SEEKING SOLUTIONS SYMPOSIUM

ACCESS TO HEALTH CARE FOR THE UNINSURED IN CANADA

LINKING ETHICS, RESEARCH EVIDENCE AND POLICY-PRACTICE CHANGE

FINAL REPORT FOR FEBRUARY 21 & 22, 2012

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ACKNOWLEDGEMENTS

This second gathering builds upon the success of the first research conference on the uninsured and undocumented held in 2010 and the continuing work of many who seek to advance access to health care for the uninsured through research, policy, advocacy and practice change. It extends the discussion further across diverse sectors and disciplines as we seek collectively to identify concrete solutions that facilitate equitable access to health care for some of the most marginalized individuals and families in Canada.

Appreciation and thanks to members of the Planning Committee who gave of their time and expertise to make this Symposium possible. Special thanks to Michaela Hynie for her contributions throughout the planning process and programme development and for the writing of this summary report. Special acknowledgements as well to Miriam Wexler who as event planner single handedly managed the registration process, venue logistics and catering arrangements, to Mark Murphy, Kate Wagler and Dorothy Alves for their administrative assistance with speaker communications, and Strategic Communications at Women's College Hospital.

We thank our Symposium Sponsors – The Hospital for Sick Children and Women's College Hospital – and many Symposium Collaborators. We especially thank the Faculty of Community Services at Ryerson University for generously serving as our Venue Host.

We are particularly grateful to all the speakers, presenters, moderators, facilitators, recorders, volunteers, students and delegates who have worked hard to help make these two days a stimulating and productive experience for everyone. Thank you!

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Disclaimer: The summary report is presented with the hope that its content may be of interest to the general community and those with particular interest in issues of access to care for the uninsured. The views presented by the speakers and presenters do not necessarily represent those of the sponsoring organizations.

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INTRODUCTION

On February 21, 2012, the Women's College Hospital Network on Uninsured Clients, in collaboration with Sick Kids Hospital, organized its second conference on healthcare for undocumented and uninsured residents of Canada: *Seeking Solutions Symposium: Access to Health Care for the Uninsured in Canada.* This report describes the first day of a two-day program; the second day of the Symposium focused on maternal and child health and is described elsewhere.

In February 2012, this Symposium brought together clinicians, policy makers, lawyers, ethicists, researchers and activists from hospitals, community health centres, law firms, universities and community organizations. The goal was to foster collaboration, the sharing of knowledge and strategies across multiple sectors and regions, and the development of new strategies and arguments to promote access to health care for the uninsured. The Symposium presentations were divided into three sections: What Do We Know; What Can We Do; and Alternative Care Models.

The first morning section, entitled What Do We Know, summarized current knowledge on causes and consequences of being uninsured in Canada. The most important messages from this section focused on the complexity of the issue. Hynie noted that there are many different paths to becoming uninsured, and Goldring and Landolt explained how people can move back and forth, in and out of insured status, as policies and their personal situations change. For some, the state of being uninsured is a temporary or more easily overcome situation than for others. Others are eligible for insurance, but lack or have lost documentation, and are thus treated as if they were uninsured. A solution to ensure access to health care for the uninsured needs to be sensitive to all of these different conditions of being uninsured.

The second section, What Can We Do, focused on strategies to change health care policies. The presentations in this section highlighted the importance of approaching the issue of access to health care for the uninsured from multiple positons: Bean, Landsberg, Bozinoff and Forman drew our attention to the importance of making use of legal, political, and ethical arguments, and incorporating powerful media messages and research findings to shift policy and public opinion.

The third section presented the ways in which health care is provided to the uninsured. The first was a Skype presentation from Kadri Soova who is a representative of PICUM, an organization focusing on undocumented residents in the European Union, in which they described some of the different policies across Europe. The second presentation was by Dr. Paul Caulford, the founder and medical director of a volunteer clinic in Scarborough, Ontario that serves undocumented and uninsured clients. The third described the pathways to health care taken by women in Montreal, Quebec. These presentations offered a range of different ways in which health care can be provided to those without insurance, broadening the scope of possible solutions, and thus possible paths to providing health care for those in Canada without insurance.

Because of the risks of exposure to those who are uninsured by virtue of precarious immigration status, those without insurance were not identified during the Symposium, although steps were taken to make the Symposium accessible to all. The morning session included an extract from an ichannel documentary about the uninsured in Canada, entitled *Your Money or Your Life*, by award winning writer/director Kevin O'Keefe. The documentary provided a window into the lived experience of the uninsured. The words of the uninsured describing their concerns and experiences were also shared in a number of presentations and workshops throughout the day.

The afternoon included simultaneous workshops on major issues for the uninsured, and on populations with unique needs and risks. The workshops focused on those experiencing homelessness, migrant workers, women's health, mental health, chronic diseases, child and maternal health, and the three month wait for health insurance for new immigrants in Ontario. Each session addressed what is known, challenges and opportunities for change, strategies for change, and who the key actors are who could undertake these strategies.

A key element of the afternoon sessions was a discussion of a draft charter for the uninsured. Included in this report is the final draft of this charter. The day ended with a summary of the main elements of the day's presentations and workshops, presented by Bob Gardner of the Wellesley Institute, and a discussion of suggestions and strategies for next steps.

In his summary, Gardner noted that obtaining health care for the uninsured is a complex systemic problem, with barriers at multiple levels. It was suggested that solutions should be aligned with other drivers in our health care system, namely quality improvement and excellent care for all, with an effort made to reframe "all" to actually mean all. Gardner noted that solutions need to be systemic, rather than local work-arounds, and he praised the European approach of framing health care access in terms of equality and fairness. He also argued for the importance of working with the media, and recognizing that the media works most powerfully through the sharing of personal stories.

Gardner summarized the suggestions for action that emerged from the day's events; these are presented in the final section of this report. Two overarching themes that emerge from these suggestions are noted here. The first is the importance of recognizing the complexity of the problem, in terms of how it is embedded in the larger social contexts of immigration, labour policies, globalization and health care policy, and in terms of the situations of those affected. No solution can succeed that does not recognize and address this complexity. The second is the importance of collaboration, through the finding of allies, the support of networks, and the sharing of information and strategies.

It is because of the complexity of this issue that co-operation and collaboration are so important, and it is in the spirit of collaboration that this Symposium occurred. The sharing of information is critical as the context for accessing health care is constantly changing. At the time of writing, recent changes were made in Canada's Interim Federal Health Insurance for refugee claimants that will increase the number of uninsured in Canada, and may increase the barriers to accessing health care for other refugees. However, over the past year, the Toronto Central Local Health Integration Network has been taking steps to address inconsistencies and barriers in accessing health care in Toronto. Moments of change, in any direction, are opportunities for action; we hope that this Symposium, and this subsequent report, will help support these actions, now and in the future.

Policy Changes Increase Uninsured Clients: Impacts of Changes to Interim Federal Health Program for Refugee

By Angela Robertson

Less than two months after the February 2012 *Seeking Solutions Symposium* the situation for uninsured worsened when the CIC Minister on April 25, 2012 announced changes to the federal regulations governing the IFHP, which took effect on June 30, 2012. The changes greatly reduced or eliminated health care coverage for refugees, leaving many who previously had coverage now without.

Citizenship and Immigration Canada (CIC) has funded the Interim Federal Health Program (IFHP) since 1957 to provide temporary health-care coverage to eligible protected persons, refugee claimants and rejected refugee claimants who do not qualify for provincial or territorial health insurance plans. The changes to the IFHP coincided with the introduction of Bill C-31 as part of wide ranging changes to Canada's refugee determination system. For the government, C-31 provides for Designation of Countries of Origin, faster processing of claims, limits on appeals, detention in an expanded number of circumstances, faster deportation, restrictions on work permits and measures to delay sponsorship of family members. The changes to the IFHP are linked to the Designation of Countries of Origin. The government has the authority under C-31 (2010) to identify Designated Countries of Origin (DCO) under the Balanced Refugee Reform Act (BRRA). DCOs are countries that do not normally produce refugees, and are deemed by the government to respect human rights and offer state protection. In December 2012 the Minister released the list of DCO Countries and they are:

Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, United Kingdom, United States of America

In February 2013, eight other countries were added to the DCO list, including:

Australia, Iceland, Israel (which excludes Gaza and the West Bank), Mexico, Norway, Japan, New Zealand, Switzerland

Effective June 30, 2012, the Interim Federal Health Program (IFHP) essentially eliminated "supplemental" benefits for all refugees who are not "government-assisted refugees" (including pharmaceutical care, dentistry, vision care, and mobility assistive devices) and provides basic health care only if it is "urgent or essential" for resettled refugees (refugees invited to settle in Canada), and refugee claimants from non DCOs. Medications and vaccines will be provided only if needed to prevent or treat a disease that poses a public health or safety risk. All refugees will retain coverage for issues of public health or public safety concerns. Public health issues refer to conditions on the Public Health Agency of Canada's notifiable disease list where there is human-to human transmission or where a vaccine has been recommended. Issues of public safety concern refer to mental health conditions where an individual has been identified as being a risk to possibly committing harm to others. This means that hospital services, services of doctors and nurses, laboratory and diagnostic services, medications and vaccinations will only be provided if they are needed to prevent or treat a disease that is posing a risk to public health or safety.

In its public information, the government presents the changes as aimed at reducing "extra" healthcare coverage supposedly provided to refugee claimants, compared with what Canadians receive. In fact the government's own figures show that the per capita cost for refugee claimants under the IFHP is only about 10% of the average per capita cost for Canadians. In 2011, there were 61,171 refugees accessing the IFHP in Ontario. Among the 61,171 refugees, 5,685 were resettled refugees and 55,489 were refugee claimants, failed claimed and others. Of the total 61,171 refugees accessing the IFHP, 13,344 were accessing drug benefits, 4,573 were accessing dental benefits and 6,139 were accessing vision benefits.[i] According to information provided with the April 25th announcement, the IFHP program costs a total of $84.6 million in 2011-12. CIC claims that 128,000 persons were covered by IFHP during that fiscal year. This amounts to a cost of $660 per refugee claimant per year. Similarly, in response to a 2010 access to information request by the Canadian Council for Refugees, CIC provided a figure of $46 per month ($552 per year) for IFHP costs per refugee claimant. By comparison, according to CIC's own figures, the current overall per capita cost for health and social services for Canadians is $6,141. The cost for Ontario of eliminated IFHP health benefits is $7.8M (this figure is based on IFHP claims processed from January 17 to December 31, 2011) and accounts for 16.8% of current total IFHP expenditures in Ontario. [ii]

The federal government has stated that after these changes are implemented to the IFHP, cost savings are projected to be about $100M over the next five years. Advocates and healthcare providers reject this claim and instead assign the government's changes to a political ideology that seeks to curtail acceptance and welcome of refugees and immigrants into Canada.

The evidence tells us that people without health coverage tend to go to hospital emergency departments for care, and sometimes they wait longer than advisable to seek medical treatment. Those who wait and save up their medical appointments until they receive coverage can compound costs, especially if illnesses worsen.[iii] Lack of access to health services, particularly preventive and primary care result in unmanaged chronic diseases and over utilization of emergency rooms, placing a greater burden on the health system.

Inequities in health care access already exist for the refugee population and changes to the IFHP will further limit access to a population greatly in need due to their socioeconomic circumstance (e.g., poverty).[iv] De-listing of services covered by the IFHP will further create disparities in the access to health care services and make the refugee population even more vulnerable. It will be nearly impossible for newly arrived refugees to purchase health insurance for the services they require.

These cuts will likely disproportionately affect refugee women. The removal of coverage for sexual and reproductive health and labour and delivery will put refugee women at particular risk. Removal of health coverage also means that refugee women who experience intimate partner violence will have reduced access to support and are further put at risk, as often issues of violence is identified in the provision of primary care.

There has been a significant response from health professionals, academic researchers, refugee networks and councils, and immigrant settlement agencies expressing concern around the policy change that reduces health coverage for refugees and creates yet another group of uninsured individuals. Some of the advocacy actions included:

- On May11th, Ottawa doctors gathered on Parliament Hill, and dozens of physicians' occupied Member of Parliament constituency offices in Toronto and Winnipeg, to protest the changes to the Interim Federal Health Program. In Toronto 90 doctors from across the GTA participated in the Toronto event.
- On May 18th an initial group of eight national health care associations issued a joint letter to the CIC Minister expressing their grave concerns about the implication of the cuts on refugee health and calling for the decision to be reconsidered. Since then over a dozen national associations have sent letters to the Minister objecting to the cuts.
- On May 28th Toronto Board of Health approved recommendations calling for a reinstatement of the IFHP.
- The group Doctors for Refugee Care launched a campaign for a National Day of Action scheduled on June 18th. Actions were carried out in Ottawa, Hamilton, Vancouver, Calgary, Saskatoon, Winnipeg, Montreal and St. John's.
- Advocacy efforts also took the shape of policy and strategy convenings, notably in Ontario the Hospital Collaborative on Vulnerable and Marginalized Populations and Community Health Centres in July 2012, hosted a conversation with the TCLHIN CEO and in September 2012 Refugee Health Network and Women's College Hospital Refugee Health Advisory convened a conversation with Dr. Grondin, Director General of the Health Branch of Citizenship and Immigration Canada. In both meetings providers spoke about the adverse effects of the IFHP cuts on patient health and access to preventive care and the cost to the health care system when care is delayed or denied.
- Jan. 23, 2013 the group Health for All organized a public rally and petition calling on the Ontario government to fill the IFP gap. The group was successful in garnering a meeting with Minister of Health and Long-Term Care.

Health and community support providers have already seen the adverse impacts of these cuts on refugees and are collectively calling for a review and evaluation of the changes on refugees and the tracking of the increase in "newly" uninsured who were previously covered under IFHP. Critics of this policy continue to argue that "withholding basic health care from refugees is a very crude and cruel lever to regulate immigration and is not a fair or equitable way to address perceived problems in the refugee claims system".[v] The WCH Uninsured Network remains an ally in advancing this argument given its predictably detrimental impact on access to care for those who are uninsured.

i Health Canada, Health Branch. Source: IFHP Database on claims, as of December 31, 2011.

ii IFHP Database on claims, as of December 31, 2011.

iii Khan M, Lalani M, Plamadeala C, Sun E, Gardner B. *Highlights:* February 12, 2010 *research conference on healthcare for the uninsured and undocumented.* Toronto, ON: Wellesley Institute; 2010 April.

iv Beiser M. *The health of immigrants and refugees in Canada.* Canadian Journal of Public Health 2005 March-April.

v Barnes, Steve, *Refugees are feeling the real cost of cuts to health benefits* Wellesley Institute, June 2012.

TORONTO CHARTER ON ACCESS TO HEALTH CARE FOR UNINSURED PEOPLE IN CANADA

On February 21, 2012, over 300 health system leaders, front-line health workers, researchers and community members met in Toronto to identify concrete solutions to improve access to health care for people who are uninsured in Canada. The following is a statement of common beliefs and a call to action based on these discussions.

Preamble

Whereas Canada has ratified the International Covenant on Economic, Social and Cultural Rights (1976) that establishes the right to *"the highest attainable standard of physical and mental health"* for all;

Whereas the Canada Health Act (1984) guarantees, *"to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers;"*

Whereas the principles and values of the Declaration of Alma-Ata (1978), from the WHO/UNICEF International Conference on Primary Health establishes: Health as a fundamental human right; primary health care as the route to achieve Health for All; and that primary health care involves providing basic preventive, promotive, curative, and rehabilitative care at an affordable cost;

Whereas the Ottawa Charter for Health Promotion (1986) establishes that *"the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity;"*

Whereas the current federal, provincial and territorial administered health systems are significantly challenged to provide adequate care for people in Canada who do not have or are unable to secure public or private health insurance;

Whereas in British Columbia, Quebec and Ontario the three-month waiting period for health insurance for landed-immigrants to Canada and returning Canadians significantly hinders the health system's ability to provide care, resulting in a call for its removal from numerous clinical and professional organizations;

Whereas evidence indicates that costs associated with providing on-going primary care, including mental health care, to uninsured populations is less expensive than the current system of attending after health conditions have worsened and the subsequent required emergency, tertiary, quaternary or chronic long term care;

Whereas people who are uninsured contribute socially and economically to Canada;

Recommendations

We propose the following recommendations to increase equitable access to health care for people who are uninsured in Canada:

1) Reaffirm that without fear or debilitating debt all people who reside in Canada with health needs not be refused care, treatment or support;

2) Remove the three-month waiting period for provincial health insurance across Canada;

3) Establish mechanisms through a consultative process to facilitate:

   – safe access to same standard of care, treatment and support received by all Canadians;

   – assistance in securing public insurance whenever possible;

   - secure funding to meet the healthcare needs of all uninsured people unable to access health care or pay for public or private health insurance or independently pay directly for care;

   - monitoring of trends, statistics and socio-demographic data so accurate information is available for service planning, research and policy considerations;

4) Require health care institutions to develop and implement a system-wide ethical framework for health equity that include provisions for uninsured individuals and populations.

5) Recognize the importance of the social determinants of health and their links to complexity of care and commit to ensuring that everyone living in Canada, irrespective of immigration status, race or language has access to all social services, including health care, education and housing.

6) Regularization of uninsured people's status.

Approved in Toronto, Ontario, Canada on February 21, 2012

KEYNOTE ADDRESS

Dr. David McKeown
Medical Officer of Health, City of Toronto

Dr. McKeown observed that Ontario has a number of uninsured and underinsured residents who face challenges in accessing health care. He also noted that in our attempts to seek solutions to this problem we must acknowledge that there is a great deal we do not know about the health status and health needs of the uninsured. We do not know with any precision how many Ontario residents are undocumented or uninsured. We do not know what it costs the health care system to provide the care that these individuals receive, or the cost, either financially or in lost health, we all bear because of their delayed care, or absence of care altogether.

Dr. McKeown stated that there is also much we do know. We know that there are many different reasons why people find themselves uninsured; that they have difficulty finding care for which they are eligible; that they often do not have screening or preventive care and often delay getting care until their health situation is urgent. We also know that being uninsured often intersects with other health inequities because the uninsured are more likely to be newcomers from racialized groups or living on low income.

Dr. McKeown identified two types of barriers in accessing health care. Hard barriers are the result of public policies, laws, regulations and institutional rules that create categories of ineligibility. Hard barriers can only be changed by changing policy. Soft barriers result from the lack of knowledge about service eligibility among the uninsured, and among health care providers; loss of documentation; misapplication of policies; and fear of deportation. Soft barriers can be changed through education, outreach and changes to administrations and systems.

Ontario's public health policy is full of inconsistencies. Uninsured residents are eligible for a range of taxpayer services such as education and libraries but not health care. Uninsured residents are eligible for health promotion and prevention services, but not illness treatment. Dr. McKeown used the case of a newcomer who may have TB to describe how the inconsistencies in health policies and programs are failing newcomers and the larger community, and how these policies do not align with public health objectives.

Dr. McKeown noted that the gaps in health care for the uninsured have led to creative informal solutions but these are ultimately unsustainable because they depend too much on the generosity of individuals. Despite the economic challenges facing Ontario, Dr.McKeown notes that Toronto welcomes, and needs, people from around the world and thus there will always be residents in our community who are not insured. Because ensuring that all residents have access to health services is good public policy, this needs to be an integral part of building a healthy city.

what do we know?

WHAT DO WE KNOW?

Michaela Hynie, Ph.D.
York University

Hynie noted that there are number of different pathways to becoming uninsured and that they differ in terms of whether they are a temporary state or a more permanent one, and whether they are a consequence of actually being without coverage (uninsured), or of being eligible for coverage but not having the documents to prove it (undocumented). The uninsured include landed immigrants and returning Canadian citizens, who in Ontario are not eligible for insurance for their first three months; those who have had their refugee claims refused; immigrants who have had a breakdown in the relationship with the person who has sponsored them; temporary workers who have violated any aspect of their work permit; those who have overstayed a visa; and those who are visitors or on certain visas that do not provide coverage. The undocumented include those who have had their documentation lost or stolen, who are often people with precarious housing; and Canadian born children of parents with precarious migration status.

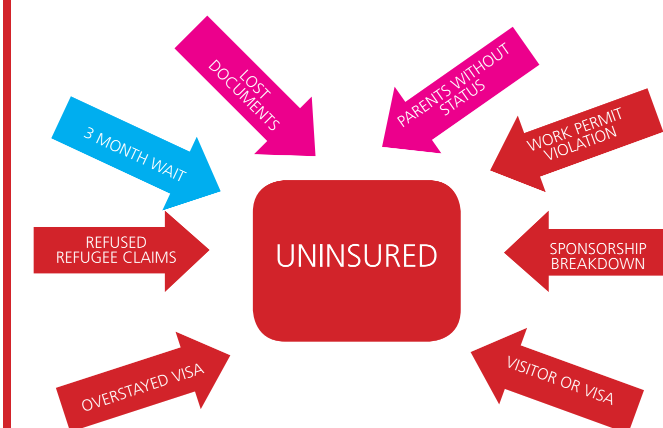
It is difficult to determine the number of people who have precarious migration status, but the global estimate is that they constitute 10% to 15% of all migrants[1]. In Canada, the numbers have been estimated to be between 200,000 and 500,000[2]. In Toronto, the numbers have been estimated at about 40,000[3],and a study of emergency room visits found over 5,000 visits by those without insurance in one calendar year[4]. As for the undocumented, it is estimated that there are over 5,000 people in Toronto[5] who are currently experiencing homelessness, of whom approximately 20% to 30% have lost necessary documentation to prove they are insured[6].

Not having access to health care because of precarious migration status has been associated with: delaying seeking needed health care or forgoing it altogether; delaying seeking prenatal care or forgoing it altogether; denial of care by service providers when care is sought out; and experiencing discrimination in the health care system.

The health consequences of having precarious migration status have been identified as: having higher rates of infectious diseases; being triaged as having more serious health problems in emergency rooms; higher rates of complications in pregnancy, labour and delivery, and higher rates of newborn anomalies; greater exposure to hazardous environments; and aggravation of mental health problems.

Hynie noted that pathways to care in Toronto are primarily through hospitals and community health centres. Those without insurance also access Toronto Public Health, midwives and private physicians. Barriers to accessing these forms of health care include fear, lack of knowledge of what is available, cultural and linguistic barriers, costs, discrimination, and availability.

How does one become uninsured?



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WHAT DO WE KNOW: PRECARIOUS MIGRATORY STATUS IN CANADA

Luin Goldring[1], Ph.D. & Patricia Landolt[2], Ph.D.
York University[1], University of Toronto[2]

Goldring made the distinction between de facto uninsured, who are eligible but lack documentation, and the formally uninsured, who are not eligible. She noted that there are a range of pathways to being uninsured: being denied a refugee claim; arriving as child, and having no status now; sponsorship breakdown; being a temporary worker; being a student or tourist who overstayed their visa. She also cautioned against discussing these issues using the language of 'illegals' and 'bogus' claims.

When looking at the number of people affected, temporary entries into Canada plus those who entered temporarily and are still present constitute almost one million people, or about one in every 34 people in Canada. Although the exact numbers are not known, the non-status population is estimated to be about half a million people.

Goldring noted that immigration policy has two routes, one permanent and one temporary. The permanent is supposed to offer a pathway to citizenship; the temporary one does not. Over the years, the balance between temporary and permanent migration into Canada has changed. Temporary entries are increasing, permanent are decreasing. The government is institutionalizing temporariness. Many temporary entrants become de facto settlers; they return year after year or stay on. Many temporary entrants experience movement across various categories of legal status, and can fall in and out of holding legal status.

The term *precarious status* captures the vulnerability and uncertainty of non-citizens' rights and access to services. Authorized temporary residents are temporary workers, refugee claimants, students, those making applications on Humanitarian and Compassionate grounds, and tourists. Those who are unauthorized are those who are failed claimants, who have over-stayed their permit, or have unauthorized entry into the country. Goldring noted that rather than considering these as fixed categories, however, one must note people's trajectories over time, with people moving from one vulnerable category to another. These trajectories are caused by state policies that institutionalize temporariness and irregularize people. We must also consider the role of employers, service providers, legal consultants, and health care providers in this system.

Goldring summarized her talk by noting that one's current status is part of a complicated status trajectory, and that the immigration system contributes to status precarity in various ways; but it is unlikely to change. Legal status is a key determinant of health. Those with secure status early on have better health outcomes. She also noted that health care professionals are part of the system in that they provide, limit, and regulate access to care.

what can we do?

UNINSURED PATIENTS: WHAT CAN WE DO?

Sally Bean
Sunnybrook Health Sciences Centre & University of Toronto

Bean framed the ethical issues in terms of the following question: Should every person (physically present in Canada) be entitled to access to health care? If the answer to this question is yes, then the discussion turns to identifying the conditions under which care should be available. This debate occurs in the context of the need to set priorities because of finite resources, and the competing obligations and duties of health care organizations to those who are fully ensured and to the system that serves them.

Bean highlighted that the Canada Health Care Act is directed towards Canadian residents and Ontario Health Insurance Plan (OHIP) coverage is also predicated on clearly defined residency requirements. However, the Ontario Medical Association's code of ethics requires providing care to anyone in urgent need of medical assistance and the Public Hospitals Act of Ontario implies that admission to a hospital cannot be denied if doing so would jeapordize the person's life. A critical issue in determining when and to whom care is provided is thus also clarifying the distinction between urgent and non-urgent care.

Bean also noted that there are many different categories of being uninsured. One distinction rests on whether the person is resident in Canada. Those who are non-resident include visitors and medical tourists. Those who are resident include those in the 90 day wait period, those with precarious migration status or denied refugee claims, and those on short-term work permits. Those who are resident uninsured meet the Canadian Medical Protective Association's requirement of "having close connection to Canada" and should be treated differently than non-resident patients. For example, they should be charged OHIP rates for procedures whereas those who are non-resident are charged an out of country rate that is typically about 30% higher.

Bean recommends that policy clarify the distinctions between urgent and non-urgent care, and between different categories of uninsured. She also suggests that stakeholders be engaged to establish values and principles to guide decisions around providing care that reflect justice, humanitarianism, stewardship and transparency; that resources be established to help front line staff in decision making and that a systematic method for archiving decisions and rationales be maintained in order to ensure fairness and consistency.

> **"That the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."**
> **– Canada Health Care Act 1985**

ENGAGING THE MEDIA

Michele Landsberg
Women's College Hospital

Landsberg remarked that most people outside of the field are uninformed and know nothing about this problem. They don't know that it exists and they don't know the difference between illegal and undocumented. These issues were never a concern to the media.

Women's College Hospital felt passionately about the issue and set up the Network for Uninsured and Undocumented Clients. The Network included representation from all downtown hospitals. They heard stories about health care for immigrants that shocked them; nobody was attending to this issue outside of health care. As a journalist, she thought "Why didn't they come to me when I was in the paper… only you know these stories, and you're not telling."

The media has an appetite for stories of human crisis. People concerned about this issue need to organize a communications committee to speak on behalf of the group to the media. Landsberg also suggested engaging a blogger to tell stories weekly. The group could then feed stories to the blogger. Ideally, the group needs to be equipped to put out weekly press releases. For example, the Ontario Health Coalition established visibility by constantly sending out information.

Landsberg noted that Health for All is a good organization, but you get different clout if this is coming from a professional group. She therefore recommends establishing a committee. People in this work are deeply absorbed in their work, and may have a distrust of the media. In periods of austerity, however, there will be no action unless you sway the public. Landsberg therefore suggests that you start with the newspapers, Toronto's big four: The Globe and Mail, The National Post, The Star and The Sun. Learn who the columnists are who are receptive to the message and then reach out individually to each. Note that journalists love an exclusive story. This issue will not advance unless we take up the task of communicating.

HEALTH FOR ALL

Nikki Bozinoff

Health for All is a multidisciplinary group that believes health is a human right and supports access to health and social services without fear of debt, denial, detention, or deportation. They note that borders are political constructs and call for universal status regularization of all people in Canada. Bozinoff quoted Clarence Tam that public health needs to recognize that the health needs of immigrants are symptoms of structural processes linked to equity and human rights.

Bozinoff noted that people move because they want to and because they have to. Now only the rich can move, those born in certain countries and holding certain passports.

Health for All states that migration is a fundamental human right; it is associated with the right to health and dignity. In contrast, our policies are increasingly creating permanent temporary migrants. Bozinoff noted that the number of refugees granted permanent residency has dropped by 25%; family class immigrants by 15%; there is a new moratorium on parents and grandparents migrating; and the quota for spouses has been reduced by 4,000.

Bozinoff described the example of Solidarity, Sanctuary City, which was created in the USA in the 1980s. At this time, the USA government did not recognize refugees from Guatemala and El Salvador because they were supporting their governments. A policy was adopted in several cities: don't ask don't tell. This policy was intended to allow people to access services without fear. Health for All supports a similar strategy for Canada.

Health spaces should be safe spaces; people should not fear debt, denial of care, detention or deportation in any community health centres, emergency rooms or hospitals. Bozinoff pointed out that this is justice, not charity. Health providers should use a variety of strategies to build trust with communities. The Toronto District School Board has adopted similar policies and strides have been made in Toronto shelter networks. The challenge is the trickle down to front line workers. How does one properly inform and promote these policies to all front-line workers? One possibility is to try role-playing scenarios such as what to do if an agent arrives etc.

LESSONS FROM THE AIDS TREATMENT CAMPAIGN AND HUMAN RIGHTS THEORY

Lisa Forman, Ph.D.
University of Toronto

Forman presented the strategies of the global movement to ensure access to anti-retroviral drugs (ARVs) in low- and middle-income countries as a case study in how a campaign against inequity in health care can succeed. Forman noted that in the early 2000s, ARV treatment was costly (about US$15,000 per year) and there was very little access to ARVs in low/middle income countries (about 5%) and virtually none in sub-Saharan Africa (less than 1%). Despite the striking success of ARVs in reducing deaths from HIV infection in high income countries, addressing the treatment gap was not seen as a priority for global health agencies (e.g., WHO, UNAIDS). A global AIDS treatment movement emerged that reframed the debate about providing ARVs in low/middle income countries from one of pragmatism (too expensive, prevention is the priority) to one of human rights. The combination of rights-based arguments, research evidence and mass action succeeded in shifting public perceptions and the positions of global institutions (WTO, UN). The result was a drop in the price of ARVs, the development of international funding for treatment, and the adoption of a goal of universal access by the WHO, UNAIDS, the UN General Assembly and the G8. ARV access then increased, from fewer than half a million people in 2002 to over 6.5 million people in 2010, and global AIDS-related deaths declined.

Forman noted that human rights change occurs in three stages. First, norm entrepreneurs or thought leaders advance new norms by reframing state and public perceptions. If they are successful in shifting perceptions, a critical mass comes to endorse the norms, and the second phase occurs: these norms are adopted as new rules. Once the norms are rules, they spread through coercion (e.g., laws) and persuasion. In the third phase, these new rules come to be internalized and are now taken for granted by the general public.

1. **Build your social movement**
2. **Frame issue as human rights/ ethical violation**
3. **Build evidence-base of human consequences**
4. **Find your thought leaders/ norm entrepreneurs**
5. **Build instrumental arguments (carefully)**
6. **Capitalize on political and social opportunities**

These changes occur through the combined efforts of evidence and research based knowledge; social movements and learning; and political involvement. Forman therefore emphasized the following steps (see figure): build a social movement and identify thought leaders; frame the issue in terms of human rights/ ethical violations and carefully build instrumental arguments; build an evidence base of human rights arguments; and capitalize on political and social opportunities. Forman drew two lessons from her case study and the work of other scholars. First, don't sacrifice the possibility of transformation for pragmatism. Second, "civilization advances when what was perceived as misfortune is perceived as injustice".

alternative care models

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN EUROPE

Kadri Soova
Platform for International Cooperation on Undocumented Migrants (PICUM)

PICUM promotes rights of undocumented migrants through monitoring, research, advocacy, awareness raising, and capacity building activities. It gives visibility to undocumented migrants and brings undocumented migrants to policy agendas at national and European Union levels through evidence-based advocacy. PICUM has been monitoring and collecting information about health care for undocumented migrants (UDMs) since 2001.

Soova noted that they found there is a lack of compliance with international obligations. No EU member state specifically forbids access to health care, however publicly subsidized health care is not entirely guaranteed in Europe. PICUM has found that health care is being used as an instrument of immigration control. Policies are increasingly restrictive, but there are some efforts on the local level. The impact of this is incoherence with public health, social cohesion, and medical ethics and a strain on frontline service providers and increased health care costs.

Across the EU, there are different levels of access in national legislation. The most restrictive are in Austria and Sweden, where all care for UDMs is provided on a payment basis (except for children in Sweden). In Hungary and Germany, there is free health care in emergencies. In the United Kingdom there is free access to primary care. In France, Belgium and the Netherlands, UDMs can access mainstream care but through parallel administrative systems. Finally, in Spain and Italy, there is wide public health care coverage.

While there are a range of legislated means of access, there are barriers to access in practice. Many UDMs do not access care even if they are entitled to it. They fear being reported to police (which is required in some countries like Lithuania and Germany). They lack financial resources and information. They face barriers in language and communication, and they are deterred by negative attitudes among care providers. Often frontline administrators, rather than health care providers, act as a 'gateway' to care. Medical staff generally apply professional codes and duties. Health care professionals are thus potentially invaluable in influencing policy. Administrators have no ethical obligation to provide medical care; finance is the main concern.

UDMs mainly seek care when they are seriously ill. They have an increased risk of worsening health status (because of poor access, insecurity, poor living and working conditions). A high percentage do not access care even if entitled. Usually they use non-governmental organization clinics or emergency rooms. Many are unable to pay medical fees. UDMs are concentrated in some "undocumented friendly hospitals." Soova concluded by recommending that human rights and professional ethics are respected, and ensuring that entitlements in law are accessed.

OUT OF THE SYSTEM? PATHWAYS OF PRECARIOUS STATUS WOMEN AND CHILDREN ACCESSING HEALTH CARE

Francesca Meloni, Audrey Lamothe, Sophie Laniel, Alexandra Ricard, Dr. Cécile Rousseau, & Monica Ruiz Casares
McGill University

Meloni presented the findings of a qualitative study looking at pathways and barriers to accessing health care for women and youth with precarious status. The study incorporated interviews with key informant health care providers and community workers, and in-depth interviews and focus groups with women and youth with precarious status.

Front-line practitioners identified three main barriers among their clients with precarious status. Clients with precarious status fear coming to health care institutions. Clients lack information about what services are available for them. Finally, front-line providers find themselves in an ethical dilemma because treating clients without formal status is consistent with their personal values, but inconsistent with the financial and human resources constraints of their institutions.

Women and youth with precarious status identified several barriers to accessing care. These were the high fees that they were required to pay to access care; a fear of exposure or deportation if they tried to access services; a lack of information about services available; and the fact that their Canadian born children lacked health care coverage because of their parents' status.

> **"For community health centres, the main challenge is that mothers with precarious status are terrified to come"**
> **– Front-line Provider**

Meloni also presented the key strategies identified by front-line providers and by community residents. Among the front-line providers there was a considerable heterogeneity of responses. Some focused on engaging in activism within the constraints of the existing system. Others relied on informal networks of support. There were others, however, who refused to provide services to those without coverage, or emphasized the need for cost recovery for services provided. Among community residents, strategies essentially involved reliance on an informal network of information and support. This included sharing names of health care providers and organizations who would provide services or advice, and the validation of information about services.

Melini concluded that there is a need to support community organizations and primary care centres working with those with precarious status, and to engage in more outreach. She also noted that there is a danger of professional abuses with this vulnerable population, and that we need to monitor the application of existing policies.

PUBLIC HEALTH CARE FOR MEDICALLY UNINSURED IMMIGRANTS AND REFUGEES

Dr. Paul Caulford
Scarborough Clinic for Medically Uninsured Immigrants and Refugees

Caulford noted that Scarborough is Canada's most ethno-racially diverse community. In 1999, community health workers became aware that many uninsured new Canadian immigrants and refugees lived and often worked in Scarborough. Approximately 3,000 uninsured new Canadian immigrants were on the waiting list at Scarborough's only Community Health Centre. The hospitals advised those wanting to serve this population not to interfere as they were a good revenue stream.

The clinic was founded in 1999. Solutions for providing care to uninsured were modelled on other centres. For example, in 1997, the University of New Mexico Health Sciences Centre created a managed care plan for 13,000 uninsured immigrants and enrolled them. The clinic provided primary care across determinants of health with an inter-professional team with around the clock telehealth support. They found that they saved US$1.9M in costs in the clinic's first year of operation and that the number of hospital days was significantly reduced.

In Ontario, approximately 20,000 people are in the three month wait period for insurance per year. What would it cost to provide care for 20,000 people? Caulford described and costed out two models. Option 1: In this case, the clients are rostered into a Family Health Team. With 15 family physicians, the cost would be about $4.2M/annum. This is not a lot of money. One could fund this with a $50 one time insurance payment by 80,000 new immigrants, which would bring in $4M. Option 2: This option involves hiring Nurse Practitioners who are assigned to Community Health Centres and Family Health Teams plus telehealth to meet this population's need. Here, the costs would be 25 staff at $2.75M. It wold also involve the Ontario Telehealth Network, at a cost of $30,000.

Scarborough Clinic for Medically Uninsured Immigrants and Refugees: Original objectives and guiding principles

- **Provide a free, front-line health care to uninsured neighbours**
- **Provide health care identical to the quality and standards that insured Canadians receive**
- **No politics in health care**
- **Use an inter-professional team concept**
- **Change policy through advocacy and information**

In reviewing these options, Caulford notes that the issues are essentially political. Support for providing care to the uninsured is 'soft'. People see migrant workers as taking jobs, etc., making this a difficult battle to win. However, there are feasible solutions available.

workshops

WOMEN'S HEALTH

Dr. Lea Rossiter & Kristen Cocchetto RN
Bay Centre for Birth Control
Facilitator: Ayesha Adhami

WHAT DO WE KNOW:

Women experience a great deal of fear

- Biggest barrier to accessing care is fear: detention, deportation, immigration officials, police, "unfriendly" attitudes among health care providers; discrimination
- Financial/fear of debt
- Fear of illness/fear of death/fear of treatment
- Fear of impact of illness on family

Women experience structural barriers to accessing care

- Language and literacy (for example not having the right words to describe symptoms accurately in their second language)
- Transportation (money for, access to, help with)
- Child care responsibilities

Women have limited information

- Lack of information about available services
- Lack of knowledge about preventative health care

Other challenges faced by women without insurance

- Social isolation
- Women sometimes charged higher fees for care than those originally quoted by community health centres
- Sometimes women feel that they need to consult with their husband or partner or community leader
- Competing demands for women's time

CHALLENGES/BARRIERS TO CHANGE:

- Women come from varied backgrounds and experiences (i.e. socio-economic, abuse/torture, cultural, religious), so the problem is complex
- Sometimes women prefer to consult with a care provider from their cultural group and pay out of pocket rather than go to a CHC or hospital
- The current system is not transparent
- Hard to navigate through various services
- Differences exist in the care provided
- Two-tiered system (community health centres and hospitals)
- Disorganized system: case by case basis used to solve their medical issues
- Disorganized system: done on a charity basis

The Bay Centre for Birth Control is a large urban sexual health centre in downtown Toronto. The focus is providing a range of SRH services, including:

- **STI screening/treatment**
- **Contraceptive counselling and provision**
- **Pregnancy options counselling and abortion services**
- **Pap smear screening and education**
- **Provision of other sexual health services (HPV vaccination)**
- **Referrals to other community health services**
- **Diagnostic colposcopy**

WOMEN'S HEALTH *cont'd*

Table 1:
Retrospective Analysis of Severity of BCBC Clients' Histological Abnormalities, by Insurance Status

Abnormality	Uninsured	Insured	Total (N=180)
High grade referral Pap smear	8/23 (23%)	42/157 (26.8%)	50/180 (27.8%)
Histology CIN3	5/23 (21.7%)	18/157 (11.5%)	23/180 (12.8%)

ACTION:

OPPORTUNITIES FOR ACTION:

- Create an interactive Google map that lists which services are available for the uninsured and where they are located (this has been done in New York City)

STRATEGIES FOR ACTION:

Co-operation and co-ordination between organizations

- Consider an exchange of services between organizations

Media strategies to shape public opinion

- Build media relationships, however frame the message very carefully;
  - liaise first with those who are sympathetic;
  - remember that many articles have been published about refugees and immigrants that are quite disparaging
  - focus on economic contributions of undocumented persons
- There should be critical mass on the ground first before involving the media so that there is sufficient support

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED:

WHAT CAN BE DONE WITHIN CURRENT SYSTEM (SHORT TERM/ LONG TERM ACTION):

Health care services

- At the registration level i.e. at the reception desk – staff should ask women if they have any special needs, for example if they require translation services
  - "It's our job to offer these services. If women are already feeling ineligible they are unlikely to ask for things they need."
- Consider designing a logo that indicates 'safe services are offered here'.
  - This could only be done if all staff are educated about issues affecting the uninsured and if everyone works collaboratively to live up to the sign/logo that is posted.
- If women could hear a comforting voice over the phone before they come in for care that would help reduce the fear (as is done at BCBC @ WCH)
- Hospitals should discuss the situation with women beforehand and see if the client can pay through small installments

Information

- Information should be provided at point of entry into Canada about what services are available for the uninsured
- Families new to Canada should be told about 311 when they first arrive
- Information should be available about finding the right resource to match the need; avoid inappropriate use of ERs

Policy changes

- Revisit system of providing block OHIP cards (bill service to the health card)
- Women could pay a portion of hospital costs
- Conversations need to take place with immigration officers, front-line care providers, teachers and others
- Provide access to public health insurance irrespective of immigration status

Public information/media

- Build a campaign around basic justice, basic ethics

CHILD AND MATERNAL HEALTH

Joanna Anneke Rummens, Ph.D. & Manavi Handa RM

WHAT WE KNOW:

- Inconsistencies in cost/access
- Problems are systemic
- Solutions must be collaborative and systemic

CHALLENGES/BARRIERS TO CHANGE:

- Differences in opinion on legality of people, "should people be here in the first place."
  - Stumbling block, "they have no right to be here therefore, no right to healthcare"
- Providers should feel comfortable advocating for care for the uninsured without feeling that they are sending a statement on immigration.
- Inconsistency in access/cost of care at different hospitals (reported from CHCs that refer)
  - Front-line staff unaware
  - High levels unaware
- Funding structures
  - How front-line providers get paid (salary vs. fee for service)
- Impact on interprofessional care

Community Health Centres report inconsistencies in access/cost of care at different hospitals

- **Front-line staff are unaware of policies**
- **High levels of staff are unaware**

ACTION

OPPORTUNITIES FOR ACTION

- Hospitals could waive fees
  –"hospitals to walk the walk"
- Change the funding structure

STRATEGIES FOR ACTION

- Examining values – using ethics/values based language (accessible)
- Need to stay away from this debate and focus on people being here and the need for healthcare.
  - It is an access to care issue not an immigration issue.

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED

- Toronto Central LHIN is currently working with range of stakeholders to improve access to care/consistency

WHAT CAN BE DONE WITHIN CURRENT SYSTEM (SHORT TERM/ LONG TERM ACTION)

- Foundation money
  - Language services, etc.
- Education of front-line staff
- Systemic and collaborative
  - Policy change
  - Different messages at different levels (strategic)

MENTAL HEALTH

Soheila Pashang, Ph.D.
Facilitator: Branka Agic

WHAT WE KNOW:

- There are approximately 40 million people worldwide that are displaced who live without clear status
  - There is no regulating convention within international law, which leaves the role of protection at the discretion of individual states.
  - The Canadian Charter of Rights and Freedoms guards these rights to citizens in Canada, however it does not address the rights of residents or non-citizens.
- At any given time we might have approximately 1 million people in Ontario that might not access health care.
- First Nations population are migrants in their own country.
  - They are also a category of uninsured people in Canada who do not have access to MH services.
- Based on liberal migration theories, immigrants leave their countries for two interrelated reasons:
  - "Push" factor – push people from global South to global North, because of exploitation of their countries resources and land, colonization, military invasions, war, increasing global economic gap, health disparities, violence and gender inequality.
  - "Pull" factor – global North attracts global South as it needs the cheap and unregulated labor such as caring for family members especially taking into account the cutbacks in social funding (i.e. nannies are taking care of our children), construction workers.

- **First Nations population are migrants in their own country.**
- **First Nations are also a category of uninsured people in Canada who do not have access to MH services.**

The discourse about morality is complicated and takes away the responsibility from the state, leaving it to ethical individuals and charities.

- Not providing care for children, elderly, poor and people with disabilities within our geographical boundaries undermines basic human rights.

Of 153 non-status women:
- **143 had been sexually abused**
- **67 developed severe depression**

Source: S. Pashang

Based on Dr. Pashang's work with non-status women:

- Majority came legally to Canada (overstayed visa, refugees waiting status or refused)
  - Some were trafficked as sex workers (unknowingly)
- 143 out of 153 had been sexually abused by employers, landlords (resulting in unwanted pregnancies and some ended with abortions))
- 67 out of 153 developed severe depression as a result of "living underground".
- They had to move constantly because of
  - fear of being located and deported,
  - lack of any information on what their options are,
  - lack of education in the Canadian system.

CHALLENGES/BARRIERS TO CHANGE:

- Mental health is the responsibility of the provincial government and is related to social factors.
- The system is fragmented and is not set up to provide adequate mental health care.
  - Even Canadians who are born, raised and educated here have big challenges accessing mental health services.

Challenges for providers:

- Uninsured and undocumented patients can't be properly referred to necessary and adequate mental health care.
- The majority of these patients need prescription of controlled substances (such as benzodiazepines and sleeping meds) that are dispensed at the pharmacies only after ID verification.
- Those who provide services to these patients often bear a double work load and risk losing their job or jeopardizing the funding for the organizations where they are working.
- Front-line providers experience continuous frustration,
  - often dealing with the indifference and ignorance of other institutions and organizations
  - inability to address the gaps and barriers in health care services for this category of population.
  - They are perceived as "annoying complainers" if trying to change the situation

Challenges for patients/clients:

- Many immigrants do not know what depression is;
- Women are more vulnerable,
  - It is easier to access them; they are often used to track down their spouses for detention and deportation
- They are in constant fear of being disclosed, sometimes when they need services for their kids.

ACTION:

OPPORTUNITIES FOR ACTION

- Provide networking for these categories of patients:
  - Churches, soup kitchens, support groups, charities.
- Redefine the notion of citizenship, regulate the status of uninsured.
- Collect the evidence that it is more cost-effective to provide timely and preventive care than deal with emergencies.
- Define "safe" places and educate these patients about their opportunities to access care.

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED

- Professional Organizations (i.e. nurses, doctors, midwives)
- Clients have to talk for themselves.
- Organizations that advocate their problems.
- Institutions (i.e. Children's Aid Society, Legal Aid Ontario) should move out of their comfort zone and start working to resolve these issues. So far these institutions are kept out of the loop.
  - Many social institutions do not have the mandate to provide advocacy to non-status or uninsured people.
- Multisectoral approach is necessary to be implemented.
- Central LHIN's motto is "Excellent care for all". Who are the "all"?

ADDITIONAL NOTEWORTHY POINTS:

1. Challenge the definitions of "citizenship" and "residency".
2. Cost-effectiveness analysis/fiscal arguments.
3. Emphasize "safety for all". (No CBSA?)
4. Deportation, detention for non-status –what can be done?

CHRONIC DISEASE

Lisa Brown
Black Creek Community Health Centre
Facilitator: Simone Atungo

WHAT WE KNOW:

- Chronic diseases can lead to more serious health complications
- Many chronic diseases, like diabetes, can be prevented in the early stages
- Rates of chronic diseases are steadily increasing in the community
- A lot of resources are going into supporting heavy chronic conditions
  - But prevalence rates still not decreasing
- Community Health Centres provide primary care through an interdisciplinary approach
  - High percentage of clients uninsured and living with chronic condition (e.g., diabetes)
- Populations of concern include:
  - Chronic diseases (mental health) for pregnant women who are newcomers to Canada
- Pregnant women also need prenatal care to ensure health of their children
  - Asian African communities
  - Clients living with two or more chronic conditions
- Treatment needed
  - Early screening
  - Providing support
  - We have physicians who are working towards to management
  - Understand the perspectives of individuals (changing eating habits, lifestyle)
- Risk factors

– Social factors – (newcomer's community, low-income) are at risk
– Poverty

The prevalence of Type 2 diabetes among adults in Toronto has increased from 4% in 2001 to more than 9% in 2010.

CHALLENGES/BARRIERS TO CHANGE:

At the level of individuals

Risk:

- 4 D's – debt, decline, detention, and deportation
- Social determinants of health place them at risk
  - Newcomers, poverty
- Many patients are not aware of the complications, which affects the entire family
- Issues are more complex for these individuals
- Emotional issues

Barriers:

- Fear of deportation can result in denying condition
- May not be able to afford treatment
- Language barriers

At the level of the community

- Low-income and racialized communities
- Cultural aspect (some communities do not talk about chronic diseases)
- Community that is very vulnerable

At the systems levels

- Resources to provide support are decreasing
- Language barriers
- A history of violence by authorities
- Many practitioners are scared to collect data and report
- Mixed messages

ACTION:

OPPORTUNITIES FOR ACTION

Recognize change is a process

Research

- We have a model of care that supports that management of conditions
  - If we have models (for people staying healthy) then our health care would be better in the long term
- Set up model to collect data to project long term costs, treatment
  - Many models are collecting data and write reports on various topics (treatments, population, etc.)
  - Need more consistency in collecting data through improved data software
  - Financial costs can be projected through data collection
  - Societal costs must also be included
- Future studies to track the trends
- Documenting the complexities of care

Collaboration

- Health coalition – how can we do that all together and be able to make decisions together
- Working with others (researchers, policy makers, community leaders)
- Need to build trusting relationships with all stakeholders

Services

- Diabetes Education Program
- Intake – care program for clients
- How to create a safe space for people?
  - Settings (hospitals)

Education

- Workshops on prevention in and around the city
  - People could self-refer (do not need to be registered)
  - Less expensive through community workshops to reach larger groups of people
- Staff need to be more knowledgeable, explicit
- Additional resources (e.g., brochures) need to be available

Funding and support for community members

- Individuals need to be supported all the way through the system

Change public opinion

- We need to start role playing
- Consider attitudes, beliefs, opinions
- Consider laws, policies
- Be aware of our own values and beliefs

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED

Hospital

- Frontline admitting people (different forms of communication)
  - Overcome automatic intake procedures ("can I please have your health card?")
- Additional training for staff

Marketing

- How do you convince people (the general population)?
- How can ALL people understand?
- How can we package the message?

Media

- Tell a success story (what happened, their experiences, etc.)

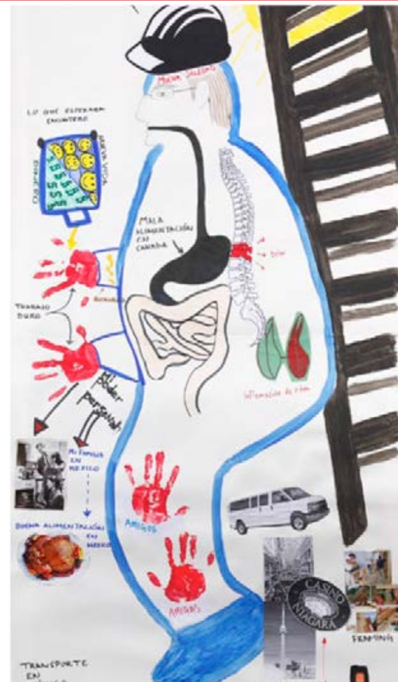
The Four D's that Challenge the Uninsured

- **Debt**
- **Decline**
- **Detention**
- **Deportation**

MIGRANT WORKERS

Lilian Magalhães Ph.D. & Christine Carrasco
Facilitator: Dr. Abeer Majeed

"Making Visible those that Should Remain Hidden: Review of the undocumented worker context in Canada and opportunities for action"



- Goal of work is to bring to light the lives of a huge population that live their lives in shadows.
  - Used "bodymaps" rather than photovoice to protect confidentiality – don't wish to be visible
- Study with:
  - 9 males, 11 females – 20 total. 2 overstayed permits, 10 tourist visas, 7 student visas, 1 border crossing, 3 failed refugee claims.
  - Almost all of them had a document at entry time, but became undocumented.

WHAT WE KNOW:

- Global economic migration is on the rise.
- In Canada, largest concentration of undocumented people worked in Ontario, estimated over 200,000 people.
- There are risks to front-line workers producing services to undocumented people.
- We are narrowing avenues of health access to this population.
- Situation becoming increasingly complex.

Physical and mental health problems result from enormous stress of living without status.

- Psychosocial: isolation, limited social participation, pervasive fear, long-term stress, depression, anxiety, low self-esteem, loss of dignity
- Physical: poor nutrition, diet, sleep deprivation, exhaustion, weight loss/gain, chronic medical conditions, dental emergencies, vomiting (eg. multiple jobs)
- Pregnancy/women's health: sexual abuse, harassment, higher risk to women contracting STDs, limited access to birth control, limited health access
- Work related risks/injuries: cuts and burn (kitchen jobs), construction jobs, heavy lifting, long hours standing, repetitive strain, high workplace
- Health-seeking behaviour

CHALLENGES/BARRIERS TO CHANGE:

Complexity

- Workers experience combination of linked problems
- "web of solidarity and exploitation" as those who employ others are deeply entrenched in exploiting others as well
  - Those who think they are helping, also exploiting.

Lack/limited access to health care (quality, continuity, affordability)

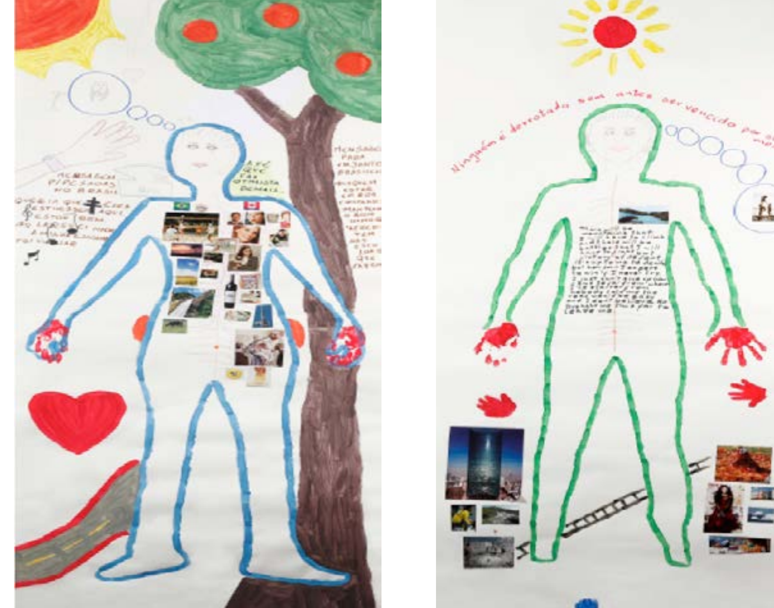
- Use community services
- Second-most used avenue is self-care (techniques learned from informal networks, internet, self-prescribed medicine, etc.)
- Alternative care: chiropractor, naturopathic care, etc.
- Mainstream care (walk-in, hospital, CHCs, TPH, etc.) least used avenue of care, most likely because fear of exposure, documents being required to prove residence, etc.
- Where to refer clients?
  - Barrier is costs most of the time.
  - Even if you apply for Compassionate Grounds, you still do not have access to health care.

Difficult questions

- How can research contribute to action?
- How do we engage silenced voices in dialogue and action?
- How do we advance an agenda of inclusion rather just access?
- Are we truly underpinned by emancipatory access?
- What type of society are we working towards?

Political barriers

- An unchanged pre-migration context coupled with high availability of jobs in cash economy and active labour recruitment make undocumented migration an unstoppable phenomena.
- State turns blind eye to situation because it benefits the economy.
- Canada has specific ties with certain colonial countries (Jamaica, etc.) so there are limited avenues for those who do not originate from these countries to get to Canada.



ACTION:

OPPORTUNITIES/STRATEGIES FOR ACTION

- Stimulating informed dialogue and new public discourse
  - Create frame of reference through accessible media (e-book, website, etc.) for understanding who is an undocumented worker, how undocumentedness is produced
  - Changing discourse through broad and innovative knowledge exchange strategies
  - Engage those people who disagree as well
- Documenting the economic contributions undocumented workers make to the economy.
  - They file taxes at the end of the year.
  - Can file taxes not as an individual, but as a company.
- They have a registered business number or individual tax number, but not SIN number.
  - Many allowed to function as a business, but not as an individual and remain undocumented.

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED

- People should be moving forward in various avenues.
  - Colleges/universities could push forward agenda to government.(e.g. legal action)
- Health care providers can advocate but are under stress on who to provide care to.
  - Physicians marginalized and not supported for the advocacy work they do
- Inclusion of local/national champions
  - Leading health/social agencies – e.g. country consulates.
  - They have a system in place to intervene in emergencies (e.g. sick workers taking flights back home)

WHAT CAN BE DONE WITHIN CURRENT SYSTEM (SHORT TERM/ LONG TERM ACTION)

Delivering services

- Finding who provides services for less has been their way around this challenge.
  - Networking
- Give access to OHIP, regardless/irrespective of immigration status from ethical and cost-benefit perspective.
- Undisclosed information: how much hospitals charge uninsured clients.
  - Each hospital charges different.
  - Service providers learn which charge lower fees and are more sympathetic
  - Front-line workers spend too much time and energy on researching,
- Difficulty with navigating the hospital system.
  - Canadians do not even understand, so migrant workers will and probably cannot.

Promote solidarity and sense of belonging (with communities)

- This is a protection for health
- Mental health protected this way
- Proves as opportunity to disseminate knowledge about existing avenues of care (e.g. WCH network, Davenport-Perth Resources Guide)

Legal strategies

- Can use Dual prevent provision in temporary status and apply under the agency.
  - Bill C-31 will change this.
  - Migrant workers typically have low English access, rely on community members who also do not know much information either.
  - Undocumented workers probably wouldn't trust advice from unknown sources

THREE MONTH WAIT

Axelle Janczur[1] & John Wellner[2]
Access Alliance Multicultural Health Centre[1]
Ontario Medical Association[2]
Facilitator: Cathy Tersigni

WHAT WE KNOW:

About the policy:

- This is not about undocumented people but people who have applied for citizenship, arrived and have to wait three months, including interprovincial travel
- Canada Health Act does not require a three month waiting period, rather it is a maximum of three months
- It is a myth that there is a threat of medical tourism
- Opposition is based on faulty assumptions
- Can potentially lead to a reduction of sponsored immigrants and newcomers in general
- Quebec, which also has a three month waiting period, has exceptions for pregnant women and children

About experience of physicians with this policy:

- There is no medical justification for the three month wait
- Doctors in Ontario are very concerned about this issue
- Doctors that are paid fee for service often ended up working for free
- Emergency doctors are frustrated because they could not treat those in three month wait as regular patients
- There are different protocols and they are aware they could not access care anywhere else
- OMA felt it was important to put the pressure on government officials to present numbers

About the costs of the policy:

- Perception is that it is cheaper to impose a three month wait.
- The system not abused at emergency but things could be taken care of in much more cost effective ways.
- In dealing with government the OMA chose to not present figures on what the costs are.

CHALLENGES/BARRIERS TO CHANGE:

Perceived costs

- In the era of cost cutting it is difficult to do this type of work
- We live in a time of extreme austerity

Politicians and policy makers

- Politicians fear an anti-immigrant backlash if they pushed policy (perceived as benefiting newcomers).
- Politicians argue that it is a nuanced topic – the electorate is not astute enough to understand that complexity
- Policy makers want to know costs - .01% of healthcare budget

Public opinion

- There is a general voter perception that "other people are getting something I am not getting".

ACTION:

OPPORTUNITIES FOR ACTION

- A study tried to find health reasons why Quebec has three categories of exemption – pregnancy, infectious disease and abuse victims.
  - Found that these three categories were not medically more important than other types of health issues. Arguments can be made along these lines.
- There are opportunities for alliance across political parties.

STRATEGIES FOR ACTION

- Need to find the health story rather than the equity story
- If it is sensible, cost effective, etc., what is missing?
- It is newcomers that will be paying for the healthcare of Canada's aging population, so it is in Canadians interest to provide the best care now

IDENTIFICATION OF WHO SHOULD LEAD ACTIONS SUGGESTED

- In 2011 'champions' were identified who would step up – the need is to scale up efforts
- Get behind large interest groups like OMA to lobby the Ministry

WHAT CAN BE DONE WITHIN CURRENT SYSTEM (SHORT TERM/ LONG TERM ACTION)

Providing insurance:

- People could buy OHIP within five days of arriving to Canada
- Charging the patient for the three months - $40/month to counter the notion that it is a free for all
- People can buy OHIP or it can be covered through the Family Health Centre or CHCs

Addressing public opinion and awareness:

- Public awareness to make distinctions clear between the uninsured, permanent residents, etc.
- We should not weaken the position publicly in order to gain public support
- If people can prove that people die or babies die from this policy Canadians will become outraged enough to act

Approaching policy makers and politicians

- We need to mobilize
- Have a consistent platform between different groups going to the Ministry
- Need more political pressure – if an MPP receives 15 calls on one topic, they will bring it up

STRATEGIES FOR ACTION

1. Make it a charter challenge – a human rights issue.
2. Give new permanent residents IFH for three months.
3. Take it out of the discussion and give newcomers OHIP immediately upon arrival.

HOMELESSNESS

Dr. Stephen Hwang[1] & Kate Mason[2]
Centre for Research on Inner City Health[1], St. Michael's Hospital
South Riverdale Community Health Centre[2]
Facilitator: Kapri Rabin

- **5,086 homeless people on a single night (City's Street Needs Assessment, April 2009)**
- **32,000 different people use a homeless shelter in Toronto each year.**

WHAT WE KNOW:

- Homeless people have poor health, high mortality rates and difficulty in accessing health care
- There are two groups: Uninsured versus those with lack of proof of health insurance
  - There are not only uninsured but also underinsured (dental, medications, etc.)
  - There is a three month wait period when you move to another province to have health benefits.
- Homeless people cannot show their eligibility, because they do not have OHIP, also because they need a fixed address
- Policies are not always put into practice

Street Health Report 2007

- Representative sample of 368 absolutely homeless men and women recruited at meal programs and shelters in downtown in Toronto in 2006/2007
- Survey topics: demographics, health, health determinants, access and barriers to services

Barriers to health care:

- 28% of all respondents had been refused health care in past year because they didn't have a health card
- – Walk in clinic (46%)
- – Emergency Department (40%)
- – Family Doctor's office (32%)
- Not having a family doctor was associated with lack of health card.
  - Only 26% of people without health card had a family doctor
- Other barriers include:
  - attitudes of health care providers
  - past experiences with health care
- Unwelcoming and stigmatizing
  - discrimination on the basis of SES (socio-economic status)

Consequences of people not getting health care:

- Declined in health status
- Avoidable emergency department visits and hospitalizations
- Acute deterioration in health vs. emergency department as walk in clinic
- Perception that uninsured people use the emergency room because cannot access walk in clinic.
  - In fact access emergency because their health has deteriorated.

CHALLENGES/BARRIERS TO CHANGE:

- No national housing strategy
- Massive cuts to social assistance in mid 90s
- Weakened rent control and tenant protection
- Criminalization of homeless people's survival activities
- Austerity agendas/competing priorities (even from your allies)
- Attitudes/values
  - judgment around health issues that are tied to behaviour/ lifestyle 'choices'
- After 9/11 majority of homeless were rejected to get their ID. High rate of Refusal = suspicious of everyone

ACTION:

OPPORTUNITIES FOR ACTION

PAID

- Started in 2000 by MOHLTC (city/HRSDC funded)
- Access to health cards for homeless/partners for access and identification program to provide broader ID service with a focus on employment and housing-services
- Two community workers and MOH reps:
  - kiosks at CHCs to help people get instant health cards (being phased out)
  - serves 8,000 people/year
- Fees waived for birth certificates, simplified process
- Developed exception handling protocols (no address, no B.C)
- Resolved systemic barriers-contradictive policies between jurisdiction/levels of government
- Eliminated three month wait to prove provincial residency

ID SAFE

- Established in 2002, as a pilot in community-based organization (Street Health), one full time staff
- Stores identification documents for 500 people
- Protocols with service providers so that people don't have to continually show original ID
- 94k operate annually
- Insecure, project based funding CITY via SCPI/HPI
- Space constraints/other priorities for community based agencies,
- Fear regarding: privacy issues, time required

CATCH (coordinated access to care for the homeless)

- Program to help homeless people who have unmet complex health care needs to access health resources in the community
- Partnership between Inner city Health Associates, Toronto North Support services and Toronto Central CCAC care connectors
- Work with family physicians, psychiatrists, CATCH co-ordinator and a CATCH transitional case manager to support access to medical care, nursing care

Community Health Centre Model

- Funding tied less to individual encounters-salaried physicians
- Utilize inter-professional groups: nurses/nurse practitioners
- No shadow billing/capitation
- Funded to cover diagnostics/specialist consults and medications for uninsured clients wellness/preventative health care
- Multiple low-thresholds entry points: group programming and community initiatives
- Equity mandate
  - But marginalized and underfunded compared to rest of health care system
- CHCs have varying capacities

WHAT CAN BE DONE WITHIN CURRENT SYSTEM (SHORT TERM/ LONG TERM ACTION)

Solutions: BEYOND ID

- Insurance is not enough
- Perverse incentives in fee-for service health care system
  - Doctors are motivated to work for quantity rather than quality
- What is needed is incentives to provide:
  - Quality of care, not quantity of care
  - Co-ordination of care
  - Health care for the most difficult to care for
- Family Health teams?
  - Problem is that they have been constructed not to help those who are most in need, but instead help those that are easy to take care of
- Chronic disease as model of success at receiving funding?
  - Cost/benefit argument

Solutions: beyond Health Care

- Health care sector needs to advocate upstream/for social services
  - Address poverty-increase to social assistance rates
  - Address housing, serious lack of affordable, adequate housing in Toronto.
- Health care as human right or simply the right thing to do
- Need to pair values with evidence (Insite example)
- ADVOCACY around provincial budget
  - City 'Stop the cuts' mobilization as model
  - Community mobilization is needed (Free for all)
  - Need to speak up together

2007 Street Health Report
Of 368 homeless women and men:

- **34% did not have a health card**
- **19% did not have a health care provider**
- **59% did not have a family doctor**

what's next?

A SUMMARY OF ACTIONS TO ACHIEVE SOLUTIONS FOR ACCESS TO HEALTH FOR THE UNINSURED

Bob Gardner
Wellesley Institute

HOW DO WE DRIVE CHANGE ON KEY ISSUES?

1. We need hard-nosed analysis that researchers, professional associations, and policy analysts provide
2. We need to be aware of the wider context
   – Precarious migration status is increasingly common and trends in immigration are increasing the numbers of temporary workers
3. We need to think beyond health care to social determinants of health
   – Precarious work, racism, poor housing etc. - reinforcing and cumulative inequitable effects.
   – We need to identify the coalitions and collaborations that can address these broader social determinants
4. We must recognize that the problems are systemic, and so the solutions must be systemic too
   – We need to get at the roots of the problem by identifying the different pathways through which people can be uninsured and the different policy solutions to address each
5. We need to build solid evidence-based and achievable business cases for action:
   – designed for different policy, provider and community audiences
   – clearly setting out the levers and strategies to drive action
6. We must reframe the public debate from anti-immigrant/unfair entitlement to fairness.
   – Every person (physically present in Canada) should be entitled access to health care?
7. We must be flexible and respond to windows of opportunity
   – Work to require commitments to ALWAYS provide care into each hospital's quality improvement plans
   – Use the policy, provider and community forums where we happen to find ourselves to build support for these solutions
8. Challenge political allies to be bold and imaginative – that's their job
   – Even friendly and progressive politicians don't think this is winnable, but we can't afford for them not to take action.
9. Speak from a credible base
   – Doctors and nurses have a particular credibility
   – Who are other possible thought leaders?
10. Integrate information from different sources
    – E.g. homeless information database at St. Mikes as an example of what can be developed
11. Sustain and build networks
12. Talk about our success stories
    – Local innovations
    – Work arounds

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SEEKING SOLUTIONS

ACCESS TO HEALTH CARE FOR THE UNINSURED IN CANADA

LINKING ETHICS, RESEARCH EVIDENCE AND POLICY-PRACTICE CHANGE