Research

Equal for whom? Addressing disparities in the Canadian medical system must become a national priority

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When disparities in care within the Canadian health care system are demonstrated as Fowler and colleagues have in this issue of *CMAJ*,[1] we are disconcertingly reminded that we do not deliver health care in a vacuum. Rather, we deliver it within a sociopolitical context where a myriad of factors influence our patients' interactions with the health care system. In Canada, health care delivery is based on a premise of universality: by mandate of the Canada Health Act, all insured residents "must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions." The fact that patients have access to care irrespective of sex, race, sexual orientation or ability to pay is a source of pride for many Canadian physicians; however, it would be naive to believe that equal treatment at the point of care could obviate economic, educational and social inequities that, in some cases, have affected our patients not just throughout their lives, but even in utero.

Yet, how equitable is our health care system even at point of care? The study by Fowler and colleagues provides some insight. It evaluates the patterns of care in the intensive care units (ICUs) of 13 Ontario hospitals and demonstrates that the sex of the patient influences not only the care he or she receives in the ICU, but also whether he or she is admitted to the ICU in the first place. Although the number of admissions (excluding obstetrical admissions) to these hospitals were similar for women and men over a 2-year period, only 40% of patients admitted to the ICU during the same period were women, whereas 60% were men. In addition, despite having equally severe illnesses at the time of ICU admission, women received ICU care for a shorter duration then men. These women were not healthier than the men, nor did they experience better outcomes: after adjustment for potential confounders, critically ill women aged 50 years or more had a greater risk of dying than their male counterparts within 1 year of admission. The disparities identified in this study are particularly disturbing because it included only critically ill patients who had already been admitted to hospital, where it is assumed that care is delivered strictly on the basis of need.

Although Fowler and colleagues are to be congratulated on the quality of their work, their conclusion that there may be important sex- and age-related differences in the provision and outcome of care in Canada is not new. Numerous studies

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Key points of the article

- Universality is a central premise of our health care system; however, disparities in provision of health care and health outcomes occur in our system on the basis of sex, age, socioeconomic status, race and geographic location, to name a few.
- Our understanding of how to address these disparities is inadequate; however, addressing — not just documenting — disparities must become a national priority.
- Canadian granting agencies should do more to support research that evaluates the root causes of disparities and tests creative interventions to remedy those disparities when they occur.

in Canadian populations indicate that disparities exist. They have been found in determinants of health;[2] in the use of preventive services;[3] and in the use of medical care, including access to renal transplantation,[4] joint arthroplasty,[5] cardiac interventions[6] and delivery of palliative radiotherapy.[7] Studies have also demonstrated disparities in health outcomes in Canada. Examples include a greater risk of adverse birth outcomes among poor and less educated women,[8] an increased risk of emergency visits due to asthma exacerbation among poor children,[9] an increased risk of suicide in First Nations communities,[10] an increased risk of readmission for congestive heart failure and unstable angina among women who have undergone a coronary artery bypass,[11] and an increased risk for those living in remote areas in Canada of developing an acute complication of diabetes.[12] Despite the numerous published examples of disparities, such findings remain alarming and continue to be published in our highest quality journals. But since we live in a society that discriminates based on sex, age, race and socioeconomic status, and in which access and opportunity vary depending on geographic location, why are we surprised to find that our medical care and outcomes reflect these realities? Universal health care does not in fact guarantee equal access or outcomes for all. Given the lack of a systematic approach to counter our patients' inequitable realities and the lack of sufficient investment in research that

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explores biological interactions between sex, race, socioeconomic status, disease prevalence and response to therapy, shouldn't a failure to find disparities be more surprising?

In the United States, where inequities should be expected simply because they are built into the health care system, high-impact journals frequently publish research demonstrating disparities in care based on race, and these articles are often a source of substantial media attention. Yet after more than 20 years and literally thousands of articles demonstrating such disparities in health care delivery in the United States, little appears to have changed. In fact, demonstrating the persistence of racial disparities (and bemoaning the failure to make progress) appears to be the latest trend in research. Documenting disparities clearly is far simpler than addressing them; however, unless systematic approaches to remedying disparities in health care are developed and implemented, further documentation serves no real purpose. We know disparities are prevalent. But continuing to focus our research primarily on describing inequities is unlikely to improve care or outcomes.

There are seemingly insurmountable obstacles to addressing disparities in health care delivery and outcomes, and perhaps this explains our fixation with describing problems for which we have demonstrated no collective intention of tackling. As physicians, being burdened with the responsibility of compensating for social inequities over which we have little control may seem unreasonable, but nothing will change for our patients without action. There are numerous barriers that make it difficult to eliminate health care disparities in Canada. Foremost, the research base on which to devise and implement interventions to address inequities in health care delivery and outcomes is limited,[13] particularly within Canada. Fostering research in this area should become a priority for all Canadian granting agencies. The Canadian Institutes of Health Research has taken a leadership role by founding the Institute of Gender and Health; however, granting agencies should do more to support research that evaluates the root causes of disparities and tests creative interventions to remedy those disparities when they occur. This type of research is challenging and often involves qualitative and mixed-method approaches. In addition, journals with wide readership do not generally publish this type of work. Journal editors should be receptive to such studies and ensure that quality research in this area is published and promoted. Finally, in order to really begin to address disparities, it is necessary that we, as physicians, acknowledge that our behaviours and practices may contribute to health disparities.[14] Although this may be painful and difficult to contemplate, understanding our unconscious biases may provide an opportunity to prevent unintended and unwanted biases at the point of care.[15]

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