Hospital Care for Patients Uninsured due to Immigration Status during the COVID-19 Pandemic in Toronto: Lessons from Front-Line Knowledge Translation

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Abstract

Before the COVID-19 pandemic, patients in Ontario who were uninsured due to immigration status faced barriers to hospital care that resulted in preventable illness and death. In March 2020, the Ontario Ministry of Health issued a memo indicating that it would pay for medically necessary hospital services for uninsured patients (Ontario Ministry of Health 2020). Front-line providers and research workers associated with the Health Network for Uninsured Clients (HNUC) set out to ensure that hospitals in Toronto implemented the ministry's memo. In this paper, we demonstrate a model of front-line worker–led knowledge translation informed by real-time data and anchored in clearly articulated values and goals. On April 1, 2023, the Ontario Ministry of Health cancelled this uninsured coverage (Ontario Ministry of Health 2023). Healthcare provider associations, grassroots groups and coalitions – including the HNUC – are mobilizing to see this uninsured coverage reinstated.

Introduction[1]

In March 2020, the Ontario Ministry of Health issued a memo indicating that it would begin paying for what it termed "medically necessary" hospital services for uninsured patients, a funding program that came to be known as the Physician and Hospital Services for Uninsured Persons (PHSUP) (Ontario Ministry of Health 2020). Before that date, uninsured or underinsured patients in Ontario (i.e., individuals without access to the Ontario Health Insurance Plan [OHIP]) faced a range of barriers to essential treatment (Medical Officer of Health 2013; Schmidt et al. 2023; Siu et al. 2022). For example, a province-wide study found that uninsured patients who visited emergency departments (EDs) in Ontario were more likely than insured patients to present with severe conditions, to leave without treatment and to die (Hynie et al. 2016).

Soon after its release, the ministry memo came to the attention of the Health Network for Uninsured Clients (HNUC) – a group of more than 40 healthcare and social service organizations at the time; it has since grown. The HNUC is committed to facilitating access to healthcare for uninsured residents in Toronto and acts as a forum for people working in healthcare and social services to problem-solve and share resources and best practices. The HNUC also helps to build capacity across Toronto through webinars, through online resources and by conducting and contributing to research. In addition, the HNUC identifies barriers to access for uninsured patients and advocates for solutions. The HNUC is led by two co-chairs who are approved by the general membership. Rotating organizations act as a secretariat, providing resources such as meeting space and administrative support (HNUC 2023; Hudson et al. 2017).

In March 2020, a group of front-line providers and knowledge workers associated with the HNUC began organizing

to ensure that hospitals in Toronto implemented the ministry memo. Strategies included generating multilingual, plain-language materials for both patients and providers; establishing a rapid response team to advocate for individual patients; creating direct communication channels between front-line staff and hospital leadership; and holding frequent online meetings and webinars to share information.

This paper was written by front-line providers, knowledge translation workers and researchers in Toronto – most of whom were directly involved in the HNUC's pandemic response. Our goal is to document these activities and share recommendations about mobilizing the knowledge of front-line workers to improve access to care. This paper draws on our experiences with the HNUC's pandemic response and with uninsured patients before and during the COVID-19 pandemic. It also draws on our experiences with knowledge translation and on both academic and grey literature.

We would like to emphasize that many individuals, grassroots groups and coalitions have been working tirelessly to facilitate access for uninsured patients throughout the COVID-19 pandemic. The initiatives described here are one piece of a much larger picture.

Finally, we note that the Ontario Ministry of Health announced the reversal of the PHSUP funding program with one week's notice in late March 2023, with no contingency measures publicly communicated for people currently receiving hospital-based treatment (Ontario Ministry of Health 2023). The HNUC, along with many grassroots groups and coalitions, has been mobilizing to stop these cuts. Activities that were announced in the days after the cuts included urging professional organizations to make public statements, circulating a petition, holding a press conference and rally and undertaking direct action (Healthcare for All Coalition n.d.). Shortly before the cuts were announced, the HNUC also published a research report documenting the positive impacts of extending hospital care to uninsured patients (Schmidt et al. 2023); it has been widely used to demonstrate the program's life-saving benefits (Balintec 2023; Star Editorial Board 2023).

As of this writing on May 16, 2023, more than 4,900 people have signed a petition calling for the Ontario government to immediately reinstate the program (Healthcare for All Coalition n.d.). In addition, groups including the Ontario Medical Association, Ontario Medical Students Association, Canadian Paediatric Society, Canadian Association of Emergency Physicians, Association of Ontario Midwives, Ontario Psychiatric Association, Registered Nurses' Association of Ontario, Ontario AIDS Network, 19 legal organizations and a range of groups representing primary care providers have released public statements urging the Ontario government to put the program back in place (Healthcare for All Coalition n.d.).

Background: Pre-Pandemic Healthcare Access for Patients Who Are Uninsured due to Immigration Status in Toronto

In Canada, provincial healthcare coverage is tied to immigration status. As a result, many people who live in Ontario do not have access to OHIP. People can be uninsured due to immigration status in Ontario for many reasons. For example, before the COVID-19 pandemic, Ontario did not provide OHIP coverage for new and returning permanent residents for three months. In some cases, refugees and temporary foreign workers do not have access to OHIP. International students and people without status are excluded from OHIP altogether. Due to the complexity of the Canadian immigration system, "people frequently [shift] in and out of status, and are often dependent on third parties like employers or partners to secure legal immigration status" (Gagnon et al. 2022: 1029).[2]

People who are uninsured in Ontario may be able to access primary care at no cost through community health centres (CHCs), midwives and dedicated uninsured walk-in clinics. Some people, however, may have trouble finding access to a CHC due to eligibility criteria (Medical Officer of Health 2013; Schmidt et al. 2023). For example, someone may live outside a CHC catchment area – there are catchment gaps across Toronto. In addition, many CHCs have periodic intake freezes or long waiting lists for uninsured patients, or in general. CHCs may cover hospital and specialist procedures and diagnostic fees for their patients. CHCs, however, do not generally cover hospital administrative fees, often termed as *facility fees*, which can cost patients thousands of dollars per day (Izenberg et al. 2018).

Before the memo was issued in March 2020, hospital care was particularly hard to access for uninsured patients living in Toronto and even more challenging if they were not attached to CHCs. While EDs generally treated people in acute crisis, they engaged in various practices that deterred access to care. For example, patients were often quoted high fees, asked for payment before or during treatment and/or repeatedly contacted by hospital collections staff or external collections agencies following treatment. In-patient and outpatient hospital clinics engaged in similar practices, often implicitly refusing care by quoting patients inaccessible fees for life-saving treatments, such as chemotherapy or heart surgery; explicitly refusing care; or discontinuing care when patients could not pay or ran out of money. Hospitals have resumed many of these practices in the weeks since the Ontario Ministry of Health suspended the PHSUP. Uninsured patients can also face intrusive questions and derision from some healthcare providers and administrative staff because of their immigration status (Campbell et al. 2014; Gagnon et al. 2022; Simich et al. 2007; Siu et al. 2022).

Front-Line Knowledge Translation Interventions

While the PHSUP memo did not extend OHIP to all people who were not previously eligible, it did direct hospitals to provide uninsured patients with what it termed "medically necessary" hospital care (Ontario Ministry of Health 2020). In the weeks that followed, the HNUC – along with the other grassroots groups and coalitions that worked tirelessly on this issue – received reports from patients and front-line workers that the ministry memo was being applied differently across the hospital system. Some hospitals had stopped charging uninsured patients in their EDs, but not in the context of in-patient care. In other hospitals, some in-patient departments had implemented the memo, but EDs continued to charge patients for care. In addition, some COVID-19 testing centres were turning away uninsured patients and, in some cases, patients who did secure tests were unable to access their results as the online portal required an OHIP number.

In response to these reports, a group of front-line providers and knowledge translation workers from the HNUC implemented a series of interrelated interventions led by the HNUC co-chairs who were in place at that time in the hopes of ensuring that hospitals across Toronto fully implemented the ministry memo. We refer to this group as the HNUC's pandemic response group. This paper documents the first year of the pandemic response group's activities.

Developing plain-language materials, webinars and meetings

In April 2020, the HNUC's pandemic response group collaborated with other groups to produce plain-language guides to the ministry memo in order to raise awareness about the new policy (HNUC 2020a, 2020b). Using funding and in-kind contributions from multiple member organizations, the HNUC translated patient materials into eight languages and disseminated these through multiple networks over e-mail and during online meetings and webinars. HNUC members and others reported that patients, social workers, clinicians and settlement workers used these materials on a regular basis. The HNUC also provided both PDF copies of the ministry memo and letter templates to advocate for individual patients directly to front-line workers and patients to present to hospital staff. In addition, the pandemic response group hosted and participated in webinars that outlined the memo and shared tips with front-line workers and patients about navigating uninsured patients through hospital care (Cheff 2020; Alliance for Healthier Communities 2020). Finally, the HNUC disseminated and discussed the memo at HNUC meetings, which bring together front-line providers, researchers and some policy makers across Toronto.

Forming a rapid response team to provide support to individual patients

As a result of the efforts detailed earlier, both front-line workers and patients began to contact the HNUC directly for assistance. To respond, the pandemic response group invited front-line providers from CHCs to participate in regular, online, rapid response meetings to problem-solve specific cases. Workers from three Toronto-area CHCs joined the founding rapid response team. This small rapid response team began meeting or communicating several times a week in order to ensure timely support for people encountering barriers to medically necessary care at hospitals across the Greater Toronto Area (GTA). The rapid response team resolved a range of cases, securing medically necessary hospital care for people who were erroneously quoted fees they could not pay or who were simply turned away; participating in hospital discharge planning; working to ensure that patients were attached to CHCs; and ensuring that people received follow-up hospital treatment.

Communicating directly with hospital leadership

Through rapid response meetings, and information received from HNUC members and other groups, the pandemic response group began to identify patterns of denials of care at specific GTA hospitals and departments. Co-chairs sent letters on behalf of the HNUC communicating these patterns to chief executive officers, chief financial officers, department heads and finance staff, urging them to apply the memo to all patients and in all departments. Co-chairs communicated directly with the leadership responsible for 10 hospitals in Toronto, along with leadership responsible for approximately four additional hospitals in the GTA. Early in the pandemic, these efforts frequently yielded rapid results. In many cases, following communication with the pandemic response group, hospital representatives told HNUC co-chairs that they conducted internal reviews, changed existing policies of charging patients, refunded charged patients and/or recirculated the memos.

Front-Line Knowledge Translation: Recommendations and Lessons Learned

We have outlined the components of this iterative front-line knowledge translation program above. In the following section, we share recommendations related to the factors that enabled the development and implementation of this model. We also outline gaps this intervention did not fill. These recommendations focus on how to mobilize the knowledge, commitments and relationships of front-line workers in order to influence the implementation of a regional policy at the local level. They may apply to other new policies or programs intended to improve access to healthcare or services.

We emphasize, however, that we are sharing these recommendations in the context of local policies and practices and in the context of the clearly articulated values, long-standing relationships and local knowledge built by individual front-line providers and through the HNUC. These recommendations may not all be generalizable outside this particular time in Toronto in relation to serving patients who are uninsured due to immigration status. Any adaptation must be informed by the deep and up-to-date knowledge of local context necessary to evaluate the potential benefits and harms to patients, communities and front-line workers.

Recommendation #1: Maximize flexibility for front-line workers

The activities of the rapid response team relied on the encyclopedic knowledge of front-line CHC workers on issues such as immigration law, housing policy, income supplements and settlement services. They also relied on the relationships front-line CHC workers maintain – often over many years – with health, legal and social service sector workers in Toronto. One front-line CHC worker on the pandemic response group also met clients where they were, providing opportunities for connection by phone or Zoom and in person in hospitals, clinics and the community.

Importantly, participating CHCs allowed workers the flexibility to apply their expertise and commitments with few limitations. CHCs gave workers the time to attend regular case-conferencing and HNUC meetings and respond to issues as they came up. CHCs also permitted workers to consult across Toronto's many CHC catchment areas, extending life-saving case coordination and other supports to clients without imposing geographic barriers.

In addition, both front-line and research workers were empowered to communicate directly with hospital leaders. Often workers must go through their management when they want to communicate with the leadership of other organizations. This can result in a time lag or a failure to convey the urgency or nuance of how policies are playing out in hospital waiting rooms, clinics and finance departments. These direct communications between the pandemic response group and hospital leadership were highly effective, in particular at the beginning of the pandemic. These early successes resulted directly from the fact that workers were not forced to navigate customary hierarchies to do their work.

Recommendation #2: Value long-term relationships and commitments

Many HNUC members have carried a commitment to uninsured patients through different job positions and have participated in this work both within and outside paid roles. They have also forged relationships over the course of long-term collaborations focused on responding to the barriers facing uninsured residents. These commitments, trusting relationships and deep wells of expertise ensured that the HNUC received real-time reports about what some uninsured patients were experiencing in hospitals during the COVID-19 pandemic. It also allowed the HNUC to move swiftly and flexibly to help address the implementation of the ministry memo.

Recommendation #3: Articulate and maintain clear values and goals

An important part of this long-term work has involved clearly articulated collective values and goals. The HNUC works from the assumption that healthcare is a human right (Gagnon et al. 2021; HNUC 2023; WHO 2022). Many members are not *neutral* but, rather, actively take the position that everyone should have access to healthcare, dignity, respect and well-being, without exception. Similarly, the HNUC's pandemic response group had a clear and unambiguous goal: to ensure that uninsured patients were able to access medically necessary hospital care without charge.

Recommendation #4: Develop and maintain the ability to assess local context and possible harms

The pandemic response group's work was grounded in the local context. All those involved have been helping to navigate uninsured patients through Toronto's hospital system and/or monitoring policies for uninsured patients for many years, in some cases for decades. For example, members of the pandemic response group were familiar with immigration policies and practices and the ways in which these interacted with the hospital system in Toronto. In addition, they were aware of some of the ways that interrelated factors such as racism, xenophobia, transphobia and discrimination against people who have nowhere to live impact access to care in Toronto. As a result, members of the pandemic response group were able to assess, communicate around and help to mitigate the potential harms facing patients. In addition, they were familiar with the matrix of services and benefits available (or, in some cases, unavailable) to people in Toronto, such as shelters, immigration law, mental health services, child care and income supplements. In this way, members of the pandemic response group – and in particular those working in a front-line capacity – were able to take a broad view of the situations patients found themselves in and work with their contacts to craft a nuanced and informed response.

Recommendation #5: Put the patient's well-being at the centre and never give up

The stakes for the work of the pandemic response group were very high. In some cases, a person's access to life-saving treatment hinged on the group's ability to secure appropriate care. These stakes are familiar to members of the HNUC, and the front-line workers in the pandemic response group had years of experience dealing with similar situations. Part of the success of the pandemic response group came as a result of a "whatever it takes" approach developed over decades. As one member of the pandemic response group put it, "Relentless advocacy is a key strategy. Do not give up." The pandemic response group did not consider a *no* to be the end of a given process. Rather, the process concluded when the front-line worker was certain that the patient was going to receive medically necessary care.

Recommendation #6: Document and share best practices

The pandemic response group found various ways to document and share its approach to securing care for patients in Toronto under the new provincial policy. For example, the co-chairs shared this information during webinars and HNUC meetings. They also shared PDF copies of the ministry memos and plain-language materials explaining the type of coverage available. More generally, members of the pandemic response group and the HNUC have generated a range of materials and presentations over the past many years designed to build the capacity of healthcare providers in Toronto to offer appropriate and dignified care to people who are uninsured due to immigration status. Most recently, the HNUC launched a website highlighting resources and information related to uninsured patients in Toronto (HNUC 2023).

Recommendation #7: Operate simultaneously at different scales using a "looped" knowledge translation approach

Members of the pandemic response group engaged hospital leadership, individual providers and individual patients, sometimes on the same day. In this way, the pandemic response group was able to notify leadership about issues at individual hospitals while also working to resolve patient issues in the short term. The HNUC also convened regular meetings, bringing together a larger number of front-line providers and a smaller number of hospital ethicists and administrators in order to gather information, resolve specific issues and influence practice. Members of the pandemic response group also met regularly with groups working on similar issues. These groups were important sources of information on topics such as policy and developments outside Toronto. Through this "looped" knowledge translation process, members of the pandemic response group saw potential in every encounter to gather and disseminate information; influence institutional processes; influence the practice of individual providers; help equip people with up-to-date and nuanced information; and resolve issues for individual patients.

Importantly, members of the pandemic response group maintained protocols around patient confidentiality and consent at all times and were sensitive to the different types of information that can impact patient well-being and safety in the context of hospital systems and beyond them. For example, no identifying patient information was shared in HNUC meetings, on shared drives, through webinars or on e-mail lists.

Recommendation #8: Do not expect local groups with limited resources to systematically address province-wide implementation processes

In the years leading up to the PHSUP funding program, the practice of charging people for medically necessary care became entrenched in hospitals through both physical infrastructure and daily activities. Examples include signage in EDs, uninsured payment forms, informing patients about costs, asking patients for payment, denying or suspending treatment and pursuing patients for payment up to and including sending them to collections. This can be compounded by derisive and often racist and xenophobic attitudes toward uninsured patients, attitudes that are well documented in the literature and that we have seen in our own work (Campbell et al. 2014; Gagnon et al. 2022; Simich et al. 2007; Siu et al. 2022).

As a result of these entrenched practices, the PHSUP funding program required a strategic and long-term program of implementation. For example, those working in hospitals required both training on working with uninsured patients and saturation messaging through e-mails, staff meetings and town halls. To ensure continued implementation of the memo, hospital leadership also needed to repeat these messages over time – as the COVID-19 pandemic wore on, some providers began to revert to usual practice.

Hospital administrators must also embed accountability in the implementation of all new processes, especially those that apply to patients who face racism and xenophobia. In our experience, at least for the first year of the pandemic, few hospitals seemed to have processes in place to monitor whether or not different departments and providers were implementing the ministry memo or to address instances where providers or staff erroneously charged uninsured patients for medically necessary care.

The HNUC's efforts to encourage hospitals to implement the PHSUP funding program led to important gains. Its reach, however, was limited, and the work was, by necessity, ad hoc. The pandemic response group addressed cases – and hospitals – that were brought to its attention by its networks in Toronto. The HNUC was not positioned to systematically monitor or address implementation at hospitals across Ontario or Toronto. Rather, this work should fall to hospital leadership and ethicists, who should take responsibility for ensuring that every patient who presents for treatment receives the medically necessary care.

An Evolving Model of Critical Front-Line Knowledge Translation

In healthcare, knowledge translation is often defined as the process of putting knowledge into action in order to improve health and the healthcare system (Graham et al. 2006). The use of the term "knowledge," rather than "research," is deliberate as knowledge translation can be applied to a range of knowledges, including academic research, organizational processes and people's experiences (Strauss et al. 2013). Knowledge translation is distinct from research dissemination in that it explicitly aims to use knowledge to influence the actions of *knowledge users*, such as policy makers, healthcare administrators, healthcare providers, patients, community groups or community organizations (CIHR 2012; Graham et al. 2006; Murphy and Fafard 2012). As a result, mainstream knowledge translation strategies emphasize cooperation with knowledge users and with decision makers in particular (Murphy and Fafard 2012). This approach embeds the assumption that when appropriately informed and supported with technical expertise, decision makers will respond to evidence. Some researchers, however, point out that there may be "contested definitions of policy problems," and emphasize the need to include a broader range of tools under the umbrella of knowledge translation, including critical analysis, advocacy, coalition building and long-term collective action (Murphy and Fafard 2012: 272).

Evidence from academic research and the experiences of patients, communities and front-line providers demonstrated that uninsured patients did not have access to medically necessary care (Hynie et al. 2016; Schmidt et al. 2023). In spring 2020, many groups across Ontario moved to put this *knowledge into action*, working quickly and creatively to help implement the ministry memo and address this long-standing policy problem. To contribute to this multi-faceted effort, the HNUC's pandemic response group used tools from both mainstream and critical knowledge translation, such as communicating directly with decision makers, developing plain-language communications for patients and providers, participating in coalition building and applying critical analysis. These tools were both bound together and supplemented by an iterative front-line knowledge translation approach, built on the HNUC's long-standing practice of gathering information from front-line providers and supplemented by the mobilization of front-line work across hierarchies and siloes.

Conclusion

During the COVID-19 pandemic, the HNUC responded to emerging policy contexts through a series of simultaneous, interrelated and dynamic interventions that had positive material impacts for patients. The rapid response team secured or expedited hospital access for issues such as acute injuries, cancer treatment and pregnancy care and helped patients access primary care through CHCs. The team also helped secure refunds for patients who were erroneously charged for hospital treatment and whose hospital bills affected their ability to pay for necessities, such as rent, food and transportation. More broadly, the HNUC's plain-language materials, meetings, webinars and communications with Toronto-area hospital leaders resulted in greater access to medically necessary hospital care for uninsured patients. This iterative, front-line knowledge translation approach was made possible by putting knowledge translation into the hands of front-line workers; allowing front-line providers and knowledge translation workers to circumvent customary siloes, hierarchies and catchment areas; building on a foundation of long-term relationships and commitments; articulating clear values and goals; assessing local context; putting patient well-being at the centre; documenting and sharing best practices; and approaching every encounter as an opportunity to problem-solve and gather and share information.

Since March 2020, the HNUC has grown, and it now includes more than 70 organizations from across the GTA. The HNUC is anchored by committed leadership; clearly articulated values and goals; and the knowledge, experience, relationships and inspiration of front-line providers. As a result, the HNUC is positioned to respond to changing policy environments. This includes participating in urgent work to communicate the impacts of the loss of the PHSUP funding program and advocating to see the program reinstated (HNUC 2023). HQ

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Notes

1. The authors of this paper share the view that patients should have access to medically necessary treatment without barriers. Most of the authors of this paper have direct experience treating uninsured patients or navigating patients who are uninsured through the healthcare system. The background information provided throughout this paper does not provide a comprehensive view of Ontario's healthcare system or policy context during the COVID-19 pandemic or beyond it. Rather, we provide the specific aspects of the policy context that have been relevant to our work and goals over the past decade.
2. While this paper focuses on people who are uninsured due to immigration status, there are many other reasons why people may find themselves without an OHIP card. For example, an open letter to the Ontario government from the Income Security Advocacy Centre (2023) explains that people "may be unhoused and lose their identification" or "leave a violent home with no belongings". They also outline the struggle people who lack mobility may have in renewing their OHIP cards (Income Security Advocacy Centre 2023).

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