INTRODUCTION

In the Canadian Medical Association’s Code of Ethics, 54 basic principles provide some insight into the responsibilities and societal role of the physician. The first principle reads, “Consider first the well-being of the patient.” It is the fundamental role of the physician to advocate for their patient, first and foremost. Not until the 43rd principle is the physician reminded of “the responsibility of physicians to promote equitable access to healthcare resources.” These principles sometimes call for seemingly incompatible actions: patient advocacy seeks to draw preferentially from a limited pool of resources, often at the expense of resource allocation to individuals without access to an advocate. Arguably, one of the most important resources available to the general public is access to a primary care physician. Access to a primary care physician is particularly important given their role in facilitating access to specialized care in addition to their management of chronic conditions.

The Canadian and provincial governments are ultimately responsible for balancing the pressures of public access to healthcare with individual needs. Decisions regarding how resources are allocated are made based on a variety of factors but, as in any government program, are subject to influence by lobbying and political bias—which may or may not reflect the objective needs of a given population. For this reason, it is crucial to ensure that an evidence-based approach to healthcare resource allocation is utilized, for the purpose of identifying and rectifying underlying causative variables.

THE NEED TO IMPROVE ACCESS TO CARE

The current state of Canadian healthcare is akin to a legal system with a lawyer shortage. If there were not enough lawyers to represent everyone, those who were represented would be at a clear advantage over the unrepresented. In a situation such as this, one could not expect every member of a population to have equal access to justice. With governments ultimately responsible for the distribution of healthcare resources, people or populations without a physician must rely on public policy for advocacy. In 2008, there were 4.1 million Canadians without a primary care physician. Thus there is a large niche for special-interest lobbying, which has become an integral component of public health policy-making. Lobbyist groups like the Centre for Social Justice utilize an evidence-based approach to shed light on the multitude of socioeconomic factors that affect an individual’s need and ability to access healthcare.

The impact of socioeconomic and cultural factors on health outcomes can be appreciated through consideration of the Aboriginal (which includes Canada’s First Nations people, Inuit and Metis) and recent immigrant (those who have lived in Canada for less than five years) populations. For example, the Centre for Social Justice statement on improving access to healthcare for Aboriginals identifies factors such as exposure to education, socioeconomic status and language barriers. The correlation between health outcomes and access to a primary care physician is also demonstrated clearly in the Aboriginal population. Amongst Aboriginals, rates of access to a primary care physician are much lower than the Canadian average, while rates of health issues such as Human Immunodeficiency Virus (HIV) prevalence are much higher, and life expectancy is much shorter. Cultural factors intrinsic to a group may largely affect their

KEY POINTS

• A disproportionate number of Aboriginals and recent immigrants do not have a primary care physician, and poorer health outcomes in these populations are due to a combination of cultural and socioeconomic factors.

• Evidence-based allocation of healthcare resources calls for a multi-factorial approach to public policy-making, to gear medical training and clinics towards meeting specific population needs.
attitudes towards healthcare and thus could have a significant impact on their willingness to search for a primary care physician. For example, Aboriginal people living off-reserve are 5% more likely to report unmet healthcare needs due to personal circumstance (which includes not pursuing healthcare because they are too busy, deciding not to bother, believing that their care would be inadequate, not knowing where to go, or disliking/fearing doctors) than their non-Aboriginal counterparts. This holds true even when controlling for variables such as household income and health status. This evidence suggests that there are certain attitudes, values, or other cultural factors that are independent and significant determinants of access to healthcare.

Yet the 5% difference in reporting unmet healthcare needs accounts for less than half of the disparity between the Aboriginal population (24% without a primary care physician) and the Canadian national average (12% without a primary care physician). Attitude toward Canadian healthcare also cannot account for the even more dramatic lack of access for recent immigrants (35% without a primary care physician), as personal circumstance was not found to be a significant variable within this group. Other factors in addition to cultural values must be considered in order to rectify these disparities in population healthcare. The disparity between Aboriginal and recent immigrant access to a primary care physician serves as an example of how, when cultural factors are addressed without acknowledging other socioeconomic variables, groups that are less efficient at lobbying and making themselves visible in the public eye may not receive equal allocation of the resources they require.

**SUPPORT FOR AN EVIDENCE-BASED APPROACH TO POLICY-MAKING**

Improving the efficiency of government healthcare spending requires a better understanding of the problems that face specific populations. Addressing these underlying causes could help to meet the needs of many people who depend on public health policy for their advocacy. One example is low income, which is not only more common in both the Aboriginal and recent immigrant populations, but is also linked to diminished access to healthcare. Canadian universal health insurance reduces financial barriers at point-of-care, but low income correlates with unmet health needs due to a variety of other factors, such as lack of transport to primary care physicians or an inability to pay for prescription medications. These financial barriers can lead to delays in access to care, particularly cost-effective and life-saving preventative management, and accounts for much of the disparity in income-related health outcomes.

It is crucial that public policy continue to reflect the accumulating data on the causes of diminished access to healthcare. Increasing evidence suggests that programs geared toward specific cultural groups can serve a greater number of people if they seek to address other social determinants of health. Maintaining an evidence-based policy program depends on the availability of quality research to identify these determinants and evaluate pilot interventions. The relative and combined impact of cultural factors, immigration status and income, in addition to variables such as geographic distribution, language barriers, and access to education, requires further study.

The impact of the above variables on population health supports a multi-factorial approach to the provision of healthcare. This approach calls for the incorporation of more varied services in pre-existing programs, such as community health centres that seek to address a population’s unique needs. Prioritizing cultural-sensitivity training in clinics in optimal geographic locations to service low-income areas could help serve several populations in need simultaneously. Moreover, facilitating access to culturally-sensitive clinics for individuals from isolated communities or low-income households of all cultures could be both cost-effective and beneficial, as it uses existing infrastructure to serve multiple populations while still meeting specific cultural needs.

Identifying barriers to access and incorporating specific solutions into public health policy improves efficiency at all levels, from individual communities to nation-wide. An evidence-based approach to public health helps to identify and rectify causes of disparity without painting populations with broad brush-strokes of generalized interventions in programs or policy. This is not only cost-effective, but more importantly it enables access to care for those whose needs are not specifically targeted by current programs.

This article is intended to spark a much-needed and long-overdue discussion about healthcare allocation in Canada. The examples provided only begin to illustrate how small changes in public policy in light of new information can improve access to healthcare for underserviced populations. An evidence-based approach to policy-making accounts for socioeconomic and cultural factors, allowing us to effectively advocate for the populations that need it the most.

**REFERENCES**


**Author Biography**

Andrew Mulloy is currently a first-year student at the Michael G. DeGroote School of Medicine, McMaster University. He is originally from Sudbury, Ontario, where he completed a three-year Bachelor of Science degree in biology and chemistry.