Report on February Research Conference

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WCH Network on Uninsured

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For Today

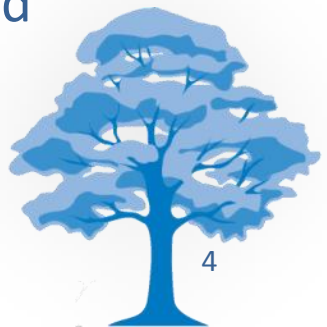
- **will discuss networks' requirements for Conference Report**
- **will outline key themes → get confirmation**
- **will set out key implications and possible directions or action → discuss and elaborate**
  - will separate implications from conference and other evidence on what needs to be done
  - from what Network could do – will set out a few options for discussion of Network actions and collaborations
- **will outline possible structure of Rpt → confirm**

Structure of Report

- **not just summary of presentations, but analysis of inequitable health impact and policy implications**
  - with options for next steps?
- **structure:**
  - preamble: details on conference
  - key findings
  - implications and impact on health equity
  - policy implications and directions/options
  - what next for Network
- **plus:**
  - detailed summary of proceedings will either be part of report or appendix
  - summary, program schedule available presentations from conference and other decks (e.g. Linda to OHA) will be posted on WI site

Promising Research/Valuable Conference

- **long had anecdotal evidence telling a consistent story**
- **conference highlighted that we are starting to get solid and systematic survey, quantitative and case study research**
  - more and more research, policy and provider interest in addressing issue of inequitable access and impact on uninsured people
  - major multi-year and comprehensive research projects underway
- **research has clearly identified:**
  - inequitable impact of denying access to uninsured
  - lines of action needed – from reforming institutional and provider practice to policy changes



Themes from Conference

- **Quantitative data demonstrates that people without health insurance tend to present at hospital Emergency Rooms with more serious problems.**
  - However, they receive differential and unequal triage and treatment; with fewer being admitted and more leaving hospital without being treated.
- **This + research on diabetes management, obstetrical monitoring and care, midwifery, mental healthcare and other service areas demonstrates that those without health insurance**
  - have far more restricted access to healthcare
  - tend to delay seeking care longer than advisable.

Themes from Conference II

- **This research + considerable practice evidence from healthcare providers indicates that lack of access to insurance and inadequate access to healthcare adversely affects health outcomes and opportunities.**
- **In addition to inequitable access to healthcare, those without insurance generally occupy inequitable positions within the wider social determinants of health**
  - with many in precarious employment or facing social exclusion because of language and cultural barriers and racism

Themes from Conference III

- **Many also face uncertain immigration status.**
  - For the latter, their vulnerability and precariousness leaves some with a fear of speaking up about their problems because of perceived threats to their immigration status.
- **This inequitable access to healthcare, plus insecure immigration status and overall social and economic inequality, contributes**
  - →to heightened stress and anxiety
  - → and appears to be associated with increased risk of mental health problems.

Themes from Conference IV

- **While those without health insurance for various reasons face common problems in terms of access to care, their immigration status, position within the labor market, income, living conditions, and other factors can vary considerably.**
- **It is particularly important to distinguish the legal and regulatory reasons why different categories or sub-populations are uninsured. While all share common needs for more equitable access to care, the policy solutions to their lack of insurance are very different.**

Themes from Conference V

- There are many innovative and responsive initiatives from healthcare providers to support the uninsured, and this is an enormous resource to be built upon.
- However, there needs to be greater coordination and more systematic policy and practice on issues of access to services and high-quality care that can address the complexity of people's needs.
- A multi-pronged approach to policy and practice is needed and diverse stakeholders need to be engaged.
- Researchers argued that access to healthcare and health needs to be reconceptualized and reframed as a human rights issue and for the language of rights and social justice to inform discussions and actions about accessibility and care for the uninsured.

Quantitative Research

- **quantitative analysis of hospital data in Toronto:**
  - uninsured tend to present with more serious problems
  - but receive poorer triage and care:
    - Higher % not admitted – higher for women
    - Higher % leave without being treated
- **but quantitative can't tell us what factors drive people away form receiving care they need:**
  - discrimination, inadequate and inequitable treatment
  - fear of disclosure
  - fear of greater costs
- **evidence indicates all of these factors can be important**

Impact of Inequitable Access

- **consistent findings from research on:**
  - colposcopy
  - diabetes management
  - obstetrical care and midwifery
  - mental healthcare
- **because of costs and restricted access patients tend to:**
  - delay care longer than is medically advisable
  - choose mix of care that is not the most optimal
- **while these studies did not always have data on clinical outcomes as a result of this less than optimal care, we can presume from broader evidence that:**
  - not following up tests and choosing treatment options on the basis of cost will have adverse effects
  - this could contribute to avoidable hospitalization and more intensive/costly treatment later on

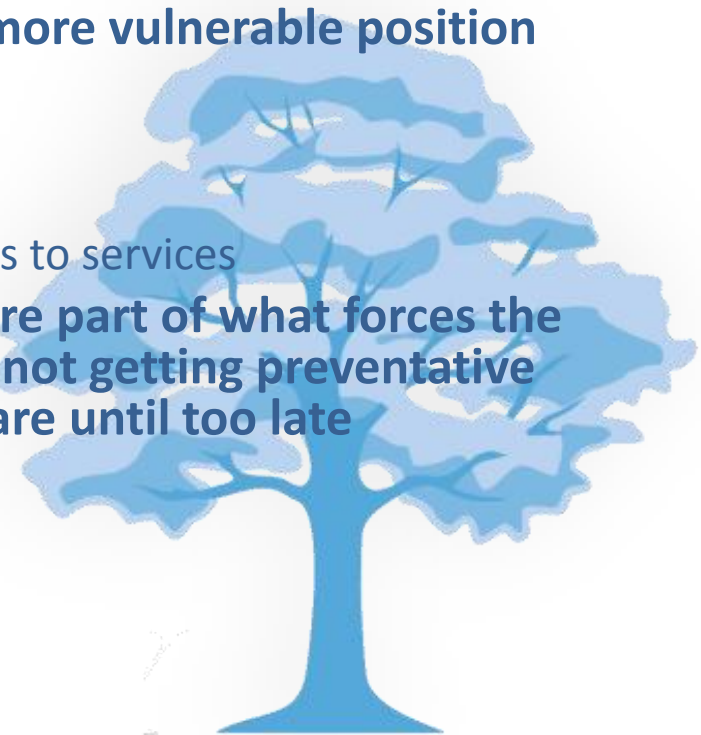
Health Equity = Reducing Unfair Differences

- **Health disparities or inequities are *differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage***

- **The goal of health equity strategy is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes**
- **if equity is addressing inequalities that are avoidable, then uninsured are classic case:**
  - problem is that certain categories of people are explicitly denied healthcare
  - solution is to remove those barriers
  - the basis of this particular line of inequity is certainly avoidable – and certainly open to policy action

Layers of Inequality

- **can't understand the roots of problem of uninsured health in isolation**
- **problem is not just very inequitable and restricted access – as bad as that can be**
- **but different and unfair treatment:**
  - from first contact all the way through time in hospital
- **and limited access to health promotion and preventative care/support**
- **and way upstream – uninsured tend to be in more vulnerable position within overall social determinants of health**
  - lower paid and more insecure employment
  - precarious legal and immigration status
  - social exclusion through racism or lack of access to services
- **these conditions of inequality and exclusion are part of what forces the uninsured into such harsh decisions – such as not getting preventative prenatal and other care or avoiding seeking care until too late**



Gender Affects Everything

- **whatever the medical or access problem, it is different and generally more severe for women**
  - mental health challenges related to experiences of violence and family abuse
  - access to pre-natal care
- **women are in worse position in SDoH terms → inequitable access and treatment within health system → reinforcing inequality**

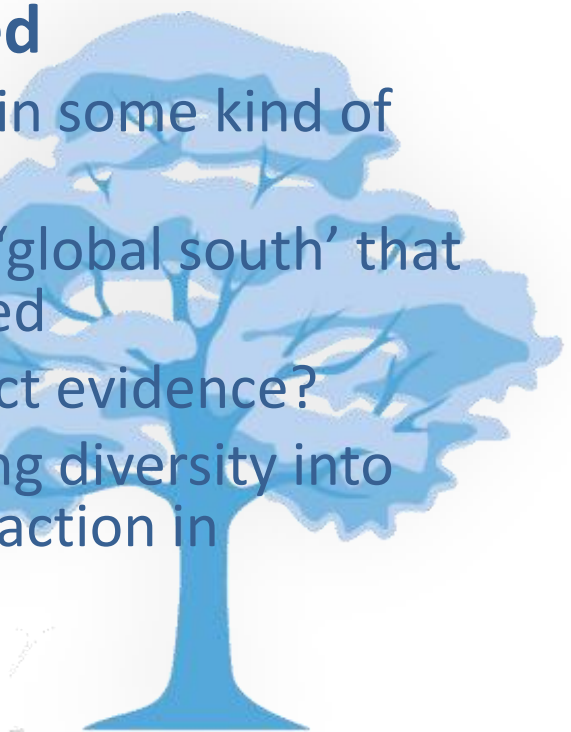
Racism Frames Whole Issue

- **racism is well documented as a wider determinant of health and overall social inequalities**

  → shapes experience of so many uninsured and undocumented newcomers

- **racist and xenophobic assumptions define the whole discourse and debate around uninsured**
  - it's not immigrants or non-status people in some kind of abstract sense
  - its racialized immigrants and those from 'global south' that are over-represented within the uninsured
  - possibly tricky – do we have enough direct evidence?

  → none of solutions will work without taking diversity into account and building anti-racist analysis/action in



Moving Forward

- **certainly some areas where further research would be vital:**
  - long-term impact of denying access to uninsured:
    - on specific chronic conditions
    - over the life course for children from families denied access
  - specific processes and attitudes that underlie differential and inequitable treatment of uninsured within hospitals and other institutions
  - potential of policy and practice changes and of training, incentives and other behaviour changes
- **but existing evidence tells us more than enough about the big questions:**
  - does lacking health insurance lead to restricted and inequitable access to needed care -- yes
  - does this have adverse impact on people's health – yes
  - have policy and practice solutions been identified – yes
- **we have enough evidence to act**

Two Levels of Analysis

1. **What needs to be done?**
    1. within healthcare institutions and practice
    2. health policy and funding – LHINs, MOHLTC, fed govt
    3. upstream macro immigration, social and economic policy
2. **what is role for Network within this?**
    1. not just on its own, but what collaborations with others

What is To Be Done?

- **will set out options for immediate changes within existing policy and constraints:**
  - to eliminate some of most glaring and damaging inequities
  - including identifying potential risks for hospitals of not acting
- **elaborate possible improvements to existing 'work-around' policies**
  - e.g., systematizing the provincial funds to CHCs to care for uninsured
- **ideas and options for more systematic and wider reaching solutions**
  - building on policy conclusions and opportunities raised at conference
  - and on lessons learned from other jurisdictions

Policy Conclusions From Conference

- **scope of problem can be overwhelming – from underlying SDoH to immigration and economic policy to healthcare access and practice**
- **can't do everything at once, but we need to start somewhere**
- **be strategic + opportunistic, but get going**
- **need sophisticated analysis to differentiate the different social and policy reasons that people are uninsured**
  - → to develop specific policy solutions
- **then nimble mix of:**
  - breaking full range of problems that need to be addressed into issues that are manageable
  - picking issues that are winnable – both to make a difference and build momentum
  - keeping fundamental principles and long-term goals always in mind
  - build for the long haul
  - be ready for windows of opportunity

Build On Innovation

- **lots of innovative ideas**
  - providers setting up special clinics or services within other institutions
  - creative partnerships – CHCs and pharmaceutical industry to get meds to uninsured
  - unusual suspects coalitions – health and other service providers, social justice advocates, neighborhood groups
- **we know what kinds of care are needed and what works:**
  - comprehensive primary care
  - customized mental health, health promotion and other support that takes account of the precarious and vulnerable life situation of many uninsured people
  - partnerships and collaborations to address full scope of people's needs – e.g., community groups to provide interpretation and culturally specific support

Build on What Works

- **we can build on innovative and energetic grass-roots responses in many communities**
  - Physicians and other providers that have established clinics to provide care
  - Midwives who are provincially funded to provider care for those without insurance
  - Services provided by Community Health Centres and funds they administer to cover care in hospitals
  - Innovative and inventive ‘work-arounds’ developed in hospitals across the province to ensure vital care is provided – whatever the formal rules and procedures

Actionable and Staged Solutions

- **within current system and constraints:**
  - systematize procedures within – and across hospitals in a LHIN – which are very inconsistent and arbitrary
- **Toronto Central LHIN has funded project with GTA CHCs to systematize and streamline the money available to cover hospital care for uninsured**
  - need to ensure results and lessons learned are shared
- **more broadly, the existing pool is not adequate to meet demand and should be increased**

Work Within Hospitals and Other Components of Health System

- **clarify expectations on all professionals to treat uninsured appropriately**
  - e.g. no demands presented to patients while recovering in their beds
- **providers should no longer bill uninsured patients at higher than OHIP rates**
  - as first step in reframing issue within hospitals so that most vulnerable are no longer seen as revenue stream
- **move responsibility from administrative/financial side to CEO and quality/equity sides of management**
- **hospitals should no longer use collections agencies**
- **hospitals can creatively use the levers they have to hand**
  - hospitals provide space and other support to family medicine physicians
  - part of deal could be treating a certain % of uninsured
- **confirm and publicize duty of confidentiality -- that no information will be passed to immigration authorities**
- **educate staff on these procedures – within broader training on cultural competence**

Build on Existing Initiatives

- **the Hospitals Collaborative on Marginalized Populations**
  - established by CEOs of Toronto hospitals to address common equity issues and needs of disadvantaged populations
  - led development of hospital equity plans
  - has been working on this issue, especially how to systematize policies and procedures
    - has recommended to their CEOs that they advocate for end of three month waiting time for OHIP for newcomers
    - will take issue of systematizing and improving practice to key forums such as TASIN

Building the Policy Case

- **look to other jurisdictions – to show manageable impact of reforms such as removing 3 month wait**
  - most provinces do not have a three month waiting list
  - New Brunswick recently repealed theirs – explicitly to eliminate a barrier to immigrant settlement
  - Quebec has made exceptions to their waiting period for pregnant women, those with infectious diseases, and others
- **cost-effectiveness – to show reforms are practical and possible:**
  - partially from other jurisdictions
  - extrapolations and estimates for Ontario

Options for Network

- **build on strengths and results so far:**
  - providing a forum to bring together providers from diverse settings, researchers and policy analysts/advocates
  - conference highlighted that value of bringing researchers together to showcase developments and coordinate future research direction
- **identify gaps in research and knowledge, and inconsistencies in practice**
- **collaborate on common agendas with:**
  - Hospitals Collaborative on Marginalized Populations to keep issue on hospital agenda
  - Wellesley to take research and options into MOHLTC
  - HfA and RTHCC on policy advocacy

Following Up

- these speaking notes and further resources on policy directions to enhance health equity, health reform and the social determinants of health are available on our site at http://wellesleyinstitute.com
- my email is bob@wellesleyinstitute.com
- I would be interested in any comments on the ideas in this presentation and any information or analysis on initiatives or experience that address health equity

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