Hart who seized the opportunity provided by general practice in the National Health Service (NHS). Tudor Hart pioneered a population approach to the management of high blood pressure and developing paper and computerized information systems to "measure omission" and address the rule of halves.^{14,15} He was the first to describe coproduction in general practice, working with patients over the long-term, "initially face to face, shifting gradually to side by side." Over 25 years he was able to show a 30% reduction in premature mortality in his patients compared with a neighboring

population.¹⁶ This was achieved not only by the delivery of evidence-based medicine, but also by the unconditional personalized continuity of care for all patients whatever problem or combination of problems they might have.

Integrating Clinical and Public Health Perspectives (Belgium)

Sara Willems, PhD, a public health academic from Ghent University, Belgium, discussed her clinical experience working in a community health center serving a population with many living in government-subsidized housing. Their team identified that one of the barriers to people attending appointments was that the elevators did not work in many of the buildings, making it difficult or even impossible for frail residents to attend the clinic. They advocated for improvements in the state of the social housing, as well as an expansion of the services available at the local community health center. The story illustrated connecting a clinical issue in primary care (frail patients not attending appointments) with advocacy at a policy level with the local government (improving resource allocation for social housing). She described the underlying principle as *proportional universality*, ensuring that those who need more care receive it, and presented an example of a mobile breast cancer screening facility that was brought to an under-resourced area to facilitate access.

At the Ghent University medical school, Dr Willems supports medical students in learning about the social determinants of health by teaching them from the beginning of medical school, embedding sessions early on that are focused on the basics of inequity and social determinants of health, along with anthropology, diversity, and interprofessional collaboration. This information is provided through plenary lessons, tutorials, and problem-based learning, and then followed up with a “community oriented primary care project” week where students are able to dive deeper into a specific issue related to the social determinants of health, including addressing societal and health provider attitudes toward these issues.

Addressing the Determinants of the Determinants (Canada)

Andrew Pinto, MD, is a family physician and researcher from St Michael's Hospital in Toronto, and is focused on the importance of identifying and addressing the “determinants of the determinants”, moving toward a more thorough understanding of how social determinants of health affect health status. This work involves going beyond traditional models of social determinants of health to think about structural issues in society such as racism, neoliberalism, and colonialism. He

asked how context shapes the effectiveness of “screen and intervene” efforts and encouraged conference attendees to think about how best to intervene in order to move primary care organizations along a continuum of “upstream thinking.” Dr Pinto described programs in which attorneys, income support workers, and employment services are embedded (not just co-located) within the clinic itself, and are available for consultation when patients are identified as having inadequate income.¹⁷ One of the key barriers to improving equity he identified is clinicians and policy-makers lack information about sociodemographic data that is available for identifying who may benefit from additional resources. His Screening for Poverty And Related social determinants and intervening to improve Knowledge of and links to resources (SPARK) program is an attempt to link enhanced understanding of social determinants of health data with novel solutions.¹⁸

Potential Actions

As one of the participants with lived experience of poverty stated: “Advocacy is about doing something.” Before the conference, participants were asked to do some blue-sky thinking about potential actions. They were asked to consider what they would change—in their immediate environment, regionally, and nationally or internationally—if they had unlimited resources to address the social determinants of health and promote health equity. Their responses are summarized in Table 2 and ranged from enhancing universal health care to adopting a universal basic income. Specific suggestions included: developing a public transportation program for rural residents to enhance opportunities for community building and to attend medical appointments, or to introduce specific efforts toward enhancing environmental sustainability within health organizations (Table 2).

Throughout the conference, participants continued to reflect on potential actions, narrowing down on what was feasible. For example, many participants

Table 2. Summary of Pre-Conference Responses to: “What Would You Change to Address the Social Determinants of Health and Promote Health Equity?” (N = 39)

82% recommended enhancing universal health care (eg, universal health insurance, a pharmacare program, or broadening access to mental health services and team-based care)
36% advocated for local or national policy decisions to be made differently in order to promote equity (eg, transportation, taxes)
20% suggested addressing social determinants of health directly through the health system
20% identified the importance of improving sociodemographic data for clinical, research, and policy purposes
15% recommended a universal basic income

thought an accessible starting point was to ensure that organizations' workforces were comprised of diverse populations. At the end of the day, conference participants were asked to commit to an action they would take in their own setting to enhance primary care's ability to improve health equity and address the social determinants of health. Examples of the commitments to action are provided in Table 3. These ranged from changing clinic processes to be more equity-informed to identifying opportunities to share what was learned at the conference with colleagues. All of the actions suggested were concrete and feasible.

REFLECTIONS/CONCLUSION

This conference brought together individuals passionate about the role of primary care in improving health equity and showcased innovative work across several countries. Several key themes emerged.

First, primary care plays a central role in addressing health equity through continuous relationships with patients over time and also through relationships with those delivering services in the health and social sectors. To do so effectively, primary care practices need to have the appropriate resources, that are proportional to patient population needs.

Second, primary care practitioners need to both be ambitious about the possibilities for the person in front of them in terms of improving and maintaining health as well as take a whole-population approach.

Third, team-based approaches are critical, especially those that include team members in the community, outside the walls of traditional clinics.

Fourth, people with lived experience of discrimination must be involved in generating solutions.

Finally, many participants discussed that truly addressing health inequities will require us to confront

structural determinants including racism, capitalism, and colonialism.

Participants identified potential actions but also many unanswered research questions. More work is necessary to understand the "determinants" of how societal factors impact health outcomes, and how to effectively go upstream beyond the social determinants of health to address the economic, political, and ethical determinants of health. A great number of examples were provided by conference presenters of promising interventions in their own settings. The evaluation and knowledge translation of effective interventions to other settings where appropriate was identified as a key research and quality improvement challenge.

As the world addresses the unprecedented challenge of mitigating the effects of COVID-19, deliberate efforts to work together across settings will be necessary. The current situation has shown that rather than being a great leveler, this global pandemic has exacerbated existing disparities.¹⁹ There has never been a greater urgency to address inequity, not only to protect all of us from the most immediate threat but to ensure a better, more just, future.

To read or post commentaries in response to this article, see it online at <https://www.AnnFamMed.org/content/18/4/364>.

Key words: health equity; primary health care; quality improvement; quality of health care; social determinants of health

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Author affiliations: Department of Family and Community Medicine, North York General Hospital, Toronto, Ontario, Canada (O'Neill); Department of Family and Community Medicine, University of Toronto, Toronto, Ontario, Canada (O'Neill, O'Brien, Kidd, Kiran); Department of Family and Community Medicine, UT Health San Antonio, San Antonio, Texas (Ferrer); UT Health School of Public Health, San Antonio, Texas (Ferrer); General Practice and Primary Care, Institute of Health and Wellbeing, University of Glasgow, Glasgow, United Kingdom (Watt); Department of Family and Community Medicine and Social Interventions Research and Evaluation Network (SIREN), University of California, San Francisco, California (Gottlieb); Department of Family and Community Medicine, St Michael's Hospital, Toronto, Ontario, Canada (Pinto, Kiran); MAP Centre for Urban Health Solutions, Li Ka Shing Knowledge Insti-

Table 3. One Action You Can Take to Enhance Equity Through Primary Care in Your Own Setting

Proactively identify patients who may benefit from additional care (such as those who have recently missed appointments) and call them to offer an appointment

Identify patients who need more time and flag them in chart so front office staff knows to give them longer appointments

Take residents and medical students on a tour of social services that are relevant for a patient they have seen. Allow them to connect with social services and build partnerships between the medical team and the community

Start tracking methods and numbers of patients who receive care in non-clinic settings—go to where the people who need care and can't access it are

Identify services that patients are using outside of the clinic and ensure that they are able to access these easily and that we have information about these services

Lead an education session for staff on promoting health equity in primary care

tute of St Michael's Hospital, Toronto, Ontario, Canada (Pinto, Kiran); Department of Public Health and Primary Care, Ghent University, Ghent, Belgium (Willems); Community Health Centre Watersportbaan, Gent, Belgium (Willems); Aboriginal and Torres Strait Islander Community Health Service Brisbane, Queensland, Australia (Currie, Leitch); Hearing Australia, Macquarie University, Sydney, Australia (Currie); University of Queensland, St Lucia, Queensland, Australia (Leitch); Provincial Patient Family Advisory Council, Ontario, Canada (Zsager); Inner City Family Health Team, Toronto, Ontario, Canada (Zsager); Canadian and Toronto Alliance to End Homelessness, Toronto, Ontario, Canada (Zsager); Homeless Connect Toronto, Toronto, Ontario, Canada (Zsager); Coordinator, Voices from the Street, Toronto, Ontario, Canada (Harriott); Principal Medical Advisor & Deputy Chief Medical Officer, Department of Health, Australia, Woden, Canberra, Australia (Kidd); Australian National University, Canberra, Australia (Kidd); World Health Organization Collaborating Centre on Family Medicine and Primary Care, Toronto, Ontario, Canada (Kidd, Kiran, O'Brien, O'Neill, Pinto); Murdoch Children's Research Institute, The Royal Children's Hospital, Melbourne, Australia (Kidd); Southgate Institute for Health, Society and Equity, Flinders University, Adelaide, Australia (Kidd); Health Quality Ontario, Toronto, Ontario, Canada (Kiran); Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada (Kiran).

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References

- Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
- Health Quality Ontario. Health equity plan. https://www.hqontario.ca/Portals/0/documents/health-quality/Health_Equity_Plan_Report_En.pdf. Published 2019.
- Braveman P, Gruskin S. Defining equity in health. *J Epidemiol Community Health*. 2003;57(4):254-258.
- Schäfer W L, Boerma WG, van den Berg MJ, et al. Are people's health care needs better met when primary care is strong? A synthesis of the results of the QUALICOPC study in 34 countries. *Prim Health Care Res Dev*. 20:e104.
- O'Neill B, Aversa V, Rouleau K, Lazare K, Sullivan F, Persaud N. Identifying top 10 primary care research priorities from international stakeholders using a modified Delphi method. *PLoS One*. 2018;13(10):e0206096.
- Tjepkema M, Bushnik T, Bougie E; Statistics Canada. Life expectancy of First Nations, Métis and Inuit household populations in Canada. *Health Rep*. 2019;30(12):3-10.
- National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: National Academies Press; 2020.
- Aboriginal and Torres Strait Islander Health Service. Brisbane Australia. <https://atsichsbrisbane.org.au/>.
- Aboriginal and Torres Strait Islander Health Service. Deadly choices. <https://deadlychoices.com.au/>.
- Working For Change. Voices from the street. <https://voicesfromthestreet.com/>.
- Hart JT. The inverse care law. *Lancet*. 1971;1(7696):405-412.
- Watt G; Deep End Steering Group. GPs at the deep end. *Br J Gen Pract*. 2011;61(582):66-67.
- Watt G, ed. *The Exceptional Potential of General Practice: Making a Difference in Primary Care*. Boca Raton, FL: CRC Press; 2018.
- Hart JT. Measurement of omission. *Br Med J (Clin Res Ed)*. 1982; 284(6330):1686-1689.
- Hart JT. Rule of halves: implications of increasing diagnosis and reducing dropout for future workload and prescribing costs in primary care. *Br J Gen Pract*. 1992;42(356):116-119.
- Hart JT, Thomas C, Gibbons B, et al. Twenty five years of case finding and audit in a socially deprived community. *BMJ*. 1991; 302(6791):1509-1513.
- Jones MK, Bloch G, Pinto AD. A novel income security intervention to address poverty in a primary care setting: a retrospective chart review. *BMJ Open*. 2017;7(8):e014270.
- St. Michael's Hospital. CIHR funds two DFCM projects to support Canadian primary care. http://stmichaelshospital.com/media/detail.php?source=hospital_news/2018/0501. Published May 1, 2018.
- Wang Z, Tang K. Combating COVID-19: health equity matters. *Nat Med*. 2020;26(4):458.