Health Equity & Diversity: Ensuring Quality in Healthcare

Tackling Barriers to Health Equity: the Uninsured

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Thought Exercise:

what does good quality care look like?	do uninsured get this?
• access to primary care	• if lucky enough to be with CHC
• access to acute and specialized care when needed	• if lucky enough to be with CHC and if good relations with hospital
• high-quality person - centred care and respect	• only in CHCs and limited community settings
• seamless continuity of care	• no
• up-stream preventative support and health promotion	• no

The Challenge of the Uninsured

Precarious population

+

Access denied

=

Critical equity problem

Challenge for Hospitals and Providers

- long been recognized as an issue on front line
- Women's College Hospital's Network established three years ago as forum for providers

  → uncovered horrendous examples of inadequate and inappropriate treatment

  → need for systematic research →recent conference

  → need for consistent treatment within hospitals → Hospital Collaborative on Marginalized Populations in Toronto and others

  → need for policy changes

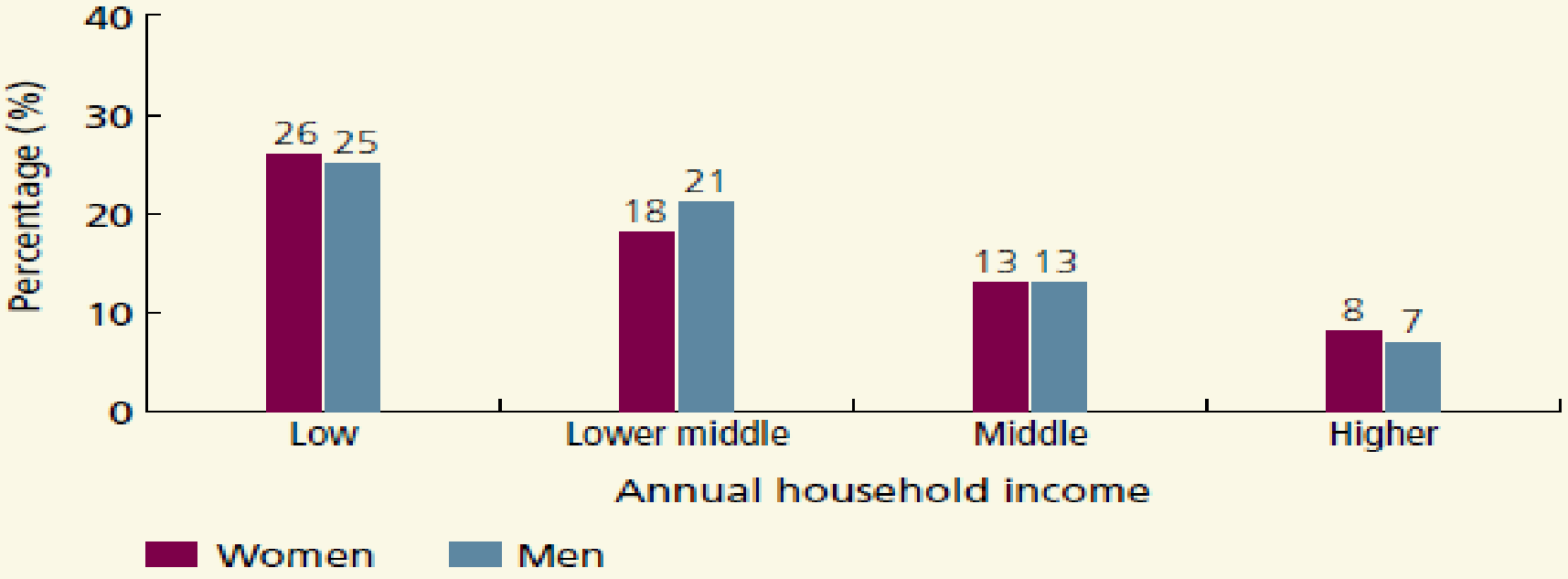
Presentation Outline

1. step back to look at the big picture:
   - pervasive health inequities in Ontario
   - health equity defined
2. show how the “Uninsured” are an important equity issue for hospitals
3. report on recent research conference organized by WCH Network on Uninsured Clients
4. identify emerging initiatives and ideas for what hospitals can do

Big Picture: Health Disparities in Ontario

- there are significant and systematic disparities in how healthy people are:
  - people with lower income, education or other indicators of social conditions and position tend to have poorer health
  - there is a clear gradient in health all along the social hierarchy
  - plus major differences between women and men
  - the gap between the health status of the best off and most disadvantaged can be huge – and damaging
- plus disparities in access to and quality of care within the healthcare system

Age-standardized percentage of adults aged 25 and older who reported their health as fair or poor, by sex and annual household income, in Ontario, 2005



DATA SOURCE: Canadian Community Health Survey (CCHS), Cycle 3.1

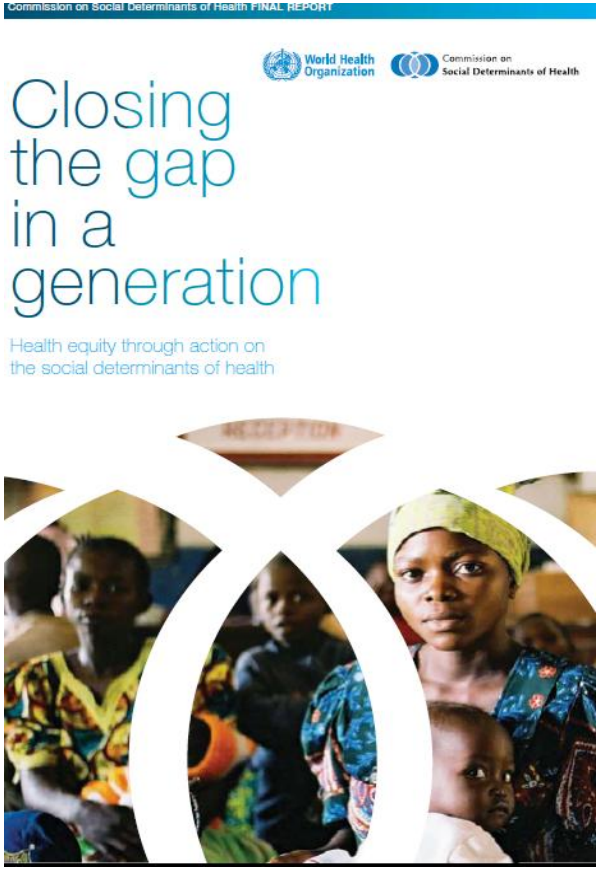
NOTE: See Appendix 3.3 for definitions of annual household income categories

POWER Study

Social Determinants of Health

- clear research consensus that roots of health disparities lie in broader social and economic inequality and exclusion

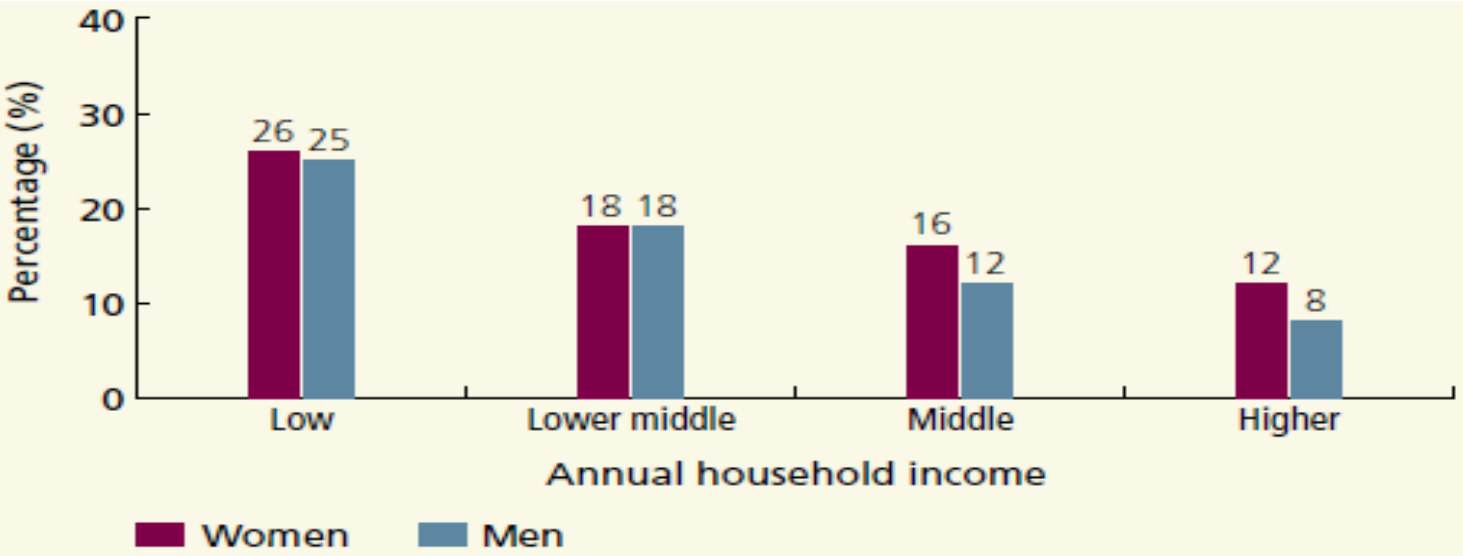
- real problem is differential access to these determinants – many analysts are focusing more specifically on social determinants of health inequalities



Damaging Impact

- the gap between the health status of the best off and most disadvantaged can be huge – and damaging
  - difference between life expectancy of top and bottom income decile = 7.4 years for men and 4.5 for women
  - more sophisticated analyses add the pronounced gradient in morbidity to mortality → taking account of quality of life and developing data on health adjusted life expectancy
  - even higher disparities between top and bottom = 11.4 years for men and 9.7 for women (Statistics Canada *Health Reports* Dec 09)

Age-standardized percentage of adults aged 25 and older who reported that their activities were prevented due to pain or discomfort, by sex and annual household income, in Ontario, 2000/01



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POWER Study

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*

- this concept:
  - is clear, understandable and actionable
  - identifies the problem that policies will try to solve
  - is tied to widely accepted notions of fairness and social justice

- the goal of health equity strategy is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes

- enhancing health equity has become a clear priority – from the Province to LHINs to many providers

Equity Into Health System: Why

- the roots of health disparities lie in far wider social and economic inequality, but ….

1. it's in the health system that the most disadvantaged end up sicker and needing care
2. there are systemic inequities within healthcare:
   - people lower down the social hierarchy tend to have poorer access to care, even though they may have more complex needs
   - unless we address inequities in access and quality within health care, we could be making overall inequities even worse

Equity Into Health System: How

- tackling disparities within the healthcare systems needs a two pronged strategy :
  1. **building health equity into all** health planning and delivery
     - doesn't mean all programs are all about equity
     - but all take equity into account in planning their services and outreach
  2. **targeting** some resources or programs specifically to addressing disadvantaged populations or key access barriers
     - looking for investments and interventions that will have the highest impact on reducing health disparities or enhancing the opportunities for good health of the most vulnerable

Access Denied for Uninsured

- those without health insurance are among the most vulnerable → need to address the foundations of barriers they face
- more generally, if equity is addressing inequalities that are avoidable, then uninsured are classic case:
  - certain categories of people are explicitly denied healthcare → solution is to remove those barriers
  - certain categories of people are treated more poorly → can change within hospitals

The Issue Is Equity

- so this is a vital issue of health equity
- at its starkest, the principle here is very clear:
  - people live and work here
  - newcomers need access to health care like anyone else
  - the human costs of denying that access are unacceptable
  - in a wealthy and open society, health is a basic human right

Women's College Hospital's Network on Uninsured Clients

- formed in April 2007 on advice from the Women's Health Community Advisory Panel at WCH
- grown to over 60 individuals and organizations sharing knowledge, skills, expertise and resources
- multi-sectoral - health, social service, settlement, housing, street, legal, academic/research, policy; institutional, community based and grassroots, etc.
- members are healthcare professionals; academics, researchers, legal workers, community based providers; administrators, activists and people with lived experience

WCH Network on Uninsured Clients: Goals

- improve access to quality health care for people without insurance
- develop a hospital and community strategy responsive to the needs of people without health insurance
- improve access to and co-ordination of health services
- provide more integrated, comprehensive, effective, efficient care and support services
- raise awareness about issues facing people without health insurance and access to health services

WCH Network: Research Conference February 12, 2010

- goals of the Conference were to
  - hear about innovative research on access barriers, differential quality and health outcomes facing those without access to OHIP
  - identify common findings and implications, and key research and policy issues moving forward
  - allow researchers and others to make connections among themselves
- 30 presentations of new, ground-breaking research
- brought together some 200 researchers, healthcare providers, policy people and others working in spheres addressing health and other needs of uninsured people
- presentations and Conference Summary Report will be on Wellesley Institute site: www.wellesleyinstitute.com

Conference: Defining Themes

- huge cost of denying access to care to vulnerable individuals = poor health and needless anxiety
- 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 provide care for those without insurance
  - Services provided by Community Health Centers 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

Conference: Findings on Impact of Denied Access

- long had consistent anecdotal evidence
- starting to get solid survey, quantitative and case study research
- many different reasons why people come to be uninsured or undocumented → different specific policy and program solutions
- overall patterns:
  - very precarious population in terms of wider social determinants → more health disadvantaged
  - inequitable access to healthcare
  - treated more poorly
  - inequitable health outcomes

Conference: Specific Research

- quantitative analysis of hospital data in Toronto:
- uninsured tend to present with more serious problems
- but receive poorer triage and care:
    - tend to be classified at lower priority level in triage
    - higher % not admitted + higher again for women
    - higher % leave without being treated
- reflecting findings from other sessions, uninsured tend to also present with mental health problems and issues associated with environmental and social conditions

Conference: Specific Research II

- qualitative study of diabetes and immigrant women of colour without immigration status and health insurance
- these women had low income and precarious social position, putting them among populations at greater risk of diabetes
- because of their vulnerable and uninsured status, they don't have access to services/resources to prevent or manage diabetes, such as:
  - medication, testing strips and specialized health care
  - food and housing

Conference: Specific Research III

- reproductive health care
  - midwifery has provided vital care to uninsured through provincial funding streams
  - but uninsured women were more likely to have less prenatal care, ultrasound and other tests, and at later stages of care, and more likely to self manage care because of costs
  - more likely to ‘choose’ home birth because of hospital costs
  - review of charts/records indicates uninsured do not follow up on colposcopy test results as often

Conference: Specific Research IV

- mental health
  - the findings from a number of qualitative studies revealed similar themes
  - precariousness of work and legal status for many different groups of uninsured – e.g. temporary workers, undocumented – and socio-linguistic and social exclusion barriers
  - these social factors were a major source of stress
  - emerging evidence of overall lack of control, and instability and insecurity, having adverse impact on stress and anxiety, and on risk of mental health problems

Conference Conclusions: 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
  - very limited access to preventative and chronic care
- and way upstream – uninsured tend to be in more vulnerable position within overall social determinants of health

Conference Conclusions: 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
  - access to pre-natal care
- women are in worse position in SDoH terms → inequitable access and treatment within health system → reinforcing inequality

Conference Conclusions: 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
  - it's racialized immigrants that are the "problem"

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

Conference : Policy Conclusions

- 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
- 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" in coalitions – health and other service providers, social justice advocates, neighborhood groups
- lots already happening to build on

Conference : Policy Conclusions II

- need really sophisticated analysis to openly address these complexities
- then strategic mix of:
  - chunking out 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

What is To Be Done?

- will set out options for easy-to-make changes within existing policy and constraints:
  - to eliminate some of most glaring and damaging inequities
  - including identifying potential risks for hospitals of not acting
- then elaborate possible changes to existing 'work-around' policies within hospitals and beyond
  - e.g., systematizing the provincial funds to CHCs to care for uninsured
  - expanding the pool of funds
- 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 Implications for Hospitals

- the issue is not going away
- major priority with equity advocates, many providers and other key stakeholders
- many are working on issue:
  - Health for All – many medical residents and other young healthcare professionals
  - Right to Healthcare Coalition – long-established
  - WCH Network on Uninsured Clients
  - OMA recently passed a resolution

Risk Management for Hospitals

- in equity terms:
  - poor treatment of a very vulnerable population
  - in danger of being out of line with Ministry and LHIN equity goals
  - let alone wider social responsibility
- in administrative terms
  - dealing with categorization, billing, follow-up
  - is it efficient in narrow cost-revenue terms?
  - takes attention away from core business
- in media and public relations terms
  - some of stories of inequitable treatment are horrendous
  - real danger of bad publicity

Actionable and Staged Solutions: Start Where We Are

- systematize procedures within every hospital
  - which are very inconsistent and arbitrary
  - develop consistent protocols and procedures
  - begin from consistent principle of providing access regardless of ability to pay
  - first concern is medical need → so credit/financial information is not part of diagnosis and triage
- many hospitals are already at work on this:
  - St. Joseph's Health Centre
  - Mount Sinai Hospital
  - Women's College Hospital

Improve Procedures II

- educate staff on these improved procedures
  - within broader training on cultural competence
- confirm and publicize duty of confidentiality -- that no information will be passed to immigration authorities
- all hospitals to collect data on uninsured they treat to be able to track care journey and outcomes

But Not Just Hospital by Hospital

- across hospitals in a region
  - all hospitals to share best procedures
  - each LHIN to take responsibility for ensuring consistent treatment and procedures in all hospitals
- perverse consequences of doing the right thing:
  - hospitals are worried that if they improve access
  - then others will send them all their uninsured patients
- that's a system issue = needs to be addressed at LHIN level

Eliminate Glaring Inequities: Financial

- 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
- no longer use collections agencies

Eliminate Glaring Inequities: Professional

- clarify expectations on all professionals to treat uninsured appropriately
  - e.g. no payment demands presented to patients while recovering in their beds
- hospitals can be creative using the levers they have to hand
  - they provide space and other support to family medicine physicians
  - deal could be expectation that physicians treat a certain % of uninsured

Systematize Existing Ministry Funding

- Toronto Central LHIN has funded a project with GTA CHCs to systematize and streamline the money available to cover hospital care for uninsured
- need to then share results and lessons learned to other hospitals and LHINs
- goal = consistent and equitable use of available funds

Getting at the Root of Problem

- and then…., the existing CHC funding pool is not adequate to meet needs and should be increased
- and then….,a major problem is three month waiting period for newcomers → should be eliminated

Getting at the Root of Problem

- 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 in TC LHIN
  - has been working on issue of uninsured, 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
- think of possible influence if OHA took up that advocacy demand

Other Jurisdictions

- most provinces do not have a three month waiting period
- New Brunswick repealed their policy in February
  - to eliminate a barrier to immigrant settlement
  - and explicitly because it was inequitable
- Quebec has made exceptions to their waiting period for pregnant women, those with infectious diseases, those who have experienced violence

Moving Forward

- hospitals can make the desperate situation of uninsured a lot worse
- or they can improve it
- have set out some initiatives underway and ideas for streamlining and improving how we treat uninsured
- including joining with other professionals and many others in demanding the policy changes needed to end this inequity

Further Health Equity Resources

- Wellesley Institute http://wellesleyinstitute.com
- Health Equity Council http://healthequitycouncil.ca
- Rainbow Health Network http://www.rainbowhealthnetwork.ca
- Ontario Women's Health Network http://www.owhn.on.ca
- Ethno-Racial People with Disabilities http://erdco.ca
- Health Equity Toolkit – blog is at http://www.smallstepsbigdifference.blogspot.com
- many LHINs have resources and material on their sites