MAKING IT EASIER TO ASK QUESTIONS ABOUT ABUSE


Background:
Between 21%-55% of women have experienced intimate partner violence (IPV) at some point in their lives. There is strong interest in addressing IPV within the health care system; health care settings provide good opportunities to:
- Make contact with victims of IPV (abuse is linked to health problems as well as frequent health care use);
- Identify IPV through “screening” (i.e. asking patients questions to find out if they’re living with abuse);
- Refer victims to needed health and social services.

Most IPV screening guidelines recommend screening all women (i.e. “routine” screening), rather than only screening those who appear to be at risk. However, several prior reviews of the evidence have concluded that routine screening isn’t a sound approach, because it’s not clear that it reduces IPV rates.

Study focus:
Using a realist approach, we re-evaluated the literature on 17 routine IPV screening programs in health care settings, focusing on how, why, and under what circumstances these programs were effective. We only focused on screening-related outcomes (rather than IPV outcomes in general) because IPV reduction is a complex process - an effective screening program is only the first step.

Findings:
Our results were different from prior reviews. We found that routine IPV screening was very effective, when staff were provided with the right supports.
The most helpful supports built staff confidence:
- Institutional support (e.g. financial investment, high-level awareness and approval);
- Clear and effective protocols that included appropriate questions, and provided clear instructions for what to do when IPV is disclosed;
- Thorough initial and ongoing training for staff;
- Immediate access and referrals to support services for victims (e.g. shelters, legal services).

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CANADIANS ARE RELUCTANT TO SHARE SOCIODEMOGRAPHIC INFORMATION WITH HEALTH CARE PROVIDERS


Background:
Most health care providers in Canada don’t collect sociodemographic information (like income, ethnicity, sexual orientation) from patients. Without this information, it’s difficult for scientists and decision-makers to fully understand and respond to health inequities (i.e. systematic differences in health between groups with different levels of social advantage or disadvantage).

Study focus:
We surveyed 1,005 Canadians to find out:
- If people think it’s important for hospitals to collect patients’ sociodemographic information;
- If they’re concerned about how that information would be used;
- How/with whom they’d prefer to share their information.

Findings:
Nearly half of Canadians didn’t think it was important for hospitals to collect sociodemographic information. Most people said they were:
- Concerned that information would be misused, and that its collection could negatively affect their or others’ care. Visible minorities were the most concerned.
- Most reluctant to give out information on current household income, sexual orientation and educational attainment. Older people were the most concerned.
- More comfortable sharing personal information with their family physician, rather than a hospital.

Implications for health policy and practice:
Stronger action for health equity depends on stronger data - but stronger data will depend on education initiatives to address the public’s concerns, and to increase awareness of how data collection can lead to more equitable outcomes in Canada.

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BEYOND THE HEALTH CARE SYSTEM: “WHOLE-OF-GOVERNMENT” APPROACHES TO IMPROVING POPULATION HEALTH


Background:
Around the world, recognition is growing that improving population health requires action from sectors beyond the health care system. However, there’s little evidence to guide intersectoral action to promote health and health equity.

Report focus:
“Health in All Policies” (HIAP) is a “whole-of-government” strategy for reducing health inequities. We searched the literature and found HIAP processes in 16 countries or regions around the world.

Findings:
There was no single “recipe” for HIAP implementation. However, there were trends - HIAP approaches were always (or almost always):
- Preceded by ad hoc intersectoral health equity initiatives.
- Based on high levels of interaction and interdependence across sectors. Individual sectors had to lose some autonomy; HIAP couldn’t be supported through simple information-sharing or consultation between sectors.
- Supported by health impact assessment tools or similar audits.
- Targeted on the health effects of living conditions (e.g. housing, employment) or (less commonly) on individual health behaviours. Most aimed to increase access to health care services. However, less than a third of HIAP programs took on fundamental interventions like income redistribution.

In addition to our scoping review, we produced a conceptual framework, an electronic resource library and an index of literature on intersectoral action for health in 43 different jurisdictions around the world.

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HIGH HOSPITALIZATION COSTS FOR HOMELESS PATIENTS ARE DUE TO LACK OF APPROPRIATE SERVICES IN THE COMMUNITY

Hwang SW, Weaver J, Aubry T, Hoch JS. Hospital costs and length of stay among homeless patients admitted to medical, surgical, and psychiatric services. Med Care. 2011 Apr;49(4):350-4.

Study focus:
We compared hospitalization costs for homeless and non-homeless adults, using data on 93,426 admissions to St. Michael’s Hospital, Toronto, 2002-2007. This was the first study on this subject to look at more than length of stay - we also compared costs within service categories (i.e. medical, surgical, psychiatric) and considered patient demographic information and severity of illness.

Findings:
The cost of hospitalizing homeless patients was about 20% ($2,559) higher per visit (compared to non-homeless). This was often because homeless patients:
- Stayed in hospital longer. Most patients recovering from surgery or medical services can be discharged to recuperate at home. For homeless patients, staying in hospital is often the only option, in the absence of community-based recuperative services.
- Were more severely ill. Among those receiving psychiatric services, homeless patients didn’t stay longer in hospital, but their illnesses were more serious.

Implications for health policy and practice:
Expanding community-based programs could substantially reduce hospitalization costs for homeless people. For example: Respite care for homeless patients has been shown to reduce hospital stays, and is far less expensive than hospitalization. Community mental health services (e.g. assertive community treatment, intensive case management) have been shown to help homeless people with severe mental illness obtain housing, access needed services and reduce hospital stays.

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