Collateral damage: The unmet health-care needs of non-COVID-19 patients

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With more health resources devoted to COVID-19, non-COVID patients may have unmet health-care needs, which predict poorer health in the future. Credit: Shutterstock

As the second wave of COVID-19 has now officially hit Central Canada (Québec and Ontario), we can expect health-care system resources to again be disproportionally demanded by COVID-19 patients. Addressing the direct health implications of the pandemic is clearly necessary, but doing so may come at an indirect cost for non-COVID patients who may struggle to access needed care.

Meeting those unmet health-care needs calls for policy actions such as better data, alignment of physicians' billings with telemedicine, including extended hours, and ensuring all Canadians have a regular point of care.

I am a health economist and health policy researcher, and in my work, I regularly analyze how the organization of health-care systems influence health care and health outcomes. In a recently published article, my co-author Ian Allan and I studied the evolution of unmet health-care needs in Canada since the early 2000s. We found a remarkable stability over a period of 14 years of the groups reporting comparatively more unmet health-care needs: women, those in poorer health and those without a regular doctor.

Unmet needs

Unmet health-care needs reflect an inadequacy between the needs perceived by people seeking health care (the patients, or those trying to become someone's patient), and the actual health-care services received, making it a measure of lack of accessibility of care. While they tend to be self-reported, unmet health-care needs are a commonly used and a valid measure, since higher unmet health-care needs in the present predict poorer health in the future. And these unmet health-care needs are poised to grow during the COVID-19 pandemic.

The negative implications of the COVID-19 pandemic for women are wide-ranging, including the fact that industries hit hardest tend to employ more women, or that the lion's share of household responsibilities during and after lockdown still fell on women.

Unfortunately, women in Canada are also more likely than men to report unmet health-care needs. We also found that over time, there has been an increasing share of women reporting unmet needs due to system reasons. Excessive wait times and areas where care is not available are

examples of systemic causes that could be addressed by health policy.

Individuals in poorer health, like those with chronic conditions, face a double-edged sword with COVID-19. On one hand, they are more likely to develop severe forms of COVID-19 if they become infected. This gives them incentive to limit social exposure, including contacts with health-care providers and clinic environments. On the other hand, these individuals are likely to become more seriously ill if their conditions are not properly managed and monitored, which requires contacts with the health-care system.

Again, individuals in poorer health report consistently higher unmet health-care needs than their healthier counterparts, which means they are more at risk of insufficient care during the COVID pandemic.

For those two above subgroups, and for others too, having a regular doctor helps ensure individuals get the health care they need. But Canada does not compare well to other industrialized countries when it comes to timely access to health-care services.

Lack of access to care is often linked to Canada's high level of unattached patients (those with no regular family physician or other primary care providers). About 15 percent of Canadians are in this situation. Even worse, in Québec, the province hardest hit by COVID-19, close to 22 percent have no regular provider of care.

Targeted solutions

Targeting these subgroups should be part of the policy package to address the implications of COVID-19. Ensuring that all Canadians have a regular provider of care shall also stay high on the policy and political agendas, even though it is not absolutely necessary for the primary care provider to be a physician.

Efforts to address this issue, like the creation of a centralized waiting list , have shown mixed effectiveness. During COVID-19, accelerating formal enrolment with a family physician for those on a centralized waiting list in Québec goes in the right direction. But this will work only if patients can attend the clinic.

The use of telemedicine has jumped during the pandemic, and while this may have helped those with chronic conditions, one issue is that there has been variation across provinces in incorporating telemedicine procedures in doctors' billing schedules. In Ontario, the other hard hit province, more complications around the billings may have put some clinics in difficult financial situation and in turn affected access to care. And the telemedicine approach is likely to support women's better access to care only if it is coupled with after-hours and weekend access, due to their typically higher familial responsibilities.

Gaps in data

Overall, the effects of delayed care cannot be underestimated. For example, non-urgent procedures and elective surgeries in Ontario have been postponed for more than two months, with the queue building up as new and postponed patients seek care.

One issue is that in Canada, we do not know exactly how much care has been postponed or foregone. Other countries like France and the United States are able to report this information publicly.

While progress is made on the data front, and more co-ordination across provinces is on the way, what Canada needs is a better health data infrastructure and reporting system, not only for managing the pandemic, but also for ensuring everyone's health-care needs are met.