

Research

Standards for Equity in Healthcare Provision and Utilisation: Pilot Test in Sixteen Countries

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ABSTRACT

Background: Health systems are faced with different needs, conditions and expectations concerning health and healthcare delivery. The most vulnerable groups risk receiving poorer care due to barriers and inequities in health service provision and utilisation. However health care organisations are often not sufficiently equipped to effectively recognise and respond to the diverse needs of the population served. To this end, the Task Force Migration, Equity and Diversity (TF MED) developed a set of standards that allow health care organisations to evaluate equity in service provision and implement improvements. A test was conducted in 52 pilot organisations from sixteen countries to assess compliance with the standards, as well as to explore challenges and opportunities for the effective uptake of equity measures.

Methods: Purposeful sampling was utilised to identify participants for the pilot test by national coordinators of the TF MED (The TF MED was previously named Task Force on Migrant Friendly and Culturally Competent Health Care. The new name came into effect in 2016.). Organisations were general and specialised hospitals and other health care providers. Each pilot organisation defined appropriate structure and process to conduct assessment of service performance against the standards. A cross-sectional survey was used for data collection, participants were asked to fill in an online questionnaire with

data collected through the self-assessment process. Data were analysed quantitatively as well as qualitatively.

Results: The findings of the pilot test show that compliance with the standards was low in three main areas: policy, participation and promoting equity outside the organisation. In particular, pilot institutions revealed difficulties in engaging management and leaders on equity issues; in promoting the participation of users at risk of discrimination; in developing forms of collaboration with relevant stakeholders in the community. On a more positive side, the pilot test results show that in general organisations do have policies in place to improve access to healthcare, as well as policies to ensure that individual and family needs are taken into account throughout the care process; however their effectiveness and impact are rarely evaluated.

Conclusion: The implementation of the standards for equity contributes to a self-reflective process, involving health professionals and managers, in which gaps and potential improvements are identified. Many of the pilot organisations utilised the standards as part of a process of increasing their awareness of equity issues and changing the reorganizational culture.

Keywords: Equity in Health; Standards; Healthcare Organisations; Self-assessment; Quality of Care; Diversity; Inter-sectionality; Equity Measurement; Management Change

Abbreviations

HPH: Health Promoting Hospitals and Health Services; TF MED: Task Force on Migration, Equity and Diversity; NGO: Non-Governmental Organisation; IRCCS: Istituto di Ricovero e Cura a Carattere Scientifico

Introduction

Health systems are faced with different needs, conditions and expectations concerning health and healthcare delivery. The most vulnerable groups risk receiving poorer care due to barriers and inequities in health service provision and utilisation. However health care organisations are often not sufficiently equipped to effectively recognise and respond to the diverse needs of the population served. In this context several sets of standards

addressing the specific issue of improving access to services and quality of care for different target groups have been published [1]. A recent study analysed six different approaches and concluded that, “*despite differences in labelling, there is a broad consensus about what health care organizations need to do in order to be responsive to patient diversity*” [2]. Nevertheless the goal of standardisation is rarely to create overarching standards that tackle multiple diversities in an intersectional way, and service users with “*overlapping layers of oppression*” or several personal identity dimensions are usually stigmatised, resulting, for instance, in racist and discriminating attitudes [3]. What is required is a standardised person-oriented approach in which standards are able to reflect multiple identity dimensions or symbolic boundaries that service users present to health providers, including all kinds of dynamic and complex identities. To this end, healthcare standards should not focus on a specific target group, but on the outcome

to be achieved, and should aim at all beneficiaries. This approach does not exclude the possibility of making specific statements about particularly vulnerable target groups [4,5]. However, it is necessary for healthcare providers to adopt intersectional frameworks that address all beneficiaries, regardless of their origin, sexual orientation, impairment or other factors that make users vulnerable to discrimination [6].

The standards for equity in healthcare presented here, are an important step in this direction [7]. In 2011 the Task Force Migration, Equity and Diversity of the International Network of Health Promoting Hospitals and Health Services (HPH-TF MED) began developing these standards to help health care organisations monitor and measure their ability to provide equitable care for service users. Key concepts and principles focusing on equity highlighted in official documents [8-11] guided the development of the conceptual framework for the standards for equity in health care, such as respect for human rights and social justice, the distinction between equity and equality, the acknowledgment that inequities in health care exist and must be redressed; the need to eradicate all forms of discrimination, the right to self-determination and individual identity. The conceptual framework comprises five key domains:

- i. The inclusion of equity in all aspects of organisational policy;
- ii. The promotion of equitable access to health care services;
- iii. The provision of high quality, person-centred, care for all;
- iv. The engagement of service users including those at risk of exclusion;
- v. The promotion of equity through cooperation with other services and across sectors.

A set of preliminary standards were developed on the basis of a critical review of existing models and standards, as well as several expert workshops and consultations. In 2012 these preliminary standards were pilot-tested by 45 health care organizations from 12 countries in order to assess their clarity, relevance and applicability. In a previous study we reported on the theoretical framework and the development process of the standards for equity in health care [12]. The rationale for that study was the lack of consideration of equity issues in common quality assessment systems [13], as well as the lack of effective criteria for the assessment of diversity responsiveness in health care organisations[14,15]. Based on the results of the first pilot-test, a self-assessment tool (SAT) was developed to facilitate the implementation of the standards for equity in health care organisations. To this end in 2014 we launched a second pilot test aimed at assessing the compliance with the standards for equity in health care in pilot organisations, as well as to explore challenges and opportunities for the effective uptake of equity measures.

Methods

The self-assessment tool (SAT)

The SAT indicates the main domains that an organisation should address to ensure the delivery of equitable services in healthcare:

1. **Equity in policy:** Aiming to define how organisations should develop policies, governance and performance monitoring systems, which promote equity.
2. **Equitable access and utilisation:** Aiming to encourage health organisations to address barriers which prevent or limit people accessing and benefiting from health care services;
3. **Equitable quality of care:** Aiming to ensure that organisations develop services that are responsive to the diverse needs of patients and families along the whole care pathway, ensuring a safe environment and continuity of care;
4. **Equity in participation:** Aiming to support organisations in developing equitable participatory processes that respond to the needs and preferences of all users;
5. **Promoting equity:** Aiming to encourage organisations in promoting equity in their wider environment through cooperation, advocacy, capacity building, disseminating research and effective practices.

The tool is structured on three levels:

- 1). The main standards address the five domains identified;
- 2). The sub-standards break them down into principle elements;
- 3) The measurable elements are those requirements of the sub-standards against which organisations have to assess their performance.

Compliance with the sub-standards is measured by assigning a score to the level of implementation of each measurable element: 'Fully, Mostly, Partly, Hardly, No'. Demonstrable evidence is required to show compliance with the sub-standards. A box for comments next to the measurable elements collects information on the problems, goals, details on evidence and follow-up actions for equity improvements in the organisation. Table 1 gives an overview on the content of the SAT.

Participants and settings

Purposeful sampling was utilised to identify participants for the pilot test by national coordinators of the HPH-TF MED. Pilot organisations were selected depending on the size of the country and situational factors, such as geographic distribution. Organisations were general and specialised hospitals and other healthcare providers. Each pilot organisation identified appropriate organisational structure and process to conduct the pilot test: a project leader to coordinate and manage the data collection and to complete the online questionnaire; an assessment team to conduct assessment against each standard.

The assessment-team

Each organisation was free to decide on the composition of its assessment team; however, it was suggested that they include hospital or health-service managers; health professionals; administrative staff; representatives from relevant departments such as quality management, human resources, and communication; and representatives of service users, selected to ensure coverage of target vulnerable groups.

Table 1: Domains of the self-assessment tool.

Standards (n=5) ¹	Sub-standards (n=18) ²	Measurable elements (n=50) ³		
STD 1: Equity in policy	1. Equity strategy	1. Equity plans	7. Leadership support equity	
	2. Monitoring equity performance	2. Equity in overall strategy	8. Equity education programmes	
	3. Equity in all plans	3. Data collection on service access	9. Equity in core education programmes	
	4. Equity-competent staff	4. Data collection on health status	10. Evaluation of equity education programmes	
	5. Workforce equity policy	5. Use of data to improve equity	11. Equal opportunity of staff recruitment	
STD 2: Equitable access and utilisation	6. Accessibility, availability and distribution of health services	6. Equity impact assessment	12. Promotion of staff dignity	
		7. Reduction of communication and information barriers	19. Language barriers	
	7. Reduction of communication and information barriers	13. Access barriers to services	20. Communication barriers	
		14. Physical and geographical barriers	21. Quality of communication support services	
	8. Reduction of legislative and financial barriers	15. Access for disadvantaged people	22. Staff ability to work with interpreters	
		16. Outreach communication	23. Identifying people with no entitlement to care	
	STD 3: Equitable quality of care	9. Person-centred needs assessment	17. Evaluation of interventions reducing barriers	24. Supporting people with no entitlement to care
			18. Written material and navigation signs	31. Care environment respectful of individual identities
10. Person-centred care		25. Individual/family characteristics and situation in health needs assessment	32. Accommodate diverse patients' needs to obtain informed consent	
11. Respectful care environment		26. Individual/family characteristics and situation in psycho-social needs assessment	33. Privacy is respected in care practice	
12. Person-centred continuity of care		27. Individual/family characteristics and situation in care practice	34. Individual/family characteristics and situation in continuity of care	
		28. Individual values and beliefs in care practice	35. Collaboration with other service providers	
STD 4: Equity in participation		13. User participation in service planning and evaluation	29. Psycho-social needs in care practice	
			30. Staff trained on dealing with diverse patients	
		14. Barriers to participation	36. Users at risk of exclusion from participation	41. Participation of people at risk of exclusion is monitored and evaluated
			37. Promotion of the participation of people at risk of exclusion	42. Review of participation structures and processes
	15. Evaluation of participatory processes	38. Communication needs to effective participation	43. Feedback from users is used to improve service planning and evaluation	
		39. Support to effective participation	44. Feedback to the users and the public on participation results	
		40. Staff trained on how to engage people at risk of exclusion		
STD 5: Promoting equity	16. Cooperation and networking	45. Promoting research on inequities in health and health care	48. Dissemination of research results and existing good practices	
	17. Research and best-practices dissemination	46. Networks and partnership to deliver innovative services for disadvantaged populations	49. Partnership agreements and service contracts reflect equity standards	
	18. Equity in partnership agreements	47. Inter-sectoral collaboration to address wider determinants of health	50. Partnership agreements and service contracts are monitored	

¹The standards define the five main domains of the organisation that need to be monitored and measured

²Sub-standards denote, within each standard, the specific thematic area that need to be assessed

³Measurable elements are those items against which actual performance is assessed

Data collection

We used a cross-sectional survey addressing participants from pilot-organisations. Firstly, participants were given four months (January-April 2014) to establish the assessment team and to gather existing data from the organisation information systems (e.g.: management data). Secondly, between May 2014 and October 2014, participants were asked to fill in an online questionnaire with data collected through the self-assessment process. Both quantitative and qualitative data were collected concerning: the characteristics of the healthcare organisation and the service users mostly facing barriers to accessing good quality of care; the compliance score with the standards; the comments and additional information provided to support the score assigned.

Analysis

We calculated an overall compliance score by rating each of the 50 measurable elements as fully-compliant (4 points); mostly-compliant (3 points); partly-compliant (2 points), hardly-compliant (1 point) and non-compliant (0 points). We then computed the overall and domain-specific total scores as the sum across the items in the domain. We assessed distribution for “fully”, “mostly”, “partly”, “hardly”, “no” scores as the percentage of responses. The information provided by participants from pilot organisations in the box for comments next to each measurable element allowed us to add qualitative insights to the score given in the assessment. This information provided important background for the identification of the strengths and weaknesses regarding

the effective implementation of equity-improving measures in the organisation. The final analysis was approved by all authors.

Results

In total 52 healthcare organisations from 16 countries completed the self-assessment process: Australia (6), Belgium (6), Canada (4), Finland (2), France (1), Ireland (2), Italy (11), Malta (1), the Netherlands (1), Norway (6), Slovenia (1), Spain (6), Sweden (1), Switzerland (1), Turkey (1) and the United Kingdom (2). Table 2 describes the characteristics of the pilot organisations. Participants reported a number of factors they regularly took into account in attempting to provide equitable care for their users, such as age,

disability, gender, sexual orientation, economic situation, etc. (Table 3). A common theme in their answers was that providing equitable health care requires not only to take into account single factors impacting on access and quality of care, such as gender, age or ethnicity, but also the interactions of those factors that put individuals at higher risk of inequities [16]. When they were asked if there were specific combinations of factors that put individuals at a particularly high risk of receiving inequitable care, 'migrant status'; 'economic situation'; 'specific health situation'; 'language proficiency', 'old age', and 'lack of entitlement' were mostly cited in combination with other factors. This intersectional perspective [17] was confirmed by the comments related to this question. One participant, for instance, responded as follows:

Table 2: Characteristics of pilot-organisations.

	Frequency (%)	Total (%)
Type of organisation		52 (100)
Integrated health authority	9 (17.3)	
General hospital	14 (26.9)	
Specialised hospital	6 (11.5)	
University/teaching hospital	18 (34.6)	
Health centres (e.g. nursing home)	2 (3.8)	
Community health and social centres	3 (5.8)	
Status		52 (100)
Public	44 (84.6)	
Private not for profit	6 (11.5)	
Mixed public and private	2 (3.8)	
Catchment area		52 (100)
Rural	20 (38.5)	
Urban	12 (23.1)	
Mixed	20 (38.5)	
TF MED membership		52 (100)
TF MED	47 (90.4)	
Non-TF MED	5 (9.6)	

Table 3: Factors taken into account by organisations to provide equitable care.

Answer choices	n	(%)
Economic situation (income, wealth and poverty)	43	84,3%
Old age	40	78,4%
Specific health situation (mental health problem, HIV/AIDS, obesity, ...)	40	78,4%
Migrant status (e.g. legal migrant, asylum seeker, refugee, newcomer)	39	76,5%
Language proficiency	38	74,5%
Low information and health literacy	38	74,5%
Disability (physical, sensory, intellectual)	37	72,6%
Substance addiction (alcohol, drug, ...)	34	66,7%
Lack of entitlement to healthcare (e.g. undocumented migrant and uninsured)	33	64,7%
Ethnicity and race	33	64,7%
Childhood	31	60,8%
Gender (male, female, transgender)	28	54,9%
Adolescence and youth	26	51,0%
Housing and geography (deprived or underserved areas)	26	51,0%
Country of origin/birth	26	51,0%
Religious affiliation	26	51,0%
Sexual orientation (LGBT)	21	41,2%
Class (occupation and employment status)	19	37,3%
Aboriginal or indigenous origin	15	29,4%
Other factors	9	17,7%
Answered	51	
Skipped	1	

The factors that impact equity and access are generally not experienced in *isolation* and an individual's experience of barriers to equity and access are a 'whole of life' circumstance. While it is important that we consider each of these factors, considering each in isolation is unlikely to accurately reflect the actual consumer experience (Integrated health authority, Australia).

In the following sections we describe the results of self-assessment conducted in pilot organisations showing the level of compliance with the five standards and sub-standards contained in the SAT. A complete account of the compliance score achieved by pilot organisations is described in Appendix 1).

Organisational policies promoting equity

The first standard concerns the management level of the organisation. This domain "equity in policy" is translated into 5 sub-standards and broken down into principle components. To this end we asked participating organisations to assess whether they have:

- A specific strategy that promotes equity;
- A way to monitor equity performance and use this data reflexively;
- Leadership that promotes equity within the organisation;
- Activities to promote education in equity issues;
- Policies to promote workplace equity.

Twelve measurable elements were used to assess the performance of the pilot organisations. Each measurable element received a score between 0 and 4. The theoretical range in the compliance score was 0-48. The mean was 23.2, with a standard deviation of 7.6. For each measurable element, the mean was 1.9 and the standard deviation 0.6.

Although a good number of institutions scored well in the issue of equity strategy (fully/mostly n=20, 38.4%), participants defined it in different ways: "equality and diversity strategy", "diversity and inclusion strategy", "cultural responsiveness plan". Furthermore many organisations emphasised that rather than having a specific strategy, "equity is included in the health strategic plan" or implied "in the mission and vision statement". Several organisations focused on promoting workplace equity, declaring policies in place to ensure equal opportunity in recruitment and career advancement for all employees (fully/mostly n=36, 69.2%), and to promote dignity and respect for staff and volunteers (fully/mostly n=42, 80.8%). The organisations appeared less proactive in engaging management and leaders in the promotion of equity in their work, scoring low in a number of cases (hardly/no n=23, 44.2%). Participants from two pilot organisations explained this was a challenge as:

Currently, equity-related performance measures are not linked to executive compensation (Specialised Hospital, Canada). (...) many leaders do not have competence on the field of equity. It is not included in the leader training programmes. It is a person depending, whether a leader emphasizes equity or not (University hospital, Norway).

The majority of pilot organisations scored low (hardly/no n=30, 57.7%) in the level of implementation of procedures and tools to evaluate the impact of their policies and decisions on equity (e.g.:

health equity audit, equity impact assessment, evaluation reports). Some participants reported that "no general equity assessment or audit is done" since "a systematic approach is lacking". Findings show that one third of the organisations only partly collect data on the way people access their services in order to understand how service utilisation-patterns reflect the demography and the needs of client population (partly n=18, 34.6%), and another one third failed to collect this data (hardly/no n=17, 32.7%). Pilot organisations reported difficulties in explaining the importance of collecting this information, as the following quotation from a participant indicated: Data are partially available. When possible and useful, they are registered and reported. However some elements mentioned are not (or are forbidden) registered in the patient file (University hospital, Belgium).

This situation revealed that education and training were important, yet pilot organisations scored poorly on the promotion of educational programmes on equity issues, the majority declared to have only partly implemented (partly n=27, 51.8%) a comprehensive programme for equity education and to have either partly (n=21, 40.3%) or hardly/no (n=19, 36.6%) included learning about equity in core education programmes. Even if some organisations had equity education programmes in place they hardly, or do not, evaluate the effectiveness of these programmes (n=28, 53.9%).

Policy measures to improve equitable access to healthcare services

The second standard concerns equitable access to and utilisation of healthcare services. This domain is divided into three sub-standards against which organisations have to assess their performance through twelve measurable elements. This standard aims to evaluate whether the organisations seek:

- To improve accessibility, availability and distribution of health services;
- To reduce communication and information barriers between healthcare providers and service users;
- To address legislative and financial barriers in case of insurance or eligibility issues.

For this standard, we found a larger distribution of results. The theoretical range in the compliance score was again 0-48; and the mean was 27.5, with a standard deviation of 8.7. The mean per measurable elements was 2.3, with a standard deviation of 0.7.

In general, monitoring access barriers proved to be important for many organisations (fully/mostly n=27, 51.9%), particularly they declared policies were in place to minimise architectural and geographical barriers to facilities (fully/mostly n=35, 67.3%). To support this result, participants from pilot organisations often reported that "accessibility plans" and "building regulations" had to comply with national regulations. Important targets proved to be marginalised and disadvantaged people or those at risk of discrimination (e.g.: migrants, homeless people), but also people who are unable to properly access services once they are in the healthcare system (e.g.: disabled, people in chronic and complex conditions), as shown by the high score achieved by many organisations (fully/mostly n=33, 63.5%). For example, two health providers reported that there is a specialist service for homeless people in (...) which offers more tailored support to

homeless patients (Integrated health authority, United Kingdom). (...) 'Free of charge' programs as well as no waiting lists for marginalized and vulnerable groups are offered (Hospital and Community health service, Australia).

However, fewer pilot organisations showed they were active in outreach communication to these vulnerable groups, scoring not so high on this issue (fully/mostly n=19, 36, 5%), which some of them perceived as "not relevant for an inpatient clinic." Nevertheless, there was general awareness that, as one hospital put it, "greater outreach work is needed for hard-to-reach groups." Pilot organisations scored high in the implementation of policies addressing communication and information barriers. The main field of investment was language support services to improve communication between care providers and patients, (fully/mostly n=38, 73.1%), as well as provision of information material and navigation signage respectful of health literacy principles (fully/mostly n=23, 44.2%). Nevertheless, much effort is needed to improve staff awareness and competence in dealing with these communication support services, as shown by the low score on this issue (hardly/no n=22, 42.3%). To this purpose one participant stated "Written materials such as leaflets have been translated where practical, and individual requests by patients and/or their families can easily be accommodated e.g. to translate discharge letters, care plans. Staff could be encouraged to offer this facility more often rather than wait for it to be requested" (Integrated health authority, United Kingdom).

Surprisingly pilot organisations showed support was provided for those at risk of exclusion from health care because ineligible or without insurance coverage. Half of the pilot organisations scored high in monitoring the situation of people with no entitlement to care in their catchment area (fully/mostly n=26, 50%), and even more in the provision of concrete support initiatives, such as informal provision of care, referral to civil society groups or NGOs for these vulnerable groups (fully/mostly n=28, 53.8%). Although organisations show implementation of several measures to overcome access-barriers they seem to invest less resources in evaluating the impact of these interventions (hardly/no n=27, 51.9%). As was stressed by one participant:

Although we believe some work is being done, we are missing quantitative data to support this - there is more reactive versus proactive in targeting reduction of access barriers (Specialised hospital, Canada).

Equity-oriented care relationship

The third standard "equitable quality of care" measures dynamics related to the care relationship. This domain is broken down into four sub-standards against which organisations have to assess their performance through eleven measurable elements:

- The assessment of patients' needs according to individual/family characteristics and situation
- The inclusion of individual/family characteristics and needs in clinical practices;
- The provision of a care environment that is respectful of patient' identity and privacy;
- The inclusion of individual/family characteristics and situation at discharge and continuity of care

The theoretical range in the compliance score was 0-44, with a mean of 27.1 and a standard deviation of 8.5. This standard received the highest score, with a mean per indicator of 2.5 and a standard deviation of 0.8. It is not surprising that many organisations scored high regarding anamneses (fully/mostly n=33, 63.5%), considering that this is part of general protocols, as this healthcare provider describes: Patient needs are carefully assessed as part of established mental health procedures. Individual characteristics as well as those relating to culture, custom or family are identified and recorded as part of this process and feed into the care plan that is developed for every patient (Integrated health authority, United Kingdom).

The score for inclusion of individual/family characteristics and situations in clinical practices indicates that most of the pilot organisations only partly implemented these measures (partly n=24, 47.1%), although half of the organisations declared that care provision is considered and respectful of patient's dignity, personal values and ideas about health and care (mostly/fully n=26, 50%). This was often explained as resulting from a lack of time but also from "staff resistance to changing pre-existing practices," the fact that "clinicians are not interested in such issues," and, as one participant from a hospital stated, the biomedical approach, which focuses on the illness rather than the person: Therapeutic plans and care paths are customized only in some health settings (home care, hospice) very little in the Hospital, Day hospital, long-term care where traditional guidelines prevail. For every type of patient, the 'disease' is unfortunately considered and not the patient (Integrated health authority, Italy).

It could not be taken for granted that pilot organisations showed the same attention in identifying patient's psychosocial needs in clinical practice. However, they scored high in the level of implementation of both relevant needs' assessment protocols (fully/mostly n= 30, 57.7%), and procedures to meet these needs (fully/mostly n= 33, 63.5%). A good example was reported by one health provider: Existence of social history that is gathered by the social workers unit where psychosocial needs of patients are recorded. Social planning of hospital discharge is done. Inclusive practices in relation to: home hospitalization, medium and long term unit, child-youth mental health unit (University hospital, Spain).

Despite the existence of inclusive protocols many health professionals did not seem to receive much guidance through training on how to elicit patients' stories and ideas regarding illness and healthcare (hardly/no n=20, 38.5%). Two participants argued that: Training is offered – but guidance to elicit patient's story and ideas of illness is still a challenge (Specialised hospital, Canada).

In the last 12 months there has been training for ALL staff especially ACUTE and Senior roles on how to work with patients to hear their stories – however they are not mandatory (...) (Hospital and Community service, Australia).

In general, health care organisations also scored well concerning the creation of an inclusive care environment where patients feel safe with their dignity and identity (fully/mostly n=30, 57.7%), and needs for privacy respected (fully/mostly n=33, 63.5%). How this objective is achieved is well described by one participant's comment: The hospital (...) has a code of conduct

and a policy to prevent violence and harassment that mandates all employees treat patients, families, and each other with dignity and respect and be sensitive and responsive to other's beliefs, culture, and background (Specialised hospital, Canada).

Finally, pilot organisations self-rated themselves quite high in ensuring that socio-cultural context and individual/family needs are taken into account at discharge (fully/mostly n=24, 46.2%), and continuity of care (fully/mostly n=39, 75%). Although protected discharge and continuity of care is generally adopted by many hospitals, the importance of tailoring this approach for the most vulnerable groups is underlined by one participant: having access to translated discharge instructions and stronger partnerships with community agencies targeted to vulnerable populations (e.g., homeless, immigrant, LGBTQ) could improve continuity of care and (...) being integrated more into the health care system (Specialised hospital, Canada).

Participation and equity

The fourth standard examines users' engagement and participation, in particular of those groups at risk of exclusion and discrimination. This domain, "equity in participation" is divided into three sub-standards against which organisations have to assess their performance through nine measures addressing:

- User participation in service planning and evaluation;
- The identification of barriers to effective participation;
- The evaluation of participatory processes.

The theoretical range in the compliance score was 0-36, and the mean was 14.9, with a standard deviation of 8.1. The mean for the measurable elements was 1.4, with a standard deviation of 0.7.

The majority of organisations scored low for this standard. The results clearly indicate that healthcare organisations hardly, or do not, make efforts to identify users at risk of being excluded from their participatory processes (n=28, 53.8%) nor include them in general participation activities within the organisation (n=22, 42.3%). Participants' from pilot organisations argued that "it is a challenge that user interaction takes place via established patient support groups", usually "it is promoted users' participation, but not specifically the participation of the ones who are at risk of exclusion", and stressed the need to improve "diverse participation, including migrants, people with disabilities, etc." The low performance of pilot organisations is confirmed by the score results concerning the issues of barriers and support to effective participation. A good number of organisations failed to adopt strategies to identify and meet the support needs to effective participation (hardly/no n=19, 36.6%). Healthcare provider's identified various causes for the lack of effective participation, including the fact that meeting places and times were not suitable for hard-to-reach groups: Most of the meetings are held on site, not in the community, where people are-meeting times are mostly suitable for service providers, hardly ever evenings or weekends (Specialised hospital, Canada).

(...) The types of supports available could be improved to enable more patients and families to participate - e.g., interpretation support, child care, accessible venues, and payment/honorarium for time (Specialised hospital, Canada).

A further explanation for this low performance is the lack

of specific competence on the part of health staff. The majority of pilot organisations reported a lack of training programmes to ensure staff receive guidance on how to engage with those at risk of exclusion (hardly/non=28, 53.9%) so that they could participate effectively (e.g. communication strategies and engagement methods). The score was slightly better for feedback systems (fully/mostly n=19, 36.5%), because many pilot organisations provided client-satisfaction surveys, but lowest for identifying and monitoring users excluded from their participatory processes (hardly/non=30, 57.7%).

Healthcare organisations' lobbying activities in favour of equity

The fifth standard 'promoting equity' measures the initiatives organisations develop to promote equity in the wider environment through cooperation, advocacy, capacity building, disseminating research and effective practices. Pilot organisations were asked to evaluate their performance against three sub-standards:

- Networking and cooperation activities;
- Dissemination of results of research and best practices relating to equity;
- Their partners' respect for equity in their own practices.

This domain was measured through six measurable elements. The theoretical range in the compliance score was 0-24, with a mean of 9.9 and a standard deviation of 5.3. The score per measurable element was low, with a mean of 1.6 and a standard deviation of 0.9 (the highest of all measurable elements).

The overall result on this standard shows that healthcare organisations find it more difficult to justify and lead activities that occur outside their environment. Particularly organisations hardly, or do not, promote research on health and healthcare interventions targeting vulnerability (n=18, 34.6%), or only partly address these issues (n=16, 30.8%). It is not surprising that they also scored low in promoting the dissemination of research outcomes and information about good practices identifying ways to reduce inequity in healthcare (hardly/no n=24, 46.2%). Participating organisations scored highest in networking and creating partnerships with other services and organisations (fully/mostly n=28, 53.8%) with the goal of improving sensitivity towards equity in the community. Showing that inter-sectional collaborations are well established strategies in many contexts. A good example was suggested by a participant: The hospital has solid relationships with community based service providers in its area, (...). We have a network on migration and substance abuse and there are permanent appointments with several specialists, for example a psychiatrist, coming to the hospital (Specialised hospital, Norway).

Finally, the majority of pilot organisations scored low in ensuring that their partnership agreements and service contracts reflect equity standards (hardly/non=35, 67.3%), and in monitoring these processes (hardly/no n=37, 71.1%). Health care providers explained their difficulties as resulting from "bureaucratic constraints," a "rigid system" and the fact that they have no formal policy or procedure to ensure that partnership agreements and service contracts reflect equity standards (Specialised hospital, Canada).

There is no central index or process in place that can evidently show the monitoring of ALL partnership agreements and service contracts. There is no promotion on what to do and how to log a partnership agreement (Hospital and community health service, Australia).

General overview

The general overview of the results confirms that healthcare providers felt most successful in improving equitable access to health care services (fully/mostly 47.3%) and in delivering equitable quality of care for all patients (fully/mostly 54.5%). Whereas, they proved to be less effective in promoting equity through organisational policies and management commitment (hardly/no 36%); in providing equitable opportunity for service users to participate and engage in service planning and evaluation (hardly/no 43%); and in promoting equity outside the health sector in the wider society (hardly/no 46%).

Discussion

Creating a culture of equity in the organization means that disparities are openly recognized and that people in the organization, from leaders to front-line staff, are committed to reducing them. However, according to our findings while the workforce is well protected against discrimination, through established policies protecting staff and volunteers, there is little attempt to promote equity at a more general level of governance: management commitment, equity education, equity impact evaluation. Our findings show that organizations should invest more in training programmes for staff at all levels in order to improve awareness, knowledge and build capacity to address inequities in health care. In particular, organisations revealed difficulties in engaging management and leaders on equity issues. Considering that the pilot organisations volunteered to participate in this assessment, with the formal commitment of their top management, it is surprising that equity is rarely included in performance assessment and training of leaders and decision makers. Indeed healthcare leaders play a central role in defining strategic planning and resource allocation for those processes and services that support equity improvements in the organisation [18]. Although, lack of explicit resource allocation policies is often linked to inconsistency in operational definitions of equity and to uncertainties in the methods of assessing the costs of equity interventions [19,20].

In general the self-assessment results indicate that even when equity improvement interventions are in place, health organisations invest fewer resources in evaluating the effectiveness and impact of these interventions. As is the case for staff training, language support services and service user engagement. The need to develop more effective policies and practices to engage service users and stakeholders and ensuring they have an equal voice emerge as urgent from our findings and is confirmed in recent literature [21]. In particular organisations lack adequate strategies to identify and involve users at risk of being excluded from their participatory processes, as well as actions to identify and overcome barriers to effective participation. Furthermore, our findings report certain difficulties on the part of the organisations in promoting equity in their wider environment through forms of collaboration with other services and sectors of the society. Specifically, in promoting

collaborative research and best practice development on health care interventions targeting vulnerability, as well as ensuring that all partnership agreements and service contracts reflect equity standards. Similar drawbacks are described in a literature review reporting that evidence on the health equity effects of managed health care programs or integrated partnerships between health and social services is scarce [22].

Implication for health care organisations

Considering the feedback given by the pilot organisations throughout the evaluation process, we suggest that healthcare organisations use this SAT as part of their efforts to improve health equity, and that, to be effective, it should be supported by management commitment. Furthermore, we believe that the equity standards should be seen as a means for organisations to begin a journey towards greater equity in health care, rather than ranking them in a mere score system. Many of the pilot organisations utilised the SAT as part of a process of increasing their awareness of equity issues and changing their organisational culture. We believe that the self-assessment process documented in this paper was empowering, as the feedback we received from the organisations indicates. This effect is evident among the healthcare organisations at the centre of our analysis. In particular, the participating organisations reported a significant impact from use of the self-assessment tool and demonstrated it had become part of a process of change and empowerment [23,24]:

- Some health organisations received the support of regional/national governmental agencies to participate in this self-assessment. In Belgium, for example, the health ministry expressed its desire to work on improving equity in health organisations.
- The discussion of equity standards in health organisations revealed a need to link this kind of standards to other performance-measurement strategies and objectives that healthcare organisations are required to follow. In Canada, for instance, the discussion led to the integration of the equity standards in the Canadian Consortium for Health Equity national strategy.
- There was more than one pilot organisation in nine of the 16 countries. As a result, the organisations in these nine countries have begun to coordinate the administration of the SAT and compare their outcomes in an attempt to create a benchmark. In particular, the Italian and Norwegian healthcare organisations involved in the study reported that the evaluation process improved their national healthcare coordination networks.

The most important shortcoming identified through the SAT involves equity in participation. After having analysed their own situation, many healthcare organisations have begun to invest in new frame works to involve more service users in the different participatory instruments they have already implemented. In Australia, for instance, the experience of the equity self-assessment contributed to the development of a new strategy, Partnering in healthcare (<https://engage.vic.gov.au/partneringinhealthcare>), developed by the Department of Health and Human Services in the State of Victoria to involve health service users in order to reduce inequity.

Indeed, developing explicit, actionable and measurable equity standards can both be a crucial mechanism for ensuring strategic commitments to equity in health care delivery and can enhance quality improvement and performance measurement initiatives as drivers of change. Therefore, it is advisable that the use of SAT and subsequent interventions to improve equity in health care services should be framed within the broader context of improving quality of care [13].

Limitations

The results of the SAT pilot test undoubtedly have certain limitations. First, the participating organisations are not necessarily representative of healthcare organisations in their respective countries. Participation was not compulsory, and most of the organisations as members of the HPH-TF MED, were already committed to improving equity. Second, the data that we analysed was reported by pilot organisations based on their self-assessment, which may be biased given strong initiatives for either positive or negative score. Third, each healthcare organisation decided autonomously how to conduct the self-assessment. We suggested that they work with an interdisciplinary group of people including members of management and users' representatives, which suggestion was followed by all partners, but we had no possibility of intervening in each group's composition or, therefore, of ensuring the homogeneity of assessment teams across organisations.

Conclusions

The overall evaluation process was considered positive by pilot institutions as it allowed health care organisations to identify gaps and to plan improvements based on the findings of the self-assessment. As we have discussed above, three areas require particular attention:

- i. In terms of policy, there is evidence of inadequate implementation of equity plans, particularly equity monitoring and equity training;
- ii. In terms of participation, there is insufficient identification of groups at risk of exclusion, limited initiatives to support effective participation and assess it;
- iii. In terms of the promotion of equity, there is insufficient research on health inequities and the difficulties in ensuring equity in partnership agreements.

Declarations

Ethics approval and consent to participate: The project was considered to be outside the remit of both the World Medical Association Declaration of Helsinki and the EU regulation on clinical trials on medicinal products for human use No 536/2014 and could therefore be implemented without the approval of the Provincial Ethical Committee for Medical and Health Research of Reggio Emilia. The participants were institutional partners that gave their written consent to participate in the self-assessment process of their services against equity criteria.

Consent for publication: Not applicable.

Availability of data and materials: Additional data and

material are available from the corresponding author on request.

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