Health Care Access for the Uninsured in Ontario

Symposium Report

By Steve Barnes

Wellesley Institute
advancing urban health

June, 2016

Wellesley Institute is a reseach and policy institute that works to improve health and health equity in the GTA through action on the social determinants of health.

10 Alcorn Ave, Suite 300
Toronto, ON, Canada M4V 3B2
416.972.1010
contact@wellesleyinstitute.com

Introduction

On February 9th, 2016 the Health Network for Uninsured Clients, in partnership with Wellesley Institute and Women's College Hospital, hosted a day-long symposium on improving access to health care for people who are uninsured in Ontario. The Symposium:

1. Showcased research on barriers to health care and opportunities for policy change that have emerged since the Network's last symposium in 2012;
2. Shared knowledge and experiences with a new generation of health care providers about how to navigate systems for uninsured clients;
3. Bridged connections between researchers/policy makers and service providers to engaging decision makers and organizational leaders to address access to care for uninsured clients; and
4. Identified tools and actions to support policy change and changes to practice.

The day was divided into five sections: the context in which we're operating, federal updates, provincial updates, local updates and targeted breakout sessions.

Context

Arif Virani, MP for Parkdale-High Park and Parliamentary Secretary to the Minister of Immigration, Refugees and Citizenship

The day began with opening remarks from MP Arif Virani, Parliamentary Secretary to the Minister of Immigration, Refugees and Citizenship. MP Virani noted that his government is committed to using evidence to inform policy and asked Symposium participants to ensure that evidence on uninsured populations is shared with the federal government.

MP Virani spoke about the government's commitment to settle 25,000 Syrian refugees and how proud he is of how Canadians have sponsored so many families to settle here. Health outcomes for refugees are contingent upon a success immigration process. In that vein, family sponsorship and 'family link' programs have been established. MP Virani confirmed the government's intention to reinstate the Interim Federal Health Program that was significantly cut under the previous government, a move that has since occurred.

MP Virani ended by urging participants to use "all Canadians" framing in our work to improve access to care. We have an obligation to care for all members of our society regardless of what immigration category they arrived through and we are all Canadians.

Keynote Address: Debbie Douglas, Executive Director, Ontario Council of Agencies Serving Immigrants

Ms. Douglas began with framing health as a universal right. Canada is a signatory to UN conventions and international treaties that affirm that health is a human right. This is the cornerstone of improving access to care for people who are uninsured. In Canada, nobody should lack access to health care services.

Despite this, there are major issues regarding access to health care in Ontario. The uninsured are a large heterogeneous group and there are many reasons for non-insured status, including people in the OHIP three month wait period, temporary foreign workers, international students and people who are

undocumented. The number of uninsured people in Canada is estimated to be between 200,000 and 500,000, and many are in Toronto because of pull factors like employment. The number is believed to be increasing and there is a need for new avenues for permanent residency. Refugees have a hard time completing the process of becoming permanent refugees because of the complex system. Immigrants also face many barriers to good health when they arrive in Ontario, including:

- Low income and few services (child care subsidies, etc.).
- Underground employment in poor and unsafe working conditions. They are also more at risk of workplace explotation and abuse, including having their wages withheld.
- High stress levels as a result of settlement issues.
- Many immigrants purchase private insurance but it's expensive. Many times they cannot afford tests and are cautious about seeking health care at hospitals becuase they have heard stories about huge hospital bills.
- Many health conditions that immigrants come with are not diagnosed or detected (i.e. HIV or TB) because they do not seek out health care or denied care.

Immigrants also face specific health care challenges:

- Finding health care that is culturally sensitive.
- Women and girls are most vulnerable, especially those who are trafficked.
- Many health conditions that immigrants come with are not diagnosed or detected (i.e. HIV or TB) because they do not seek out health care or are denied care.
- Aging population who are uninsured and have been living here for a long time are vulnerable.

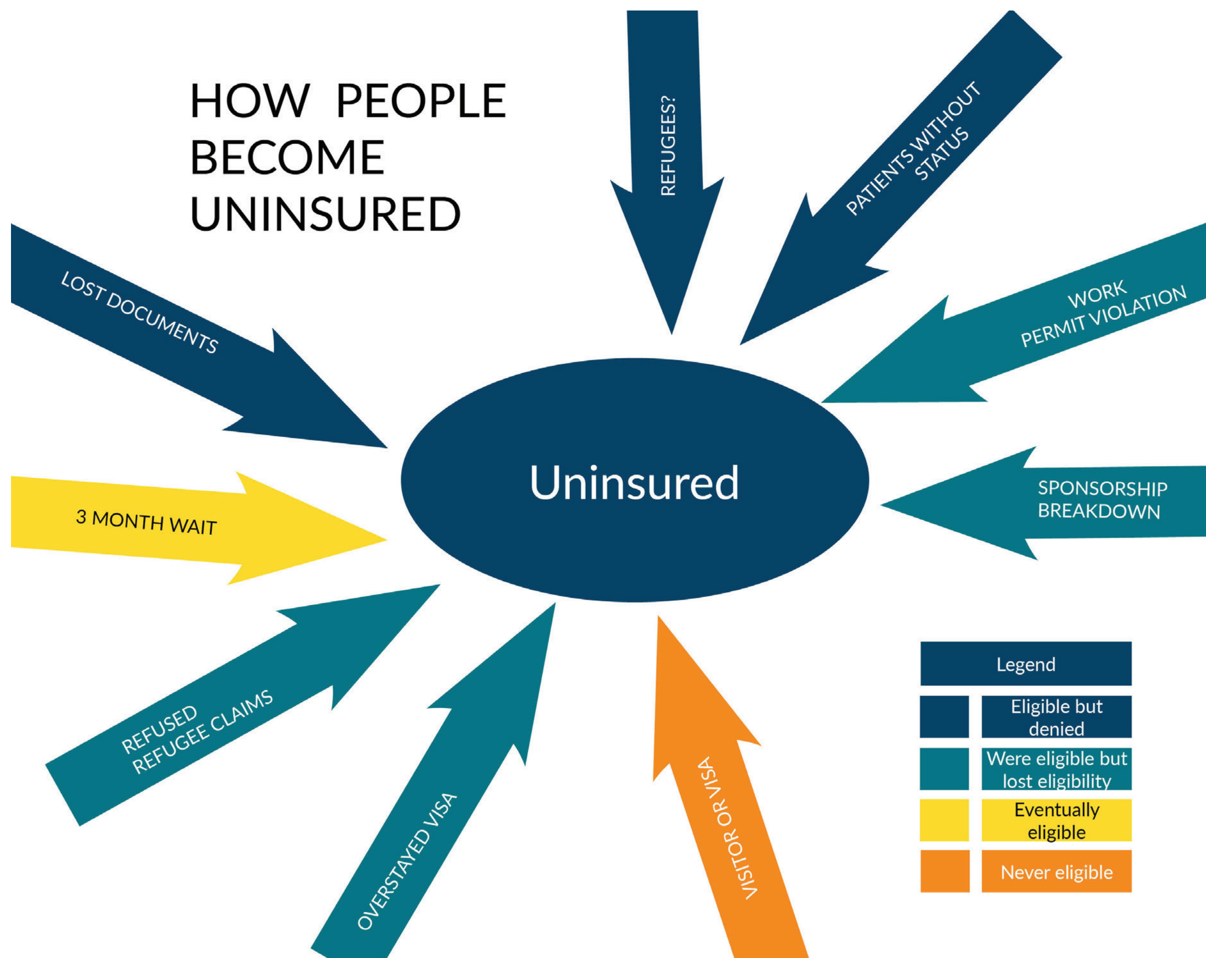
Barrier	Impact
OHIP three month wait period	Many cannot afford private insurance or may be unaware that they are not covered when they arrive in Ontario Delay seeking health care with worse outcomes and more costly care required as a result
Interim Federal Health Program	Confusion about eligibility following 2012 IFH cuts Confusion about the coverage provided by Ontario to cover the gap left by federal cuts
Front desk workers at clinics and hospitals	Informal gatekeepers but lack of knowledge about protocols for uninsured clients can lead to inappropriate refusal of care

Goals:

1. Full reinstatement of IFH coverage
2. Comprehensive immigration and refugee reforms
   - Particularly in family sponsorship
   - Make people permanent status (status regularisation)
   - Elimination of transportation loans for refugees
3. Elimination of OHIP three month wait
4. Province-wide "access without fear" policy

How People Become Uninsured: Michaela Hynie Associate Professor, York University; Associate Director, York Institute for Health Research

Dr. Hynie described the multiple pathways through which people may become uninsured.



Dr. Hynie also showed uninsured visits to hospital emergency rooms by LHIN from 2002-2011. The vast majority of ER visits occurred in the five LHINs that cover the GTA, with the Champlain LHIN that covers the Ottawa region also having higher rates. Dr Hynie articulated how being uninsured is linked to migration, vulnerability and precariousness and that those who are treated as uninsured (regardless of their actual insurance status) are among the most vulnerable populations in our communities.

How the immigration system works in Canada and how people become Uninsured: Andrea Bobadilla, PhD Candidate at University of Western Ontario and member of OHIP for All

Across all immigration programs there are prominent governance trends:

- Increase in privatization of migration programs, increased power to employers.
- Externalization: increased stratification of migrant categories with differing requirements for some groups.
- Paternalization: fulfillment of work requirements (especially for Temporary Foreign Workers).
- A move away from permanent toward temporary status. Since 2007 Canada has admitted 250,000 permanent versus 500,000 temporary residents.
- Conditional permanent residency was introduced in 2012. In this situation a sponsored spouse has to stay in relationship for two years. This is problematic for women who experience abusive relationships.
- The express entry category was introduced for skilled workers at the beginning of 2015. Connected employers with applicants who could be invited to apply. The goal to admit 186,000 skilled workers was not met.
- The establishment of Designated Countries of Origin ('safe countries') category for refugee claimants led to a 75 percent negative claim rate.
- Temporary Foreign Workers face employer mediated access to care. A policy introduced in 2015 means that no TFW can work in Canada for more than four years. TFWs must stay out of Canada for four years before applying to come back again. This creates instability and may affect mental health.

Federal Issues Panel

Impact of Cuts to IFH Coverage and Where to from Here?: Sideeka Narayan, Nurse Manager, Health with Dignity Program at Access Alliance Multicultural Health and Community Services

Cuts to the Interim Federal Health Program have been one of the most significant challenges for people without insurance in recent years. Reviewing the IFH changes is important for where we see ourselves going now that the federal government has committed to reinstate the program.

In June 2012 the previous federal government made cuts to IFH that denied basic care to many groups and created different categories of refugees who receive very different levels of care (e.g. refugees from countries that were considered 'safe' only received public health coverage).

Health care providers saw the impacts of the IFH cuts immediately. Access Alliance dealt with inequitable access to health care, confusion and anxiety for refugees, confusion among health providers about who was eligible and people left without the ability to pay for health care services. The IFH changes were opaque and poorly communicated. Bureaucratic complexity trumped patient centred care. One of the unforeseen

impacts of the IFH cuts was that some health care providers were hesitant to treat refugee clients due to confusion about eligibility and ability to bill for their services.

Following the IFH cuts there was a large and swift health sector response. Advocacy was led by Canadian Doctors for Refugee Care and a legal challenge, which was ultimately successful, asked the Federal Court to declare the cuts unconstitutional. In face of opposition the federal government reversed some aspects of cuts but also added additional tier of complexity to already complex program. Access to medication was restored to pregnant women and children but not all refugee claimants unless there was a public health concern.

A large research study was undertaken by UofT and McGill about accessibility and the costs of the IFH cuts. The study is ongoing but findings to date show poorer health outcomes after IFH cuts. For example, increased admission rates at Sick Kids Hospital suggest that children were arriving at hospitals later and less healthy than prior to the cuts.

The new federal government dropped Harper government's appeal of Federal Court of Canada decision declaring cuts "cruel and unusual." IFH has been reinstated for Syrian refugees and the health sector is mobilizing to respond to GARs and PSRs with supportive political climate.

Even with the cuts being reversed there is more work to do. At the health care practice level there is still misunderstanding and confusion regarding IFH eligibility, especially among hospital providers. Next steps for improving refugee health care include:

- All refugees and claimants who are eligible for IFH must receive care to which they are entitled to when they are living in Canada
- Public education campaign to help ensure providers understands coverage is reinstated
- User friendly IFH system to eliminate steps and complications for providers to address refusals
- The federal government looking for opportunities to streamline billing process to ensure caring for refugees is no more complex than billing for OHIP clients

Health Equity and Access to Health Care in the Canada Health Accords: Scott Wolfe, Executive Director, Canadian Association of Community Health Centres

The federal government has committed to establishing a new Health Accord to replace the agreement that expired in 2014. The previous federal government took a hands off role in health care, preferring instead to simply provide transfer funds and allowing provinces to determine how to spend their health care dollars. In 2011 the Harper government announced a unilateral health care funding agreement where the federal government signaled they were out of business of health and cut equalization funding which resulted in frozen or low increase health care budgets across the country. The lack of conditions attached to funding has contributed to health care system differences across the country. The new federal

government appears ready to take a stronger leadership role in health care. Mandate letters signaled openness to activist role and strings attached health funding for provinces.

The governing approach of the new federal government has four key components:

- Reintroduce federal activism and "strings" (conditional funding)
- Rebuild culture of cooperative federalism (federal government working with provincial governments)
- Restore evidence base and good will of public service
- Rebuild public confidence
  - federal government is taking prudent and practical approach after years of harmful government practices contributed to public cynicism
  - federal government looking for early wins to increase public confidence

Federal action in next couple of years will be closely tied to mandate letter priorities. We need to look at these letters closely, identify levers, and use them as portal to craft advocacy strategies and messages. The shape of the new Health Accord is not yet clear, but some possibilities include:

- Short term "mini accord" beginning Summer 2016
- Modest deliverables within current government's mandate
- Agreement on a few common priorities
- Agreement on the federal funding share
- Long-term funding agreement (in mandate letter but now in context of budget deficit, this may be pushed aside)

The Minister of Health's mandate letter gives some clues about what to expect. The Health Accord will be a multi year accord and long term funding agreement to:

- Improve home care services ($3B, new investments)
- Advance pan-Canadian collaboration on health innovation (largely health technologies)
- Increase efficiency and improve outcomes – important language to use to advance our messages re: access for uninsured
- Improved access to necessary prescription medications. The focus is on bulk purchasing; possibility of a national formulary. This is a good start but far from national PharmaCare
- Make high quality mental health services more available.

Federal Panel Respondent: Dr. Yogendra Shakya, Senior Research Scientist, Access Alliance Multicultural Health and Community Services and Assistant Professor at Dalla Lana School of Public Health

Dr. Shakya began by commenting on how IFH cuts and policy claw-backs are stark reminder of the incompleteness of our Canadian democracy. We lack of checks and balances and there is a need to take action on this. Challenging IFH through the federal court was ultimately effective but we need stronger democratic processes that will insert citizens into policy making and government decisions earlier rather than responding to inequitable and harmful policy and legislative changes. This is a reminder of importance of civil society and advocacy to play role of checks and balances. We need to grow this and support advocacy.

With the change of federal government we have an opportunity to build on successes and continue our advocacy work. There is a role for federal government in health care that goes beyond even a new and stronger Health Accord. The federal government needs to set national standards and provide health care

coverage to people who are not insured under provincial plans. We need to review the IFH program and strengthen it so that it provides universal coverage for those without provincial coverage. Alongside this, there is a need for institutional solutions to address IFH gaps and challenges and reduce denial of care.

Provincial Issues Panel

How the Association of Ontario Midwives advocated for uninsured populations: Juana Berinstein, Director, Policy and Communications, Association of Ontario Midwives

Juana Berinstein shared recent initiatives undertaken by Ontario's midwives to improve access to care for uninsured midwifery clients. Midwives in Ontario are a funded program of the Ministry of Health and Long-Term Care, and their services are not tied to OHIP. This means that people without insurance have been able to access midwifery care at no cost since midwifery was first regulated in 1994. However, uninsured midwifery clients were required to pay out of pocket for any services outside of midwifery care they needed during pregnancy, including lab tests and ultrasounds, and physician consultation fees, if applicable. This led to pregnant clients forgoing or delaying care and created avoidable health risks for mothers and babies.

The initial solution to increasing access to midwifery care for non-insured clients was to partner with CHCs, who were funded to provide care to uninsured populations. When midwifery clients were rostered to a CHC, they were able to access the CHC's uninsured funding to cover services outside of midwifery care such as lab test and physician consultations. This left a major gap however, since not all clients were eligible to be rostered at a CHC and CHC uninsured funds were limited.

The Association of Ontario Midwives made improving access to these services part of their bargaining position during midwives' 2014 contract negotiations with the Ministry of Health and Long-Term Care. AOM used empirical evidence on the health risks of poor prenatal care and a costing analysis of done by Manavi Handa, RM about the average costs of physician consultations/transfer and lab services for uninsured midwifery clients to make the case to the government that providing funding for uninsured midwifery clients to access lab tests and physician consultations would be both financially feasible, and would lead to significant health benefits for parent and child.

As a result of this advocacy, midwifery clients now have access to funding to cover the cost of services outside of midwifery care, including physician consultations and transfers of care, lab tests, ultrasounds, and diagnostics, but excluding hospital facility fees. . This was a major step forward for improving access to prenatal care for uninsured clients.

What can Ontario do to ensure excellent care for all?: Dr. Ritika Goel, Family Physician and Organizer, OHIP for All Campaign

Dr. Goel began by noting that uninsured people experience illnesses just like the rest of us. In Ontario there have been many cases where uninsured clients were left with huge health care bills and experienced morbidity/mortality as a result of being denied/delayed care. One Nigerian woman was charged a large

hospital bill and denied private health insurance because she was pregnant. Another Jamaican man died to colon cancer because he was denied health care. These denials of care are unfair, inequitable and avoidable.

Health care providers see many patients who present for care but cannot pay and leave before receiving treatment. These cases happen at every point in the health care system. The Canada Health Act states that people should not be denied emergency care but this happens. Sometimes the denial of care is formal, other times it is informal through hostile receptions in health care institutions and requirements that patients agree to pay the full cost of their care before they are seen. These medical, financial, and ethical costs can be avoided.

Health care providers have a mandate to provide high quality, accessible, and patient centered care. International research (conducted in Spain, France, England, Sweden) has demonstrated costs associated with not receiving immediate care. These costs can be avoided if we provide access to health care for all members of our society. The OHIP for All campaign, which launches in the Spring of 2016, calls for access to care for everyone living in Ontario. This includes eliminating the OHIP three month wait period and providing OHIP to all uninsured people with temporary status, awaiting inland immigration decisions or who are non-status while living in Ontario.

Respondent: Angela Robertson, Executive Director, Queen West – Central Toronto Community Health Centre

When we talk about developing practices and policies for people who are uninsured, we should think about who we are talking about. We should share the stories of people who live through these issues and we need to humanize the issues. Ms. Robertson identified themes from the provincial issues speakers:

- The strength of local activism and mobilizing. We need to be relentless in advocating for system level changes. The IHF program successes occurred due to activism on streets, in Ministers officers, in board rooms, and in communities.
- When talking about issues of uninsured, we need to have a gendered lens and look at differential experiences of different types of people and communities.
- The existing compensation model for health care providers demands that money has to be paid up front. We need to think more about how compensation creates barriers in access to care for uninsured.
- Providers have standards of ethics that could be used to drive for the rights of uninsured.
- At the federal and provincial level, we have many people who are politically progressive and this gives an opportunity to move to “sunny days”.
- At the core, we all want access to health care. Now is the moment for activism and mobilization.

Local Issues Panel

From Decision to Implementation: Sanctuary City: Denise Andrea Campbell, Director of Social Policy, Analysis, and Research; City of Toronto

In 2014 Toronto City Council adopted a Sanctuary City policy. The policy goal was access to city services without fear for all residents in Toronto. This policy was built off the advocacy of people and groups outside government.

The City of Toronto establishing a sanctuary city was a major undertaking. It is estimated that 50 percent of undocumented Canadians live in Toronto, so providing services to this population is a major social change and will improve the lives of many residents. People without status are working and contributing but were not getting access to the benefits that are gained by contributing. The City believed that this was unfair and there was a duty to correct this inequity.

Implementation of the sanctuary city policy has been challenging for the city. The City of Toronto Act does not require city services to only serve 'citizens' or 'documented' residents. For example, no ID or status documents are required to access recreation services or shelters, although educating staff about when they can ask for ID is important. There are, however, some services where the city is legally required to collect ID when accessing services that are funded by the provincial or federal government, for example, child care and Ontario Works. Ms. Campbell noted that now is an important time for advocates to ask the provincial and federal governments to reconsider what services require asking for documentation.

As part of the implementation of the Sanctuary City policy the city developed a 'Secret Shopper' City Service Audit, now in its third year. This means that the city gets people to attempt to access city services and see if staff follow Sanctuary City policies. The Secret Shopper process has shown that the City is achieving mixed results in implementing the policy. There has been inconsistency among different parts of the city in regards to which questions get asked, if referrals were given and level of respect given to people who identify as undocumented. There is still a lot of work to do to get consistency.

The next big challenge in implementing the Sanctuary City policy is getting the Toronto Police Service on board. Police and border/immigration communication is dangerous for undocumented residents. The first step is to work with police to get consistency on a 2007 "Don't Ask" policy that states that police should not ask about immigration/migration status. This is going to be a large challenge and will require changes to police policies for undocumented residents.

Toronto Central LHIN Work to Improve Access to Care: Cynthia Damba, Senior Planner/Epidemiologist at Toronto Central Local Health Integration Network

Ms. Damba set out a number of initiatives being undertaken by the Toronto Central LHIN to improve access to health care for people who are uninsured.

The TCLHIN is working with CHCs for marginalised groups including uninsured and undocumented and pushing for equity and access for undocumented. The goal is to ensure that nobody is turned away

from health care services. CHC funding for uninsured clients has been increasing from $1.5m in 2007 to $2.3m in 2014.

TC LHIN is also working to improve and standardize the referrals process from CHCs to hospitals. Making standardised referrals will improve efficiency and improve service to clients. For example, uninsured Alternative Level of Care (ALC) patients waiting for Long-Term Care (LTC) referrals can use a large amount of health care services. There are a small number of patients (4 people) with long wait times (collectively 15 years) in this situation within the TCLHIN but ALC is expensive ($1.1m) with poor economic efficiency (three times the cost of LTC). Improving referrals for uninsured clients can improve efficiency within the health care system as well as improving outcomes for clients.

Equity is the overarching priority in the TCLHIN's next strategic plan. The TCLHIN's planning document includes three pillars:

1. Leadership and cultural change
    a. Increasing education for healthcare providers, including cultural competency
2. Better Data
    a. Collecting and analysing better data will hopefully lead to better policies
    b. Putting in place standardised health equity screening questions
        i. Should count the uninsured
        ii. Should provide better tracking of disparities and progress
3. Innovation

Breakout Sessions

During the afternoon participants moved into rotating breakout sessions focused on policy, service and access, research and advocacy. Breakout groups answered three questions:

1. What do we have?
2. What do we want to do?
3. What do we need to get there?

A report from the breakout sessions is attached to this report.

Summary of the Symposium

Steve Barnes, Director of Policy, Wellesley Institute and Chair of the Health Network for Uninsured Clients

Steve Barnes closed the symposium with a summary of the day's presentations and key points from the breakout sessions.

1. We have a right to health
2. If we have a right to health, we all have a right to health
   - This is out vision. A Toronto, Ontario and Canada in which everyone has the right to health.
   - This includes the social determinants of health
   - We need use universal framing
3. To get there we need systems-level change
   - Right now people fall between systems.
   - We need to think about how our systems are used and where we need corrections.
   - We have a democratic deficit – we need to appeal to Canadians, not just to decision makers
4. We have the beginnings of systems change with a new federal government
   - Open to evidence, willing to talk. They need OUR evidence.
   - Prepared to be active, e.g. Health Accord & IFH
   - Mandate letter for Minister of Health focuses on improving efficiency and outcomes. This is an opening for our movement.
5. But we still need work-around solutions
   - At the government level
     * Sanctuary City: secret shopper, implementation challenges
   - At the service provider level
     * Midwives saw an inequity and put their money where their mouth is
     * Providers have an important role in pushing system change
     * Signage at clinics and hospitals that tell people their rights to access care
6. There are some concrete things that we need to realize our vision
   - Regularization of status and immigration policy reform
   - End OHIP three month wait
   - OHIP for all
   - IFH restoration
   - Ontario-wide access without fear policy
   - Elimination of hospital facility fees
7. How we need to do it
   - With lived experience front and centre
   - Using a lens that allows us to respond differently to different needs: gender, racialization, LGTBQ
   - With new partners and old
   - Research on outcomes and access. This can be scoping reviews – we know enough to get going
   - By respecting cultural practices
   - Using a hub for information sharing: like the Homeless Hub
   - Training for front-line staff
   - Training for planners and policy staff

8. When

- Now.
- We have a political window with Ministers Philpot, McCallum and Hoskins and Mayor Tory.
- We have allies inside government bureaucracies who are prepared to work with us.