

Initiative: Ethics Policy Brief Re: Changes to Interim Federal Health Program
Date: August 6, 2012
Issued by: Uninsured Patient Task Force (UPTF),ⁱ Joint Centre for Bioethics



PURPOSE:

This document seeks to broadly outline the ethical issues related to the new legislative parameters for the Interim Federal Health Program (IFHP) and provide ethics-based guidance to facilitate fair and transparent decision-making for Ontario’s policy makers, healthcare professional bodies, associations, organizations and providers regarding access to care decisions for IFHP beneficiaries. While there is significant overlap between IFHP and uninsured patient access to care issues, this policy brief addresses only IFHP associated matters.

2011-12 Refugee Statistics:

Total refugees in Canada: 128,000ⁱⁱ
 Total refugees in Ontario: 61,171

BACKGROUND:

In Canada, there are approximately 130,000 refugees currently present, with a little less than half or 60,000 residing in Ontario. Historically, these individuals have been provided expanded healthcare coverage through the IFHP. If patients are ineligible for Provincial or Territorial insurance and do not have private insurance, the IFHP provided temporary healthcare benefits for up to 12 month renewable intervals to three categories of persons: 1) refugee claimants, 2) “protected persons,” including resettled refugees under the *Immigration and Refugee Protection Act* (IRPA) and 3) other groups ineligible for Provincial coverage.ⁱⁱⁱ Effective June 30, 2012, both the eligibility criteria and benefits covered for IFHP recipients have changed significantly. Under the new legislation, depending on the category the individual belongs to, IFHP will pay for one of three different types of coverage: basic, expanded or public health and safety coverage (Table 1).

All other treatment costs not covered by IFHP will be borne by the refugee. For example, individuals with diabetes or requiring chemotherapy that qualify for basic coverage would have to pay for their medication

or IV chemo drugs out-of-pocket. See Table 2: IFHP coverage & beneficiary designation (on page 2).

Table 1: Types of available IFHP coverage

Basic:	Expanded:	Public health & safety:
Care that is “ urgent or essential in nature ” ^{iv}	Basic coverage + Prescribed medications, limited dental & vision care, prosthetics & devices to assist mobility, home care and long-term care, psychological counseling and post-arrival health assessments.	Care ONLY provided to diagnose, prevent or treat a disease posing a risk to public health or safety.
Includes: hospital services, services of a doctor or registered nurse, lab, diagnostic and ambulance services + Medications ONLY when required to prevent or treat a disease posing a public health or safety concern.		

While professional bodies and advocacy organizations across Canada have called for the IFHP changes to be rescinded, to date this has not occurred. Nonetheless, healthcare organizations and providers must implement the new IFHP parameters. The UPTF does not condone the IFHP cuts but recognizes that given the status quo, fair and transparent decision-making is required and endeavors to make recommendations to further that end.

The IFHP coverage changes will impact numerous stakeholders in various ways. Anticipated impacts to healthcare organizations include the following: 1) increased Length of Stay (LOS) in acute care for persons with basic or public health and safety coverage that cannot afford medications or access Alternative Levels of Care (ALC) 2) increased uncompensated care costs from de facto uninsured persons with public health and safety coverage, particularly through

increased emergency department utilization and presentation to Ontario’s Community Health Centres (CHC), which already receive some funding to provide primary care for people without health insurance.^v

Table 2: IFHP coverage & beneficiary designation^{vi}
(Table current as of Aug. 2, 2012)

Type of IFHP Coverage	Beneficiary Designation
Basic	Non-Designated Country of Origin (Non-DCO) claimants
	Most Privately Sponsored Refugees
	Most individuals with a + Pre-Removal Risk Assessment decision Successful refugee claimants
Expanded	Victims of human trafficking (with a valid temporary resident permit)
	Government Assisted Refugees
	Ministerial discretion ^{vii}
Public Health & Safety	Designated Country of Origin (DCO) claimants; Note: basic coverage until DCO policy takes effect, date TBD
	Rejected refugee claimants

For IFHP beneficiaries with basic or public health and safety coverage, reduced access to care caused by these changes to the IFHP will impact the health of refugees. Some likely consequences include increased rates of late stage cancer, unmanaged chronic diseases, no pre-natal care and mental health issues which translates to more costly care.^{viii-ix} Removal of medication coverage could prove detrimental as well since compliance with medical care is closely tied to the affordability of the proposed treatments. Additionally, these patients may receive sub-standard care if unable to pay for typical treatment regimens or access ALC such as rehabilitation services following a trauma. Family members and friends may also feel pressured or obligated to pay for care or shoulder unmet caregiver responsibilities.

The safety of the public is the basis for continued medical coverage of certain communicable diseases. However, many of these diseases follow indolent and asymptomatic courses, and are often diagnosed only incidentally through primary care screening. This is unlikely to occur if refugees do not have regularly established primary care. Therefore, diseases that present a public health or safety risk may not be

routinely identified and pose a greater public health and safety hazard.

Illustrative Case: basic coverage = ALC access denied

Following an acute care hospitalization for end-stage metastatic cancer, palliative care is deemed the most appropriate level of care for a non-DCO refugee with basic coverage. Unfortunately, palliative care is not covered and the patient does not have the ability to pay. The acute care team is placed in the difficult position of either keeping the patient in hospital to die or discharging the patient to the community without access to palliative care resources.

KEY ETHICAL ISSUES:

The IFHP cuts have made it more challenging for some IFHP beneficiaries to access health care. This poses important justice questions and requires healthcare organizations and providers to examine their legal and ethical obligations to provide treatment for these patients.

Ethics is at the core of resource allocation decision-making because questions of justice are at issue. Key ethical questions include:

- What is our duty to provide care for IFHP beneficiaries beyond what IFHP covers?
- What steps ought to be taken to minimize the impact of some IFHP beneficiaries reduced access to healthcare?
- As public resource stewards, how should healthcare organizations in Ontario balance competing needs to finite healthcare resources?
- Who should be accountable for making these decisions?

In light of these and other relevant questions, the principles of Justice, Humanitarianism, Stewardship and Transparency are particularly relevant.

In emergency situations healthcare professionals and healthcare organizations have obligations to patients regardless of the patient’s ability to pay. For example, Section 21 of Ontario’s *Public Hospitals Act* obligates hospitals to admit a patient if “...by refusal of admission life would thereby be endangered ...”^x Similarly, Section 18 of the Canadian Medical Association’s (CMA) Code of Ethics notes that a physician is to “provide whatever appropriate assistance ... to any person with an urgent need for medical care.”^{xi} These obligations are based on the

commitment to the ethical principles of justice and humanitarianism. However, for less urgent, chronic or preventable conditions, the ethical obligations of individual clinicians and healthcare organizations are less clear.

If resource constraints did not exist, healthcare organizations and providers would respond solely on the basis of medical need. However, for IFHP beneficiaries with basic coverage, determining which treatments are covered requires an assessment of which treatments are urgent or essential in nature versus those that are elective. For IFHP beneficiaries with only public health and safety coverage, assessments will be similar to those made for uninsured patients regarding when the legal and ethical threshold to treat in urgent or emergent circumstances exists. Medavie Blue Cross, the company responsible for IFHP claims administration, notes that providers have to verify eligibility with Medavie before providing services which poses a high administrative burden.^{xii} Where applicable, Finance departments may assist with coverage verification and clinicians may want to refer to the [IFHP coverage grids](#) if a patient's type of coverage is known.

Illustrative Case: public health & safety coverage

A rejected refugee claimant with schizophrenia who also has a history of violent outbursts when mental illness is unmanaged receives medication since the condition poses a threat to public safety. Patient has numerous co-morbidities including severe COPD which remains untreated. Patient routinely presents to ED for shortness of breath. The ED healthcare providers must decide if this constitutes an emergency situation that triggers a legal and ethical duty to care and if yes, whether to charge a patient that will likely be unable to pay for his care.

Ethical issues for healthcare organizations:

Healthcare organizations are expected to be stewards of public resources to ensure fiscal responsibility and that public resources are used appropriately. Stewardship and fiscal responsibility may be threatened if the number of patients requiring uncompensated services increases. From a stewardship perspective, healthcare organizations are placed in the position to decide whether it is more economical to deny non-urgent treatment or to provide non-urgent treatment in an effort to prevent deterioration into a more costly emergency situation.

From a justice perspective, healthcare organizations will likely need to develop decision-making criteria to ensure that decisions about access to treatment and associated costs assessed to the patient are made in a consistent and fair manner. Moreover, because healthcare is a finite resource with competing demands, fair allocation of these scarce resources becomes more challenging in the face of a new population of patients who may require uncompensated treatment. Organizations will have to consider the impact providing uncompensated treatment will have on their ability to provide for Ontario residents for which the provincial system is intended to benefit. Additionally, organizations may wish to consider how they will decide which treatments, if any, they will expect payment for, and if patients are unable to pay the full amount whether a lesser amount is acceptable?

In summary, the IFHP changes will likely require health care organizations to 1) establish criteria to decide whether to provide non-urgent treatment, 2) identify who will make access to care decisions, and 3) how much, if anything, the organization will attempt to charge and collect from the patient for treatment provided.

Ethical Issues for individual healthcare providers:

Healthcare professionals experiencing increased requests for uncompensated treatment will need to determine the amount of treatment that is fair and just for them to provide without compensation given their commitments to other patients and activities. A healthcare professional's duty to care is now complicated by the question of 'how much care am I obligated to provide' and considerations of whether external factors (i.e. IFHP funding) can place limits on a pre-existing therapeutic relationship? For example, imagine a DCO refugee who was in a pre-existing therapeutic relationship. If the physician is no longer remunerated for the patient's visits, is this grounds for terminating the relationship? The College of Physicians and Surgeons of Ontario's (CPSO) policy statement on "Ending the Physician-Patient Relationship" specifies situations under which a decision to terminate the relationship is appropriate to do so.^{xiii} This situation is not specifically addressed; however, under the regulations to the *Medicine Act*, "discontinuing required services constitutes professional misconduct unless the patient requests the discontinuation; alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative

services.”^{xiv} The changes to IFHP will make it very difficult for patients to arrange alternative services.

When there is an agreement to provide services, healthcare professionals will be faced with the dilemma of how much to charge for their services if any. Providers will likely not wish to further burden their already disadvantaged patients but clinicians may still feel it important that some compensation is necessary, even if only nominal. Therefore clinicians may struggle in determining what sort of “means” test, if any, is appropriate.

RECOMMENDATIONS:

In most healthcare settings, decision-making around requests for uncompensated non-urgent treatment is both an organizational and individual healthcare provider decision. Both organizational and individual behavior is strongly influenced by requirements established through Provincial policy and professional regulations. Due to this complex interconnection, we have outlined recommendations that are particularly relevant for government policy-makers, professional regulators, healthcare organizations and individual healthcare providers. However, it should be recognized that there is significant overlap among all four areas and the recommendations should be considered collectively.

For Provincial Government & Local Health Integration Networks (LHIN)

- 1) In order to ensure fairness, a coordinated response should be lead by the Ministry of Health and Long Term Care and occur across the Province, among the Local Health Integration Networks (LHIN), between health organizations, between health sectors (e.g., acute and community care), and between health professionals working with diverse patient populations.
- 2) Foster transparency to patients, providers and the public.
- 3) As an intermediary between the Provincial government and healthcare organizations, the LHINs should facilitate healthcare organizations and providers to:
 - monitor adverse refugee health effects in a fair and transparent manner;
 - track frequency of requests for uncompensated care and costs incurred;

- monitor associated health system effects such as ED wait times, increased occupancy and LOS.

For Professional Colleges & Associations

- 1) Provide support and guidelines to healthcare providers regarding prioritization of requests for uncompensated care.
 - Facilitate healthcare professionals to coherently and consistently navigate a complex process to reduce frustration and unnecessary treatment denials.
- 2) Facilitate interprofessional communication among healthcare providers to understand unique pressures and demands.

For Healthcare Organizations:

- 1) Establish decision making criterion that takes into consideration the following factors: medical needs of the patient, ability to pay for services, impact on Ontarians by providing or denying service, as well as the principles of justice, humanitarianism, stewardship and transparency.

Justice: entails consideration of fairness and equity as key values in decision-making regarding refugee requests for treatment demonstrated by:

- Fair and consistent decision-making processes regarding access to care across the Province, health sectors, institutions and individual healthcare providers.
- Where a fee must be assessed, charging the IFHP reimbursement rate.^{xv}
- Informing IFHP beneficiaries not to pay-out-of pocket for covered services since IFHP must be billed directly and will not reimburse individuals.

Humanitarianism: describes an extended notion of the duty to care that may be involved when considering requests to provide treatment to refugees demonstrated by:

- Patient advocacy and establishing partnerships with healthcare organizations.

Stewardship: recognizes that healthcare delivery organizations and health care professionals are charged with a duty to ensure fiscal responsibility and equitable

distribution of resources within a publicly funded healthcare system demonstrated by:

- Healthcare organizations collectively deciding what each can own and prioritize to meet unmet refugee care needs.

Transparency: acknowledges the need for consistency and openness in decision-making and that accountability to staff, patients and Ontarians are required elements in the deliberation process.

2) Establish common administrative process to ensure consistent approach and alleviate the burden of healthcare providers and institutions deciding on a case by case basis.

- Make processes transparent to patients, providers and the public.
- Ensure that persons responsible for patient accounts are aware of the definitions for “urgent and essential care.” As a matter of fairness, the applied definitions should be consistent within and among healthcare institutions so that there are no geographical inequities or perceived arbitrariness.
- To promote decision-making consistency, develop a decision bank that details relevant facts of each request, decision reached and associated rationale.

3) Establish a decision making body within the organization to deal with requests for uncompensated treatment.

- For example, Sunnybrook Health Sciences Centre has an *ad hoc* Uninsured Patient Decision Support resource comprised of senior leaders and key stakeholders to support decision-making around access to non-urgent care for uninsured patients.

4) Engage healthcare providers to raise awareness of the frequency and severity of the issue that transcends beyond administrative departments such as Finance.

5) Collaborate and engage with other local healthcare organizations to establish common policies and procedures across and between LHINs.

- Expand Community Health Centre (CHC) and hospital out-patient clinic fee agreements initiated in the TC LHIN province-wide to facilitate refugee access to primary care.
- Accept the “means test” assessment completed by CHCs.

6) Monitor requests and track outcomes of uncompensated treatment requests.

- In the home care and community health service sectors, monitor the impact of reduced access to medical supplies for in-home care, (e.g. IV infusion therapy, wound care and chronic disease management). Also, monitor ED re-referrals to as a result of limited access to equipment and supplies for in-home treatment after discharge.
- In ALC settings (e.g. rehab), monitor the impact and costs associated with loss of coverage for services.

7) Regularly acknowledge the uncompensated care provided by clinicians.

8) Consider creative fundraising opportunities to offset costs for providing uncompensated care.

For Individual Healthcare Providers:

1) Dialogue with patients about treatments that are not covered and explore potential alternatives.

2) Assess your ability to provide uncompensated care taking into account your competing duties and obligations.

- Where a physician fee or other fee is assessed, charge the OHIP rate (which is amount reimbursed by IFHP).

3) Contact the CPSO and Canadian Medical Protective Association (CMPA) regarding legal duty of care obligations to patients who present requesting uncompensated treatment, especially those patients with whom you are already engaged in a therapeutic relationship.

4) Engage and develop relationships with local healthcare organizations including hospitals, Community Health Centres (CHC), midwifery

practices and become familiar with their policies and procedures regarding requests for uncompensated treatment. For example, Midwives in Ontario are funded to take care of uninsured patients.

- 5) Consider participating in the Refugee Health Outcome Monitoring and Evaluation System (Refugee HOMES) to monitor the effects of changes to the IFHP on adverse health outcomes experienced by refugees in Canada.



RefugeeHOMESData
EntryForm.pdf

Acronym Legend:

IFHP: Interim Federal Health Program
DCO: Designated Country of Origin
IRPA: Immigration and Refugee Protection Act
ALC: Alternative Level of Care
LOS: Length of Stay
CPSO: College of Physicians and Surgeons of Ontario
CMPA: Canadian Medical Protective Association
LHIN: Local Health Integration Network
TC LHIN: Toronto Central Local Health Integration Network
UPTF: Uninsured Patient Task Force

ⁱ The Uninsured Patient Task Force (UPTF) is comprised of bioethicists and healthcare providers with ethics training and affiliation with the University of Toronto's Joint Centre for Bioethics (JCB). Members of the UPTF have significant experience consulting on uninsured patient cases, developing policy at healthcare delivery organizations or providing healthcare to uninsured patients. The UPTF was established in partnership with the uninsured subcommittee of the Toronto Central Local Health Integration Network's (TC LHIN) Collaborative on Marginalized Patients to develop an uninsured patient ethics-based guideline for healthcare providers and institutions within the TC LHIN.

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Ontario Midwives & JCB, Frank Wagner, Toronto Central Community Care Access Centre & JCB, Irene Ying, JCB.

****To provide feedback, please contact Sally Bean at sally.bean@utoronto.ca**

- ii [Explanatory note of the Order Respecting the Interim Federal Health Program](#), 2012. Accessed July 6, 2012.
- iii Citizenship & Immigration Canada. [Refugees: Health Care](#). Accessed August 2, 2012.
- iv Embedded link provides policy definition under section 2.3 Health care coverage.
- v Ontario's Community Health Centres. [About Us](#). Accessed Aug. 2, 2012.
- vi Citizenship & Immigration Canada. [Refugees: Health Care](#). Accessed August 2, 2012.
- vii For example, Humanitarian & Compassionate considerations or public policy considerations.
- viii Caulford P. Vali Y. Providing Healthcare to medically uninsured immigrants and refugees. CMAJ. 2006; 174(9):1253-1254.
- ix Pottie K. et al. Evidence based clinical guidelines for immigrants and refugees. CMAJ. 2011.
- x *Public Hospitals Act* RSO 1990, c P.40
- xi Canadian Medical Association. [Code of Ethics](#) (2004).
- xii Medavie Blue Cross. [Important information for Hospitals, et al.](#) Accessed Aug. 2, 2012.
- xiii College of Physicians & Surgeons of Ontario. [Ending the Physician-Patient Relationship](#) (2008) #3-08.
- xiv *Medicine Act*, 1991, SO 1991, c 30
- xv Medavie Blue Cross. Citizenship & Immigration Canada [IFHP Benefit Grid](#). Accessed Aug. 6, 2012.