"Oh, so we're not insured?": Exploring the impact of Ontario's Health Insurance Plan on new permanent residents and healthcare providers

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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“Oh, So We’re Not Insured?”: Exploring the Impact of Ontario’s Health Insurance Plan on New Permanent Residents and Health Care Providers

(Thesis format: Monograph)

by

Andrea Bobadilla

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment of the requirements for the degree of Masters of Science

The School of Graduate and Postdoctoral Studies
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Abstract

Annually, Ontario welcomes 100,000 new immigrants, who must go through the government-mandated three-month waiting period before becoming eligible for the Ontario Health Insurance Plan (OHIP). The objective of this qualitative inquiry was to explore the effects of the three-month wait period on new immigrants’ experiences of accessing health services in Ontario. Drawing on data gathered from in-depth field observations and semi-structured interviews with new permanent residents (n=10) and health care providers (n=4), this study examines the lived experience of this complex policy for those seeking health coverage and those struggling to provide it. The findings from this study highlight the socio-economic and cultural tensions experienced by those in the three-month wait period as they navigate care, along with the impact of the structural impediments posed by the policy on the ability of healthcare providers to deliver sound, equitable, and ethical health care to these vulnerable populations.

Keywords

Three-month wait period; immigrant healthcare; access to care; health inequalities; Ontario Health Insurance Plan; service providers
Acknowledgements

I would like to thank my incredibly dedicated supervisor, Dr. Treena Orchard, for her commitment to this project and her belief in the importance of this issue. Thank you for believing in my potential enough to challenge me and help me realize it, your guidance has been truly amazing and the ways in which you have contributed to deepening my understanding of the research process will continue to inform my work for years to come. I would also like to thank my advisory committee for their consistent support and encouragement throughout each step of this process.

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Chapter 1

1 Introduction

1.1 Introduction

Multiculturalism and its principle of the equal celebration of cultural, religious, and racial backgrounds has long been central to Canadian identity, and was adopted as part of our country’s official government policy in the 1970s and 1980s; most memorably through the efforts of former Liberal Prime Minister Pierre Trudeau (Clarkson & Mac Call, 1990). Integral to multiculturalism is immigration, upon which much of Canada has been built and developed as a nation. The chance for equal opportunity in Canada attracts thousands of immigrants every year, approximately 248,660 permanent residents in 2011 (Citizenship and Immigration Canada, 2011). In 2012, Ontario alone welcomed 102,000 new immigrants while immigration levels are expected to rise to approximately 133,000 by 2021 (Ministry of Finance, 2013).

The pathway to immigrating to Canada is established through three routes of entry: permanent residency, temporary residency, and two-step migration (Alboim & Kohl, 2012). Distinct streams of immigration categories give way to entry through these routes, and Citizenship and Immigration Canada (CIC) determines eligibility requirements that applicants must meet to qualify for immigration. Applicants may apply for permanent residency in Canada as economic or family class immigrants or as protected persons (CIC, 2011; Alboim & Kohl, 2012). Temporary residents consist of temporary foreign workers, including live-in caregivers and seasonal agricultural workers, as well as refugee claimants (CIC, 2011; Alboim & Kohl, 2012). Two-step immigration refers to those who apply through the Canadian Experience Class category or as international students and may have the chance to apply for permanent residency after fulfilling certain requirements while in Canada (CIC, 2011; Alboim & Kohl, 2012, 2012).

The kinds of social and health services that are available to new immigrants vary and depend on the program through which they immigrate to Canada and the province to
which they apply. Among the social services offered to assist newcomers with settlement in Ontario, health care coverage under the federally funded Ontario Health Insurance Plan (OHIP) is not one of them, until three months after arrival for new permanent residents. For new permanent residents to Ontario, British Columbia, and Quebec, with the exception of protected persons who are eligible for the Interim Federal Health (IFH) program for refugees, these services do not include access to provincial healthcare coverage until three months after arrival. In 2010, this meant that approximately 99,000 new permanent residents who landed in Ontario alone were not eligible for provincial health insurance coverage under the Ontario Health Insurance Plan (OHIP) and were required to wait three months before they could be covered (CIC, 2011).

In Ontario, the Ministry of Health and Long-Term Care (MOHLTC) administers OHIP and its terms of eligibility as determined by Regulation 552 of Ontario’s Health Insurance Act since 1972 (Right to Health Care Coalition, 2011). Under the Health Insurance Act, subsection 5(1) of the Act outlines, “a person shall only start receiving insured services once the General Manager is satisfied that he or she has been a resident for three full consecutive months, and has not stopped being a resident since meeting that three-month waiting period requirement”. Currently, the only Canadian provinces imposing this three-month wait period are Ontario, British Columbia, and Quebec, while new immigrants to every other province in Canada are eligible for health care coverage upon arrival (Gagnon, 2002; Ontario Medical Association, 2011; Right to Health Care Coalition, 2011). In February 2010, New Brunswick removed the three-month wait period for returning Canadians and immigrants and conceded that the wait period imposes significant barriers to accessing health services (OMA, 2011). In Quebec, recent immigrants are exempt from the three-month waiting period for health services for infectious and communicable diseases and women are provided care for pregnancy, domestic violence, or sexual assault (OMA, 2011; Right to Health Care Coalition, 2011). In Ontario, there are still no exceptions made for any new permanent residents and the onus falls on health care providers to deliver or refuse care on the basis of payment for services.
Previous research has shown that within Ontario, there is a spike in healthcare utilization by immigrants three months following arrival, and this trend seems to be unique to Ontario (DesMeaules et al., 2004). Why new immigrants delay receiving care until four months after arrival requires further research, as well as the potentially negative health consequences of delaying seeking care. The impact of not being eligible for health care for the first three months upon immigration to Ontario and the fiscal possibility of attaining private health insurance from the perspective of new permanent residents has yet to be critically examined. The Ontario Medical Association (OMA) (2011) has also taken a firm stance on the three-month wait period policy, openly stating in press releases that they “have found no evidence to suggest that this delay actually saves the health system any money” (p. 13). The downstream costs of delaying care because of the three-month waiting period have also been cited as an unnecessary increase in expenditures (Access Alliance, 2011; Asanin & Wilson, 2008; Caulford & Vali, 2006; Elgersma, 2008; Right to Health Care Coalition; 2011; Ter Kuile et al., 2007). The present Minister of Health and Long-Term Care, Hon. Deb Matthews, maintains that it saves Ontario’s health care system up to $90 million every year (Barnes, 2011; Crawford, 2009; Keung, 2011). These downstream costs from delays to care have been associated with increased vulnerability to complications, acute episodes, progression of diseases, and increased risk of communicable diseases. The figures compromising this cost-savings estimate are not clear and escalated costs for acute care due to delayed care and access to health services for new permanent residents are also unaccounted for (Barnes, 2011).

The primary aims of this qualitative study are to explore the health-related experiences of new residents caught within the waiting period, along with the perspectives of the healthcare workers who struggle to provide care for these new Canadians within a system that does not always make adequate room for them. The project was designed with the participation of the Scarborough Community Volunteer Clinic (CVC), who provided invaluable assistance in the recruitment of both client and staff participants. In-depth, semi-structured interviews were conducted with ten participants who were in, or previously in, the three-month wait period, and four interviews were carried out with healthcare providers from the Scarborough clinic. The following research questions provided the conceptual framework for this inquiry:
1) What expectations and understandings do new permanent residents have of Ontario's health care system upon arrival, including the three-month wait period?;

2) How does the three-month waiting period impact the lives and health status of new permanent residents?; and

3) In the face of the structural challenges created by the three-month wait period, what kinds of informal resources or strategies do new permanent residents draw upon to cope with their health issues?

1.2 Organization of Thesis

This thesis has six chapters, beginning with the present Introduction and preliminary discussion regarding the Canadian immigration system and the three-month wait period for new residents. The focus and objectives of Chapters Two to Six are provided below, beginning with Chapter Two.

Chapter Two:

The findings from a systematic review, using the Systematic Reviews guidelines set out by the Centre for Reviews and Dissemination at the University of York, of the literature and empirical evidence related to the impact and effects of the three-month wait period are presented. A detailed account of the methods and search strategy used as well as the results from the review are also provided here.

Chapter Three:

This chapter provides an outline of the methodology employed in this study and the research questions that guided this project. I begin with an explanation of my ontological and epistemological positioning within the critical theory paradigm, and how it relates to the narrative approach used in the design of the project. This is followed by a discussion of the theoretical frameworks of social capital and political economy theory, which have been central in shaping the approach I adopted during this research as well as the interpretation of my findings. An overview of the study design is then provided,
including my involvement with the CVC, data collection methods, study sample, and data analysis. Other considerations, such as ensuring quality criteria and ethical concerns, are then described.

**Chapter Four:**

The findings from the ten interviews with those in, or previously in, the three-month wait period are presented here. The findings and main themes are organized in sections that follow the sequential order of the immigration process: pre-migration planning, landing in Canada, and the impacts of the policy. The pre-migration subsection includes a discussion of the participants’ awareness of the three-month wait period, the unpredictability of the immigration process, private health insurance, and preparing for the three-month wait period. Themes related to the effects of the policy upon arrival in Canada consist of navigating and accessing health services at different points of care, mainly community health centres, midwifery services, walk-in clinics, and the CVC, as well as applying for OHIP. The findings related to impacts of the policy are those of out-of-pocket costs and stress.

**Chapter Five:**

The findings presented in this chapter are drawn from the four interviews conducted with healthcare providers from the CVC. The main themes featured are organized into three sections: advocacy, community collaboration, and political response. The advocacy section discusses the ethical responsibilities healthcare providers have to negotiate when providing care to those in the three-month wait, along with the ways in which they described advocacy as being crucial to the coordination of care for these clients. Next, the theme of community collaboration is presented in two subsections that deal with the importance of forming partnerships between health and social service providers, as well as the issues of inter-professional tension that can arise between providers within and across various points of care. The third theme explores providers’ perspectives on the provincial (MOHLTC) and national (CIC) responses regarding the many systemic and health-related complications arising from the wait period, including the highly politicized
discourse employed by the various levels of governments in their justification regarding recent reforms of the policy.

Chapter Six:

This discussion chapter begins with a discussion of the most salient findings from the study, organized according to the two different participant groups. The similarities between this study’s findings and those in the current literature are then discussed, and the unique data that emerged from the present study are also highlighted. A brief discussion of the limitations of this research is also provided. Drawing upon the project findings, recommendations related to policy and/or service development, along with areas for future research, are presented. The chapter concludes with a discussion of the implications of the findings and their significance relative to understanding experiences of immigration and health among new permanent residents.
Chapter 2

2 A Systematic Review of the Literature and Empirical Evidence on the Impact and Effects of the Three-Month Wait Period for New Permanent Residents to Ontario

2.1 Introduction

This chapter features the findings of a systematic review using the Systematic Reviews guidelines set out by the Centre for Reviews and Dissemination at the University of York (Centre for Reviews and Dissemination, University of York, 2008). I begin with a discussion of the aims and objectives of the review. The Search Mechanism section provides an overview of the search strategy and methodology used, including the search terms, databases, inclusion and exclusion criteria, and selection process. The results of the review and types of materials included are then described. The deductive literature review findings are then presented, followed by an analysis of the inductive themes that emerged from the review.

2.2 Aims and Objectives

This review critically analyzes information on the three-month wait period for eligibility for OHIP for new permanent residents to Ontario across various stakeholders.

The objectives of the review were to:

- assess the health impact of the three-month wait period on new permanent residents
- assess the public health impact of the three-month wait period
- identify benefits of maintaining the three-month wait policy
- determine the rationale for the implementation and maintenance of the three-month wait period

2.3 Search Mechanism

Following the Systematic Reviews guidelines set out by the Centre for Reviews and Dissemination at the University of York (Centre for Reviews and Dissemination, University of York, 2008), a range of methods were used to locate literature. Several
electronic databases were searched as a first step in the review with guiding inclusion/exclusion criteria.

Key search terms used to search electronic databases included, ‘OHIP’ and “OHIP AND ‘three-month wait’” and “OHIP AND eligibility” and “OHIP AND ‘immigrant’” and ‘access to health services’ and “‘health insurance plan’ AND Ontario”.

After consultation with Western University Library staff, search engines and databases were determined. Searches were conducted with the following electronic databases:

- Canadian Public Policy Collection
- Canadian Health Research Collection
- Canadian Research Index/Microlog
- LEGISinfo
- Dissertations and Theses
- Index to Legal Periodicals and Books Full Text
- LexisNexis Academic

An iterative approach was used over the course of the search to determine key terms, inclusion criteria, and exclusion criteria as queries located literature more focused on issues only related to the policy. The following inclusion and exclusion criteria were used when conducting the review:

**Table 1: Systematic Review Inclusion Criteria**

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settings</td>
<td>Private and public sector (Ontario)</td>
</tr>
<tr>
<td>Language</td>
<td>English</td>
</tr>
<tr>
<td>Publication type</td>
<td>Published and unpublished including ‘grey’ literature</td>
</tr>
<tr>
<td>Originality</td>
<td>Primary, secondary data</td>
</tr>
<tr>
<td>Immigration category</td>
<td>New permanent residents</td>
</tr>
</tbody>
</table>
Table 2: Systematic Review Exclusion Criteria

<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settings Other</td>
<td>Provinces, territories outside Ontario</td>
</tr>
<tr>
<td>Language Other</td>
<td>Languages other than English</td>
</tr>
<tr>
<td>Immigration category*</td>
<td>Temporary residents, undocumented migrants, military families</td>
</tr>
</tbody>
</table>

*Immigration category exclusion contents were selected to only include categories of new permanent residents that the policy is applicable to.*

In addition, search engines created and accessed through Western University Library were used, including Canadian Think Tanks and OurOntario Government Documents Collection. Using the same search terms, a wide Google and Google Scholar search was conducted as well for published and unpublished grey literature. A snowballing technique was also used for secondary references by reviewing references cited in articles. All references were recorded in RefWorks to identify duplicates.
2.4 Results

204 articles were found as meeting the inclusion criteria. Four articles were then eliminated as duplicates. 141 articles had no new permanent resident content and were removed. The focus of these articles was mainly on temporary migrants, undocumented migrants, military families or eligible claims made to OHIP. From the 61 articles remaining, 5 were excluded because the content referred to health insurance plans outside of Ontario. After screening the abstracts, 11 articles did not have to do with the three-month wait period, leaving 50 articles to compose the review (Figure 1) (see Appendix A for full Literature Review By Type of Output).
2.5 Overview of the Literature

2.5.1 Descriptive Analysis

Relevant literature came as early as 1994 continuing to 2013. One outlying relevant national legislation was enacted in 1985 and was not included in Figure 1.2 below. Only 6% of the literature was written between 1994-1997 with no articles identified before that period, while 58% was written from 2010 to the present.

Figure 2: Number of publications by year of literature

Of the 50 documents identified for inclusion, eight (16%) were empirical studies all using qualitative research methods. Qualitative data collection methods mainly consisted of interviews and focus groups with health care providers and a mix of recent immigrants across categories including, but not restricted to, those within the three-month wait period. One article from the Library of Parliament did not specify methods used to provide a legal analysis of entitlement to health services according to immigration status.

Figure 2: Number of publications by year of literature
Nine articles were identified as ‘Guidance’ material from the MOHLTC, Legislative Assembly of Ontario, and the Minister of Justice. Seventeen news releases were collected for the review and the remaining 19 articles were opinion pieces.

Each literature group is detailed in Appendix 1:

Group 1 – Empirical findings (n=8)
Group 2 – Guidance material (n=9)
Group 3 – New releases (n=14)
Group 4 – Opinion pieces (n=19)

2.6 Literature Review Findings

2.6.1 Introduction

The review of literature was conducted in two stages; beginning with a set of a priori questions to guide the first stage of deductive analysis, followed by an inductive approach to develop post hoc questions. These “a priori” questions consisted of several broad and general questions that were considered before reviewing the literature, whereas the “post hoc” questions were identified after an analysis of the literature. These a priori and post hoc questions framed the deductive and inductive approaches, respectively, used to review the literature through the two stages of analysis. The initial deductive analysis included identifying the broad and general themes found in the literature. The review then moved to addressing the post hoc questions developed from an analysis of these key themes using an inductive approach. These post hoc questions drew from the key themes first identified during the first stage of analysis, which were organized into the following themes:

- Health impacts
- Economic factors
- Legal issues
- Equity and human rights issues
• Stakeholder views

These themes will be addressed in the following sections, thus establishing a framework of analysis of the key themes identified. Afterwards, further questions developed through an inductive approach will be discussed.

2.6.2 Health Impacts

The a priori questions considered:

• Health benefits for maintaining the policy

• Adverse health outcomes

• Public health consequences

Have any benefits for maintaining the policy been identified?

The MOHLTC has not offered any medical reasons for maintaining the three-month wait period, while the OMA (p. 17, 2011) has formally stated that, “There are no medical reasons to support keeping this three-month wait, and many medical reasons to support its removal”. Introduced as a cost-saving measure in 1994 (Legislative Assembly of Ontario, 1994), no health benefits for Ontario residents or new permanent residents have been identified by any other stakeholder. In the absence of any recent formal and detailed health or medical rationale for maintaining the policy from the MOHLTC, only cost-containment goals have been determined from the past statements made by the MOHLTC regarding budgetary costs and preventing abuses of Ontario’s healthcare system by medical tourists (Sansom, 1997). There is also no evidence to suggest that the three-month wait period protects the health of other Ontario residents in any preventative manner.

Are there any adverse health outcomes created by the three-month wait period?

In the OMA’s (2011) analysis of the three-month wait period, they found that, “people without health insurance tend to go to hospital emergency departments for care, and sometimes they wait longer than advisable to seek medical treatment.” (p. 13). When
seeking private insurance, new permanent residents have been cited in several studies to be denied approval because of age exclusions and/or pre-existing conditions, such as chronic diseases and pregnancy (Elgersma, 2008). Between a lack of affordability for private health insurance or difficulty getting approval for a comprehensive private health insurance plan, new permanent residents within the three-month wait period have often been found to delay seeking care (Gardner, 2011; OMA, 2011). Some new permanent residents have also attempted to minimize their family’s activity outside the home to prevent chances of illness or injury (Barnes, 2012). Numerous health care providers have noted the problematic nature of new permanent residents delaying seeking care because of challenges that arise with acute episodes from progressed diseases, unmanaged chronic illnesses, and even death (Elgersma, 2008). The delay to care also presents difficulties with preventable trips to the emergency department, which compounds costs for Ontario’s healthcare system (OMA, 2011). In the Registered Nurses Association of Ontario’s (RNAO) (2011) statement regarding the three-month wait period, they stressed the benefit of providing early access to health services and preventative care for improved health outcomes. The Right to Health Care Coalition (2011) also remarked the dividends of improved health outcomes that would result from the elimination of the three-month wait period.

Women, children, and the elderly have been highlighted as particularly vulnerable during the three-month wait period (Association of Ontario Midwives; Gardner, 2011; Steele et al., 2002). Lack of prenatal care during pregnancy has also been highlighted as a major issue (Gray, Hynie, Gardner & Robertson, 2010). Anecdotal evidence from the Toronto Star in 2009 told the story of a mother within the three-month wait period who was unable to get approved for private health insurance coverage after applying several times because her pregnancy was considered a pre-existing condition. She then refused to get prenatal care from fear of accumulating too much debt and as a consequence, she fainted and was taken to the emergency department where she was asked for $250 for care up front and $1100 for a deposit for the delivery of her baby. An emergency C-section was performed because the doctors could not find the baby’s heartbeat. The mother continued to worry about costs after delivery when the baby’s health card was issued immediately and seventeen days later, the parents’ health cards were issued as
well. Future research should be cognoscente of men’s realities and the significant stresses they may also experience as they can also assume the role of caregivers.

The three-month wait period was seen as exacerbating stress, illness, and existing barriers to care for new permanent residents to Ontario (Association of Ontario Midwives; Steele et al., 2002). Allowing children to receive vaccinations for school registration has also been noted as another benefit of removing the three-month wait period (Right to Healthcare Coalition, 2011). Without OHIP or private health insurance coverage, the only access point for care left for new permanent residents, without incurring significant costs, are community health centres (CHCs) or two volunteer clinics open in Ontario, including the Scarborough Community Volunteer Clinic (CVC) for the medically uninsured, and the recently opened West End Non-Insured Walk-In Clinic (NIWIC), both located in Toronto. New permanent residents in the three-month wait period were found to make up one-third of clients at the Scarborough CVC (Caulford & Vali, 2006; Ontario Health Quality Council, 2007). The primary care delivered at the CHCs and volunteer clinics have been cited as sometimes being insufficient in meeting the needs of the populations they serve because of the need for diagnostic tests and other specialized treatments (Gardner, 2009). The most common health issues presented by those in the three-month wait period, as reported by health care providers, are mental health issues and pregnancy, as well as higher rates of newborn complications, disease and infection, and serious triage assessments (Barnes, 2012; Gray et al., 2010). When dealing with these cases, doctors also discussed having to create alternative care plans because they were aware that the patient would not have access to follow-up appointments, tests, or pharmaceutical medications (Barnes, 2012).

What public health consequences does the policy create?

A parliamentary report by Elgersma (2008) as well as the Toronto Board of Health (McKeown, 2011), Ottawa Board of Health (Taylor, 2012), and the RNAO (2011) have all found that the delay to care, due to the three-month wait period and limitations of private health insurance plans available to new permanent residents, also poses several public health concerns (Elgersma, 2008; McKeown, 2011; RNAO, 2011). The primary
example used to demonstrate the concerns posed by the three-month wait period to Ontario’s public health is the case of tuberculosis (TB) (RNAO, 2011; Ogilvie, 2011; Taylor, 2012; McKeown, 2011). As Dr. McKeown, Medical Officer of Health for Toronto Public Health (TPH), outlines in his report to The Toronto Board of health, the three-month wait period should eliminated to protect public health and prevent the spread of communicable diseases, such as TB.

It is estimated that approximately 1300 new permanent residents are referred to TPH’s TB-UP program for follow-up (McKeown, 2011). These new permanent residents have all passed the Immigration Medical Exam (IME), which screens for TB, in their country of origin before arriving in Canada, but showed scarring in their chest x-rays and were recommended for follow-up. When going to TPH for their follow-up, new permanent residents who show no symptoms are often recommended to delay the full medical examination until they have OHIP because of the high costs of the diagnostic tests (McKeown, 2011). As TB progresses, however, the disease advances and becomes increasingly infectious (McKeown, 2011). The delay to diagnosis poses a significant threat to public health because the infection can spread through the air (McKeown, 2011). Toronto, alone, has approximately 300 cases of TB reported each year, but Ontario and British Columbia are the only provinces that do not provide any coverage for newcomers with communicable diseases (Ogilvie, 2011). As a communicable disease and public health concern, it is also illegal to refuse treatment for TB, which further complicates the situation newcomers are faced with (McKeown, 2011). Timely treatments and diagnoses are considered imperative to controlling the spread of the disease (McKeown, 2011), although the OMA, RNAO, Toronto Board of Health and Ottawa Board of health contest that the three-month wait period is a major barrier to achieving this. Ethical considerations also arise as those who are referred to TB-UP and show no symptoms are advised to delay getting a full medical assessment, while TB becomes increasingly infectious as the disease progresses.

2.6.3 Economic Factors

The a priori questions centred on:

- Cost savings to Ontario’s health care system
• Resources available to new permanent residents

*Does the three-month wait period produce cost savings to Ontario’s health care system?*

Former Minister of Health Hon. Ruth Grier introduced the three-month wait period on April 1, 1994. In her presentation of the change in policy on March 31, 1994 to the Legislative Assembly of Ontario, she explained that the three-month wait period was, “expected to save Ontarians about $418 million annually by preventing people from coming to Ontario for the sole purpose of receiving health care, then leaving again” (p. 36). The current Minister of Health and Long-Term Care Hon. Deb Matthews has also been cited as estimating the cost-savings of the three-month wait period at $90 million each year (Barnes, 2012). The estimates, however, have received much criticism because of the lack of transparency regarding the figures used to calculate the cost-savings estimates (Barnes, 2012).

Other cost-analyses of the three-month wait period have argued that the policy actually costs the Ontario healthcare system more in the long-term (Right to Healthcare Coalition, 2007; Right to Healthcare Coalition, 2011; OMA, 2011). In the Right to Healthcare Coalition’s (2007) “Backgrounder for community members and policy makers advocating an end to the OHIP 3-month wait period for recent landed immigrants in Ontario”, they suggest that the cost of delaying care for new permanent residents is $81 million per year. This would be the cost of hospital-based care provided to immigrants following the three months, as opposed to offering less expensive preventative care upon arrival. The Right to Healthcare Coalition (2011) also addresses the costs of canceling the policy in their “Business Case for Eliminating the Three-Month Wait Period”. They state that the elimination of the three-month wait period would cost $60 million per year or 0.1% of the entire provincial budget for health care and 0.05% of the province’s total budget. This investment is supported with arguments maintaining that this cost to Ontario would pay dividends in attracting and keeping new permanent residents in Ontario as well as improving health outcomes for new permanent residents by not delaying care (Right to Healthcare Coalition, 2011). It has also been suggested that
the three-month wait period also hinders new permanent residents’ ability to fully contribute their skills, which have been sought after by the government, and fully participate in Ontario’s labour market.

The OMA has maintained the same stance as the Right to Healthcare Coalition and also debates that the three-month wait period actually costs the Ontario healthcare system more money by delaying care for new permanent residents (OMA, 2011). The OMA (2011) explicitly stated they have found “no evidence to suggest that this delay actually saves the health system any money” (p.13). By denying preventative healthcare to new permanent residents, the OMA (2011) argues that care is being sought at inappropriate delivery points, particularly in the emergency department, and also fails to prevent the spread of infectious diseases. Waiting until an acute episode often forces new permanent residents to seek care at emergency departments with progressed illnesses, thereby compounding costs for Ontario’s health care system (OMA, 2011). The long-term costs of the three-month wait period, from these reports, are debatably more than the short-term costs cited by the MOHLTC.

*Are there adequate resources currently available to new permanent residents to access during the three-month wait period?*

Before arriving to Ontario, new permanent residents are advised to purchase private health insurance for the duration of the three-month wait period (MOHLTC, 2012). Several challenges with acquiring private health insurance have been cited by new permanent residents, including affordability, comprehensiveness, and eligibility. During initial settlement, some new permanent residents had enough savings to purchase private insurance or pay for services out-of-pocket, while others delayed seeking care (Assanin, 2007). Elgersma’s (2008) parliamentary report also discussed the limitations of private insurance, such as inconsistent public services, administrative delays, and difficulties for healthcare providers to differentiate different categories of immigration categories. For those who could afford private insurance, many still did not qualify for coverage because of age exclusions and pre-existing illnesses, including pregnancy (Toronto Public Health and Access Alliance Multicultural Health and Community Services, 2011). Tuberculosis
is also considered a pre-existing disease due to the dormant nature of the illness, however, unlike other medical conditions, such as a broken arm, it is illegal to refuse care because of the threat TB poses to public health (McKeown, 2011). Again, this has been found to further compromise the situation of new permanent residents by forcing them to pay out-of-pocket costs and incur large debts (Goel, 2013; Toronto Public Health and Access Alliance Multicultural Health and Community Services, 2011). Being denied eligibility for private health insurance as well as OHIP was a significant barrier to accessing care for new permanent residents causing substantial stress during initial settlement, as most decided to delay seeking care or incurred considerable out-of-pocket costs (Gray et al., 2010).

The Toronto Board of Health and RNAO have expressed their support for new permanent residents to be eligible for OHIP immediately upon arrival arguing that the MOHLTC’s claims of medical tourists being admitted through new permanent resident immigration categories is unfounded; especially given the money, time, and stresses of the immigration process. All immigration applicants must pass the IME before being admitted to Canada and this serves to ensure that new permanent residents will not strain the health care system (RNAO, 2011). By meeting all of these requirements and undergoing the entire immigration process, which can take several years, the RNAO (2011) and Right to Healthcare Coalition (2011) both assert that it is both unlikely and inefficient for a new permanent resident to pursue immigrating to Canada to take advantage of Ontario’s healthcare system. By fulfilling all of the requirements stipulated by the CIC immigration application process, various stakeholders support and acknowledge the dedication and contributions new permanent residents make to Ontario upon arrival, thus supporting their entitlement to health services immediately. In British Columbia and Quebec, where the three-month wait period is also stipulated, the issue of medical tourism has not been openly provided as a rationale for the maintenance of the policy nor has it been supported with recent evidence.
2.6.4 Legal Issues

The a priori questions surrounded relevant legislation and legal precedents established through previous Court rulings:

- Requirements of provincial health plans under the *Canada Health Act (CHA)*
- Court precedents

*Does Ontario’s Health Insurance Plan meet the requirements set out by the Canada Health Act to qualify for the federal cash contribution?*

The *Canada Health Act (CHA)*, as a piece of federal legislation and not a guarantee of rights, sets the five criteria of universality, public administration, comprehensiveness, portability, and accessibility for every province and territory to fulfill to qualify for the federal cash contribution. The *CHA* defines “insured person” as: “a resident of the province other than…(d) a resident of province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services” (p.4). Under this definition, Ontario, British Columbia, and Quebec are the only provinces in Canada that continue to implement the three-month wait period before eligibility is established for provincial health insurance plans (Elgersma, 2008). The physical presence requirement in the *Health Insurance Act of Ontario* is outlined in subsection 5(1), “a person shall only start receiving insured services once the General Manager is satisfied that he or she has been a resident for three full consecutive months, and has not stopped being a resident since meeting that three-month waiting period requirement”.

During this time, new permanent residents to Ontario are advised by the CIC and MOHLTC to purchase private health insurance coverage, however as discussed earlier in the report, inconsistencies and a lack of comprehensiveness have prevented many new permanent residents from qualifying for private health insurance plans due to age exclusions and pre-existing conditions. A particularly problematic public health concern outlined by the Toronto Board of Health is TB because it is legally impermissible to refuse treatment, although private health insurance companies consider TB a pre-existing
condition due to its dormant nature (McKeown, 2011). The lack of options available to new permanent residents in such a case forces them to incur significant debt over diagnostic tests and potentially hospitalization. In Elgersma’s 2008 parliamentary report, it was recommended that the federal government assert more of a role in “enforcing and strengthening requirements for private health insurance” (p. 10) because of their role in admissions of immigrants. However, considering the current economic and political climate, the federal government continues to decrease their role in healthcare delivery in Canada (Elgersma, 2008).

**What have past rulings been regarding the legality of the three-month wait period?**

New permanent residents are guaranteed all rights under the Canadian *Charter of Human Rights and Freedoms*. Past cases have argued that the three-month wait period discriminates against new permanent residents and infringes on their rights for equality under section 15 of the Charter. In *Irshad (Litigation Guardian of) v. Ontario (Minister of Health)*, the Ontario Court of Appeal ruled, “this limit on OHIP eligibility was reasonable and did not infringe on the rights to equality of any particular group” (Canadian Civil Liberties Association, p. 20, 2010). The Court also reviewed that under section 6 of the Charter, some residency requirements are acceptable to qualify individuals for entitlement to some services, if found reasonable. Importantly, the Court also found that one’s permanent or non-permanent residency status is not analogous ground to be protected under section 15 because it is not unchangeable. However, this decision is contrary to the findings from the Court’s ruling in *Andrews v. Law Society of British Columbia* where permanent residents who were not citizens were considered a “discrete and insular minority” to be within protection of s. 15 (Canadian Civil Liberties Association, 2010; Sansom, 1997).

In Sansom’s (1997) legal analysis of the changes introduced by the Minister of Health in 1994, it is argued that the new policies discriminate against refugees and new permanent residents and it can not be justified under subsection 1 or 15(1) of the Charter through the *R. v. Oakes* test of proportionality. From the explanation provided by Health Minister Ruth Grier to the Legislative Assembly of Ontario on March 31, 1994, the three-
month wait period serves the purposes of “(1) fulfilling a budget promise; (2) controlling costs; (3) preserving free health care in Ontario; (4) preserving free health care for those who intend to live in Ontario permanently” (p. 217). In determining a “sufficiently important objective” to justify the changes under section 1 of the Charter, Sansom (1997) explains that immigration is a federal power, so deterring non-citizens from taking advantage of Ontario’s healthcare system could not be the subject of inquiry of the province. After a review of Canadian precedents regarding justifying cost-savings to violate Charter rights, it is argued that fulfilling a budget promise and controlling costs is also not sufficiently important to justify denying a group of people a constitutional right (Sansom, 1997). Maintaining a high standard and quality of care for Ontario could be a sufficiently important objective, but budget costs alone could not be justified.

When putting the three-month wait period through the proportionality test, several deleterious effects were found, while the only salutary effect that could be gleaned was containing healthcare costs and thereby “fulfilling an electoral promise” (Sansom, 1997). With only this found by Sansom (1997), the Ontario government would fail the minimal impairment test by reducing health care costs at the expense of discriminating against entire immigration categories.

Deleterious effects of the policy changes on new permanent residents include discouraging new permanent residents from engaging with the healthcare system and perpetuating prejudice (Sansom, 1997). After being denied OHIP eligibility, and possibly private health insurance, new permanent residents face having to pay for care out-of-pocket or foregoing care. When seeking care without health insurance, new permanent residents have reported feeling discriminated against and even being denied care in different health care settings (Gardner, 2009). The most damaging effect of the three-month wait period may be the “perpetuation of alienation and disadvantage that stems from the Ontario government’s validation of discriminatory distinction” (Sansom, p. 225, 1997). The distinction the MOHLTC makes with new permanent residents further marginalizes an already vulnerable population. Sansom (1997) goes on to argue that “The psychological effects of being treated differently, and of virtually being accused by the Minister of Health of having come to Canada to defraud Ontario’s health care system, are
deleterious effects to be considered in s. 1” (p. 226). With these considerations of both salutary and deleterious effects, it is concluded that the new policies fail to pass the proportionality test.

2.6.5 Equity and Human Rights Issues

- Structural discrimination
- Discrimination experienced when attempting to access care

**Do new permanent residents experience structural discrimination as a result of the three-month wait period policy?**

Some (Elgersma, 2008; Caulford and Vali, 2006; Right to Healthcare Coalition, 2011, Gardner, 2011) have advocated for the protection of new permanent residents’ right to equality and access to health services with OHIP coverage. On December 7, 2011, New Democratic Party (NDP) Member of Provincial Parliament (MPP) France Gelinas presented a petition of 3000 postcards calling for the end to the three-month wait period. She argued that all new permanent residents have a right to access health care under OHIP because of the principle of equality outlined in the Ontario Human Rights Code (Legislative Assembly of Ontario, 2011). It was also emphasized that not only should new permanent residents be entitled to these services, but it is also their right that needs to be protected.

The contributions and dedication new permanent residents commit to Canada upon arrival have also led many to argue that OHIP and access to healthcare are rightfully deserved (RNAO, 2011; Gardner, 2009; Barnes, 2012). By paying for provincial sales taxes, not providing new permanent residents services which they pay into has been called unfair and a matter of “basic human equity” (Elgersma, 2008; Right to Healthcare Coalition, 2011). The RNAO (2011) has also formally stated that they recognize new permanent residents “have met all the Canadian immigration requirements, made a commitment to Canada, and are starting a new life here. They are not medical tourists, nor visitors, nor temporary students – they are already us” (p. 2). The systematic denial of health services from new permanent residents created by the
three-month wait period is yet to be sufficiently justified by the MOHLTC with respect to evidence of their claims for preventing medical tourism.

**Do new permanent residents experience discrimination when attempting to access care?**

In the Ontario Health Quality Council’s 2007 report, “Q Monitor: 2007 Report on Ontario’s health system” the province’s health care system’s level of equity was evaluated and the three-month wait period was considered an additional barrier to care for recent immigrants. It is interesting to note that the three-month wait period was reported as an additional barrier faced by new permanent residents, which suggests they already face existing challenges with navigating through the health care system. This demonstrates the vulnerable position new permanent residents are in during their first months of settlement. From this, the three-month wait period can be seen as exacerbating stress for an already disadvantaged population. When seeking care during the three-month wait period, new permanent residents have discussed being discriminated against and denied care without OHIP (Barnes, 2012) or receiving inconsistent services with administrative delays with private health insurance, if they qualified (Elgersma, 2008). Other general barriers described by new permanent residents that prevented them from seeking care was fear of being deported or lack of knowledge of what services or points of care was available to them during the three-month wait period (Gray et al., 2010). The barriers and discrimination produced and endured by new permanent residents left some to describe their experience during the three-month wait period as feeling ignored by the Canadian health care system (Central East Local Health Integration Network, 2010).

2.6.6 **Stakeholder Views**

- Views expressed by healthcare and social service providers
- Political responses
**How does the three-month wait period affect healthcare providers’ ability to offer a high standard of quality care?**

Healthcare providers seem to be in consensus with the elimination of the three-month wait period (Barnes, 2011). The OMA, RNAO, Association of Ontario Midwives (AOM), Toronto Board of Health and Ottawa Board of Health have all made formal statements advocating for the end of the three-month wait period. The threat the three-month wait period has on frontline healthcare services has also been highlighted by MPP Peter Tabuns to the Minister of Finance during a meeting of the Legislative Assembly of Ontario on February 25, 2010. MPP Tabuns included the elimination of the three-month wait period as part of a set of recommendations he endorsed as “upstream investments” towards protecting frontline services, although the Minister of Finance explained that it was out of their scope of power to control (Legislative Assembly of Ontario, 2010).

During interviews with key informants who were members of the Women’s College Health Network on Uninsured Clients, the healthcare providers remarked that the main points of care accessed by their uninsured clients were CHCs, hospitals, private physicians, Toronto Public Health, and walk-in clinics (Gray et al., 2010). Twenty out of twenty-four members interviewed for the study by Gray et al. (2010) recommended the immediate elimination of the three-month wait period.

In another study by Steele et al. (2002), which also consisted of interviews with healthcare providers, staff at CHCs described feeling extreme pressures to serve such a growing population of uninsured clients, and the stress was also compounded by cuts in resources. The service providers commented on having to compromise time for counseling, preventative care, case-management, and patient advocacy to provide immediate primary care for these clients (Steele et al., 2010). The demands of this environment and these significant stressors were also described as leading to staff burnout at the CHCs (Steele et al., 2010).

Established in 2000, the Scarborough Volunteer Clinic for the Medically Uninsured is another point of access for care for those within the three-month wait period. Since its establishment thirteen years ago, there has been no change with the
three-month wait period, despite their joint lobbying efforts with the Right to Healthcare Coalition. The volunteer healthcare providers at the clinic have reported seeing an increase in the number of clients they serve and it has been estimated that approximately 50,000 new permanent residents are subject to the three-month wait period each year (Sylvain, 2005). The West End Non-Insured Walk-In Clinic (NIWIC) has also recently opened in the past year to serve this growing population. The nature of the volunteer clinics, however, has both been remarked as an unsustainable form of healthcare provision for those within the three-month wait period and changes to the policy are considered necessary for a long-term solution (Caulford & Vali, 2006).

**What has the political response been to the debate on the three-month wait period?**

During an interview with the *Toronto Star*, Dr. Paul Caulford, Chief of Family Medicine at Scarborough Hospital and director and founder of the Scarborough Volunteer Clinic for the Medically Uninsured, commented that at the policy level, changes regarding the three-month wait period come down to “a lack of political will” (Javed, 2011). He explains that despite efforts to quantify the issue in terms of cost-savings to the healthcare system or the size of the population affected, the true impediment to amending the policy is the lack of political support. In the same article, Health Minister Deb Matthews comments that they are not currently looking into changing the policy right now and that new permanent residents are aware they need to purchase private health insurance for the interim period (Javed, 2011).

Before the last 2011 fall election, the AOM discussed several health issues with representatives from different parties to determine their stance on each topic. When asked about the three-month wait period, the Liberals commented that they are currently in the process of doubling the number of CHCs in Ontario, which would serve the population affected by the three-month wait period, but they would review the policy (Association of Ontario Midwives, 2011). The New Democratic Party (NDP) responded by explaining their commitment to work with stakeholders and policy makers to eliminate the policy (Association of Ontario Midwives, 2011). The Green Party stated that the policy needs to be reviewed and investigated because new permanent residents are subject to the same
taxation as other residents of Ontario who are entitled to OHIP (Association of Ontario Midwives, 2011). The Conservative party did not provide any responses or comments on the issue.

2.6.7 Inductive Themes

Following the analysis of the a priori questions posed by the researcher, several other themes emerged from the review of the literature:

- History of Ontario health insurance schemes
- Established policies in other jurisdictions
- Ethical obligations of health care providers
- Information given to new permanent residents prior to arrival
- Partnerships established between stakeholders
- Public opinion

History of Ontario health insurance schemes

In the 2011 Right to Healthcare Coalition’s business case for “Eliminating the Three-Month Wait for OHIP”, the history of the policy is traced back to the first public health insurance scheme established in Ontario in 1959 under the Ontario Hospital Services Commission (Right to Healthcare Coalition, 2011). This plan provided health insurance coverage for hospital services in Ontario, until the Ontario Medical Services Insurance Plan (OMSIP) was introduced in 1966 (Right to Healthcare Coalition, 2011). The OMSIP provided health insurance coverage for those who did not have access to employee-sponsored private medical insurance. By 1969, all 35 private health insurance providers were put under standardized regulations under the Ontario Health Services Insurance Plan (Right to Healthcare Coalition, 2011). They were warned that this would be for a limited time until their involvement would be significantly reduced. The Ontario Health Insurance Plan (OHIP) was then introduced in 1972 and it would cover medical and hospital services through cost-sharing efforts with the federal government (Right to Healthcare Coalition, 2011). To qualify for the federal cash contribution, the Health
Insurance Act of Ontario would have to ensure and protect the five criteria of the Canada Health Act (CHA), which were previously discussed.

Due to changes made by the Ministry of Health on April 1, 1994, the definition of “resident” in section 1 of the Health Insurance Act of Ontario was changed from:

“A person who is legally entitled to remain in Canada and who makes his or her home and is ordinarily present in Ontario, but does not include a tourist, a transient or visitor to Ontario, and the verb has a corresponding meaning”

To the newly interpreted meaning under section 1.2 (b):

“In the case of a person applying to be an insured person for the first time or who is re-establishing his or her entitlement…the person, i) intended to make his or her permanent and principle home in Ontario and ii) is present in Ontario for A) at least 183 days in the twelve-month period immediately following the application, and B) at least 153 of the 183 days immediately following the application” (Sansom, p. 206, 1997).

The time period of three months had been included in most provincial private insurance plans since 1959, and then re-introduced in 1994 under the above changes to the definition of “resident”, which changed entitlement to health services for new permanent residents.

Established policies in other jurisdictions

As previously noted, Ontario, along with British Columbia and Quebec, are the only provinces in Canada that exercise the three-month wait period for new permanent residents and residents of each province that have left the country for more than seven consecutive months in a year (Right to Healthcare Coalition, 2011). Two of three Canadian territories, Yukon and Nunavut, also have a three-month wait period for new permanent residents. At the time the three-month wait period for OHIP eligibility was introduced in 1994, Health Minister Ruth Grier mentioned that the policy would follow the British Columbia and New Brunswick frameworks (Legislative Assembly of Ontario,
In February 2010, however, New Brunswick removed the three-month wait period for returning immigrants and residents to the province (OMA, 2011). New Brunswick’s Health Minister Mary Schryer stated, “Removing the three-month waiting period is the right thing to do…Our government recognizes that removing this barrier will enhance access to healthcare services for immigrants and citizens who return home” (OMA, p. 17, 2011). Despite these changes, the OMA has still criticized the New Brunswick government for not going far enough in eliminating the three-month wait period and failing to fully remove the wait period for all new permanent residents to the province (OMA, 2011).

In Quebec, exceptions are made to their three-month policy for cases of communicable diseases, pregnancy, or domestic violence (Goel, 2010). The Medical Reform Group (MRG) (2010) has supported the OMA’s position on the policy and recommended that the government of Ontario follow the exemptions made in Quebec as a first step in eliminating the three-month wait period entirely. However, others from the Right to Healthcare Coalition have pointed out that the MOHLC led by Health Minister Deb Matthews have not indicated amending the policy at all, nor have they suggested or conceded to adding the exemptions for communicable diseases, pregnancy, or domestic violence, as is the policy in Quebec. Full removal of the three-month wait policy remains the primary goal of major stakeholders in Ontario.

**Ethical obligations of health care providers**

Healthcare providers in hospitals and CHCs cannot legally deny urgent care to patients, however private physicians do not have a legal obligation to provide services to clients (Sansom, 1997). The duty to provide emergency care is outlined in section 18 of the Canadian Medical Association (CMA) Code of Ethics, as well as in section 21 of the *Ontario Public Hospitals Act*. The discriminatory treatment reported by new permanent residents seeking care at hospitals may be the result of the differential requirements of healthcare providers to serve patients with urgent versus non-urgent care, as discussed by health ethicist Sally Bean during the 2011 Seeking Solutions Symposium (Seeking Solutions Symposium Final Report, 2013). She clarified that urgent care is an obligation
healthcare professionals must provide, whereas non-urgent care can be subjectively provided without violating any ethical regulations. Urgent care is seen as immediately life-threatening illness, whereas non-urgent care would be considered acute illness (Bean, 2011). The inconsistencies of services provided, with or without private health insurance, has also been cited as stemming from healthcare providers’ experience with working diverse populations (Gray et al., 2010).

**Health services information given to new permanent residents prior to arrival**

The CIC and MOHLTC both make immigration applicants aware through their websites that in the provinces of Ontario, British Columbia, and Quebec, new permanent residents must undergo a three-month wait period before becoming eligible for provincial healthcare coverage. New permanent residents are then advised to purchase private health insurance during this time. The extent to which this is explained beyond being stated on their websites is unclear. The expectations of Ontario’s healthcare system that new permanent residents have upon arrival have not been documented in the materials gathered for this literature review. Attempts trying to get private health insurance coverage have been reported because of challenges new permanent residents have had to qualify for private health insurance. Affordability, comprehensiveness and eligibility have been particular problems with private health insurance because of a lack of coverage for pre-existing conditions, including pregnancy, and age exclusions. The federal government’s role and an increased partnership between CIC and MOHLTC to ensure consistency and comprehensiveness between healthcare insurance providers have been recommended (Elgersma, 2008).

**Partnerships established between stakeholders**

The Women’s College Health Network for Uninsured Clients have reported various strategies and partnerships they have developed to get new permanent residents needed medical attention (Gray, Hynie, Gardner & Roberston, 2010). These partnerships were created following reports from new permanent residents and other uninsured clients of problems with inconsistent costs and fees associated with care, including administrative fees, within and between different hospitals, as well as how some institutions pursued
unpaid bills (Gray et al., 2010). There are still inconsistencies between points of care, although efforts have been made to establish agreements between different institutions. Members of the Women’s College Health Network for Uninsured clients have done this through collaborating with other healthcare institutions in the Toronto area, such as CHCs, birthing centres, and other hospitals.

Strategies to provide and standardize care for uninsured clients include agreements for pregnancy and labour costs, as well as creating a set schedule of costs (Gray et al., 2010). Formalized agreements were set between CHCs and some hospitals to set a flat fee for uncomplicated labour deliveries (Gray et al., 2010). Prenatal care services through partnerships between midwives and CHCs have also been developed and have been found to be successful because of decreases in pregnancy complications, although many pregnant new permanent residents still delay seeking care until late in the pregnancy (Gray et al., 2010). Agreements with hospitals were reported as highly dependent on the culture of the hospital and understandings of the needs of the uninsured population (Gray et al., 2010). Some CHCs did manage to set stipulated standard fee schedules by formalizing agreements with hospitals (Gray et al., 2010). These standardized fees have been cited as reducing geographical barriers to care and increasing accessibility to care throughout the Greater Toronto Area (GTA) (Gray, Hynie, Gardner & Robertson, 2010).

Public opinion

Public views on the issue of the three-month wait period are yet to be surveyed or collected. Considering the Canadian values of equity, multiculturalism, and national pride for what most consider to be a universal healthcare system, some healthcare providers and health ethics experts have speculated that there would be considerable disapproval over the three-month wait period policy (Sylvain, 2005). The postcard petition presented to the Legislative Assembly on December 7, 2011 with 3000 signatures may be a sign of the public’s objection to the policy. Despite the awareness created by the Right to Healthcare Coalition’s campaign regarding the three-month wait period, the attention received and opinions voiced are yet to be officially documented. With the numerous
changes introduced by Immigration Minister Jason Kenney this past year, discussions regarding the nation’s opinions of the benefits of immigration have been mounting with widespread input from all over the country (CIC, 2012). The issue may be even timelier with budget cuts also being made to several health and social services, although in any case, the public’s opinion is a crucial factor that needs to be included during discussions and debates about the three-month wait period.

2.7 Discussion

Objectives of this review were initially identified as follows:

- assess the health impact of the three-month wait period on new permanent residents
- assess the public health impact of the three-month wait period
- identify benefits of maintaining the three-month wait policy
- determine the rationale for the implementation and maintenance of the three-month wait period

2.7.1 Health Impact of the Three-Month Wait Period

The most common health issues presented by clients within the three-month wait period, as reported by healthcare providers, were pregnancy and mental health issues (Gray et al., 2011; Steele et al., 2002). Due to lack of affordability or difficulty qualifying for private health insurance, numerous new permanent residents described delaying or foregoing care to avoid incurring significant debts from paying for services out-of-pocket (Elgersma, 2008). Delaying care was found to have several adverse health consequences for new permanent residents, including complications during pregnancy, increased rates of infections, progression of diseases, preventable acute episodes, and even death (OMA, 2011). When new permanent residents were able to seek and receive care, physicians commented on revising treatment plans because they were aware that the patients would not have access to follow-up care, tests, or drug medications (Gray et al., 2011). The quality and standard of care, that all other residents of Ontario receive, can be said to be compromised because of the three-month wait period.
The psychological impacts of the three-month wait period found in the literature review was significant stress from delaying care or incurring financial burden and experiences of both structural and personal discrimination (Sansom, 1997). New permanent residents have reported limiting their family’s exposure to activity outside of the home to prevent injury from fear of having to pay for health services out-of-pocket (Barnes, 2012). The three-month wait period produces anxiety and fear for new permanent residents during their initial period of settlement, which is an already significantly stressful time (RNAO, 2011). New permanent residents have also described feeling alienated and ignored by Ontario’s health care system during this time after having gone through the entire immigration process to prove their commitment to Canada (Central East Local Health Integration Network, 2010).

2.7.2 Public Health Impact of the Three-Month Wait Period

Most healthcare providers considered the public health impact of the three-month wait period a major concern. The spread of infectious and communicable diseases, such as TB, was reported as more difficult to control due to the three-month wait period. The delay to diagnosis of TB also results in increasing the infectiousness of the diseases, which could be transferred through the air, leaving all residents of Ontario susceptible. Services, such as TB-UP were also found to be inadequate to fully diagnose and treat TB (McKeown, 2011). Healthcare providers were forced to recommend new permanent resident to delay getting complete tests for diagnosis of TB because of the enormous costs that would be incurred, especially due to private health insurance providers considering TB a pre-existing condition and refusing to cover treatment for it. Once diagnosed, however, new permanent residents in the three-month wait period were also found to be in a precarious position because of the legal obligation to receive care.

2.7.3 Benefits of Maintaining the Three-Month Wait Policy

No medical benefits of the three-month wait period have been identified by the OMA and this claim has been supported by the RNAO, AOM, Toronto Board of Health, and Ottawa Board of health. The long-term costs of delaying care for new permanent residents has also been found to be more expensive than the short-term savings to Ontario’s healthcare
system that has been suggested by the MOHLTC and Health Minister Deb Matthews. From compounding costs at inappropriate access points for care, particularly the emergency department, and allowing diseases to advance without primary or preventative care, the long-term fiscal impact of the three-month wait period has been discovered as detrimental to Ontario’s health care system. The public health of Ontario is also not protected by the three-month wait period because it fails to prevent the spread of infectious and communicable diseases.

### 2.7.4 Rationale for the Implementation and Maintenance of the Three-Month Wait Period

The only statements to provide support for the implementation and maintenance of the exclusion period that were found in the literature review consisted of former Health Minister Ruth Grier’s introduction of the policy changes in 1994, estimates of the policy’s cost-savings by current Health Minister Deb Matthews, and the regulations outlined on the MOHLTC and CIC websites. Despite several calls from major stakeholders such as the OMA, RNAO, AOM, Toronto Board of Health, Ottawa Board of Health, and the Right to Healthcare Coalition, as well as a petition presented by NDP MPP France Gelinas, the MOHLTC is still yet to offer any further information regarding the maintenance of the three-month wait period. The basis of the rationale, besides cost savings, is to protect health services in Ontario from being taken advantage of by medical tourists, although no evidence to prove incidences of this happening with new permanent residents who undergo the immigration process has been found in this literature review. With no research to suggest that the accusations of new permanent residents as medical tourists is legitimate or well-founded and without detailed figures of the Health Minister’s estimate of $90 million savings per year (Barnes, 2011), the rationale provided by the MOHLTC is yet to fully justify its implementation and maintenance of the three-month wait period.

### 2.8 Conclusion

The three-month wait period was introduced in 1994 (Legislative Assembly of Ontario, 1994) as a cost-savings measure that would follow the policies set out in British
Columbia and New Brunswick, and former private provincial health insurance plans before the establishment of the publicly funded Ontario Health Insurance Plan. Prior to and following the changes made to OHIP in 1994, a thorough explanation of the details justifying the amendment were not made available. Public examination and consultation with healthcare providers prior to implementing the changes were also not found in this literature review.

It has since introduced various challenges for new permanent residents, Ontario’s public health, and healthcare providers in Ontario. Difficulties with private health insurance providers have been encountered by new permanent residents applying for healthcare coverage because of pre-existing conditions and age exclusions. The literature suggests that a combination of the three-month wait period and ineligibility for private health insurance have forced new permanent residents to delay care, which healthcare providers have found to endanger their health and Ontario’s public health. The inequity of access to health services for new permanent residents has led healthcare professionals to provide a lower quality of care at times due to excessive demands placed on them. Furthermore, the literature supports the idea that the three-month wait period has also compounded costs for Ontario’s healthcare system because of care being sought for advanced stages of illnesses and at inappropriate points of delivery. These health issues must be addressed by the MOHLTC through increased collaboration with the CIC, private health insurance providers, healthcare professionals, and new permanent residents.
Chapter 3

3 Methodology

3.1 Introduction

This chapter focuses on the methodological approach and frameworks that guided my data collection, analysis of the findings, and research experience more generally. I begin with a discussion of my ontological and epistemological positioning within the critical theory paradigm and continue with an overview of the methodology of narrative inquiry as it was used in this study. Outlining the theoretical frameworks that were used to approach the study, specifically social capital theory and political economy theory, follow. The methods used and issues related to data collection, including the research site, recruitment, and study sample, are then described. Next, I discuss how I approached my data analysis and ensured that the appropriate quality criteria were met during the coding and interpretation process. I conclude by describing the ethical considerations that were taken into account in designing and conducting the study.

3.2 Ontology and Epistemology

The location of this research is within the critical theory paradigm because of the way in which it aligns with narrative inquiry methodology, which values what and how participants give meaning to their stories. Critical theory “acknowledges a reality shaped by ethnic, cultural, gender, social, and political values” (Ponterotto, 2005, p. 130). The ontological positioning of critical theory is historical realism (Guba & Lincoln, 1994), which recognizes that there is a virtual reality shaped by social, political, cultural, economic, ethnic, and gender values (Guba & Lincoln, 1994).

This critical ontological positioning is imperative to understanding how, why, and through which experiences those affected by the three-month wait period come to develop their expectations and understandings of the three-month wait period, and the influence of the policy on their health. New permanent residents comprise an extremely heterogeneous group of people from diverse cultures, professions, families, and health
statuses, which can differentially shape their experiences and, in turn, their understandings of the policy. A critical ontological positioning that views individuals’ experiences as real, with the recognition that their perceptions of experience are informed by previous social, cultural, and gender interactions, aligns well with this exploration of the effect of the wait period on new permanent residents’ experiences of health and accessing health services in Ontario.

Epistemologically, critical theory is transactional and subjectivist (Guba & Lincoln, 1994; Ponterotto, 2005). The relationship between the researcher and the participant is seen as being interactional because the researcher and participant influence each other, during and to some degree after the project during the analysis and ordering of the data. The level of trust the researcher can establish with the participant will ultimately influence the nature of the collaboration between the two. What the researcher can know and appreciate from a participant’s story within critical narrative inquiry is inextricably formed by the dialectical nature of the interaction between the researcher and participant (Guba & Lincoln, 1994). This process of exchange can also be value-mediated, as the understandings of one can inform the other and potentially deepen the awareness of both parties relative to the issues being explored.

Transparency of the role of the researcher is an important aspect of qualitative research because of the way a researcher’s background can inform their understanding (Ballinger, 2006). I am a graduate student in the Health Promotion field of the Health and Rehabilitation Sciences program at the University of Western Ontario. I identify as a female visible minority as a first-generation Filipino-Canadian. I was born in Toronto, Ontario and grew up in Scarborough specifically. Growing up in Scarborough with other predominantly first-generation visible minorities, I became keenly aware of the struggles my family and friends’ families faced in immigrating and establishing themselves in Canada as racialized immigrants. This experience has contributed to my awareness of the complex challenges immigrants can face throughout settlement. As a researcher, I locate myself within the epistemological paradigm of critical theory, which considers how the researcher and participant can both influence the level of their interaction (Guba & Lincoln, 1994; Ponterotto, 2005). Throughout the study, I was cognoscente of how my
Canadian upbringing and Canadian education as a first-generation visible minority may impact participants and my analyses. By sharing my in-field reflections with my advisory committee and consulting them throughout each step of the research process, they acted as my peer-debriefers to ensure critical reflexivity.

3.3 Methodology

The study aimed to explore the expectations about and the impact of the three-month wait period on new permanent residents’ experiences of accessing health services before and after migration. It also sought to explore if recent immigrants responded to the lag in health services presented by the three-month wait period through creating informal strategies to manage their health-related issues, and whether or not such strategies represented a form of social capital within their communities or families. Given these objectives, narrative inquiry was the selected methodology because it allowed the researcher to follow the experiences of participants, as they gave meaning to them. Chase (2005) described narrative inquiry as “retrospective meaning making” (p. 656). It is a methodology bounded in storytelling and the primary method for data collection is through participant interviews. Narrative inquiry can be considered a phenomenon in and of itself because the process of an informant putting together several life events in a sequential order requires them to attribute meaning to each event, which they may never have reflected on before (Clandinin & Connelly, 2000). A key aspect of narrative inquiry is temporality because not only is an experience temporal, but organizing experiences collectively by reflecting and framing them together is a significant experience that is also bounded and influenced by time (Clandinin & Connelly, 2000).

Researchers and participants essentially “co-create” (Kirkpatrick & Byrne, 2009) a narrative as participants reflect on their lives retrospectively and offer a story, which researchers then re-interpret through their own experiential or theoretical lens and research objectives. This interaction between researcher and narrator during the interview and other research techniques has many outcomes and implications, given the layers of interpretation that occur throughout the process. It is important for narrative researchers to recognize and consider the different analytic lenses that produce their understanding of
the narrator’s story (Chase, 2005). Understanding the meaningful events people use to construct their identities and inform their lived experiences relative to their historical and social realities is a foundation of narrative inquiry.

The narrative approach employed in this study allowed participants to share their experiences as they saw importance in them over time, and in hindsight. This also applied to the data gathering process, an example of which relates to my initial plan of using a focus group to determine the potential utility of using a vignette methodology. Neither the focus group, for reasons discussed below, nor the vignette methodology took place. One participant commented during an interview that using a vignette would have taken away from his ability to tell his story. This participant described how much he appreciated being able to share his family’s experiences and what a pleasure it was to be able to do that. The process of reflection through narrative inquiry allowed participants the opportunity to express and juxtapose their stories over different times, places, and between cultures as they feel these various factors influenced their decision-making.

3.4 Theoretical Framework

In the last decade, the theory of social capital has become incorporated within public health discourse and used to identify mechanisms within particular groups that promote or hinder health; such as social cohesion and social/supportive networks (Kawachi, Subramanian & Kim, 2008). The two concepts related to social capital that have emerged as particularly influential are “social cohesion” and “network” theory (Kawachi et al., 2008). Those who adopt the social cohesion approach view social capital as a series of conceptual resources, such as trust, norms, and sanctions, which positively equip an individual (Kawachi et al., 2008). Those who employ the network theory consider social capital as resources within a social group that an individual may utilize. Some of these resources include social support, information channels, or social credentials (Kawachi et al., 2008). Within this critical narrative study, both forms of social capital have been considered in the context of informal resources leveraged by both new permanent residents to Ontario attempting to access care and healthcare staff trying to provide care. Social cohesion was observed in the ways in which participants were able to obtain
assistance from family and friends to find the CVC directly or navigate other services, such as a CHC, through which they would then be referred to the CVC. The level of awareness frontline providers had about the services the CVC offers also illustrated the network resources developed between providers across different points of care.

Importantly, the level at which a specific form of social capital is examined must be contextualized (Whitely, 2008). Social capital can be studied at the micro-level, meso-level, and macro-level also known as the level of an individual or family, community, and nation, respectively (Whitely, 2008; Lowndes & Pratchett, 2008). In working with and at a community clinic, most of the examples and forms of social capital considered here are those at the micro-level and meso-level. Social capital is also distinguished by the different forms it can take, which have been identified as bonding capital, bridging capital, and linking capital (Kawachi et al., 2008; Lowndes & Pratchett, 2008).

Bonding capital is seen as “resources accessed within social groups whose members are alike” (Kawachi et al., 2008, p. 5). In my study, this bonding capital was observed in the professional networks developed between healthcare providers, particularly the way in which the Scarborough Community Volunteer Clinic (CVC) is sustained by the volunteer efforts of a group of family physicians recruited by the Medical Director who is also a family physician. Bonding capital between the friends and family of those in the three-month wait was also observed, as these relationships and the information channeled through them acted as participants’ primary sources of information to forge pathways to care.

Bridging social capital refers to “resources accessed by individuals and groups through connections that cross class, race/ethnicity, and other boundaries of social identity” (Kawachi et al., 2008, p. 5). It was clear during the course of this study that the professional network established by the CVC’s family physicians allows for relationships to be developed with specialists to refer clients to who are in need of tertiary care. Securing medications, diagnostic tests, or tertiary care for those in the wait were due in large part to the efforts of the CVC staff, who advocate on behalf of their clients through utilizing professional relationships with other healthcare professionals. Establishing such
informal agreements to access resources outside of the network of CVC professionals can be seen as a form of bridging capital. Referrals from ethnic community groups (e.g. South Asian Association), religious groups, and other social services (e.g. Salvation Army) can also be considered a form of bridging capital, which were key to connecting those in the three-month wait with the CVC.

Linking social capital has been described as the connection between individuals and networks to “leverage resources, ideas and information from formal institutions beyond the community” (Lowndes & Pratchett, 2008, p. 685). My data reveal that several professional networks of health and social service providers were the foundation upon which some healthcare coalitions established outside of the CVC, such as the Women’s College Hospital Network for Uninsured Clients, were built on. Together, these coalitions have been integral to determining the breadth and nature of need for healthcare services for uninsured clients in other areas of Toronto. This linking of social capital between networks of providers in coalition groups has been critical to establishing the CVC and the development of other clinics that address the health services and needs among uninsured populations.

In a recent study, Zhao, Xue, and Gilkinson (2010) used the Longitudinal Survey of Immigrants to Canada (LSIC) and performed econometric analyses to investigate the health status and social capital of recent immigrants to Canada. Their findings suggest that friendship networks of recent immigrants are extremely important sources of assistance (Zhao et al., 2010). Organizational networks, including community groups and religious groups, are also important sources of support (Zhao et al., 2010). The diversity and frequency of contact with these networks were important features of the relationships that were associated with improving health (Zhao et al., 2010). Alternative care providers, such as religious and traditional practitioners, have been additional sources in managing health problems in the face of structural challenges (Hyman, 2002). Strengthening community organizations as resources for health information and advocacy has also been cited as an important strategy to increase recent immigrants’ capacity to manage their health (Hyman, 2002; Anucha, Dlamini, Yan, & Smylie, 2006).
A strong relationship between bridging networks and the attainment of good health has been observed in various studies (Kawachi et al., 2008; Field, 2008; Halpern, 2005). The mechanisms that mediate this relationship are still unclear, although material resources (e.g. money, transportation), reinforcement of healthy norms, emotional support through interaction, and transfers of information have been identified as possible resources of social capital which positively impact health (Field, 2008; Zhao, Xue & Gilkinson, 2010). What seems to be central to improving health is using social capital to access resources outside of one’s social network (Kawachi et al., 2008). This was also demonstrated in my study, as leveraging social capital within and across social and professional networks is crucial to accessing various channels of information, resources, and care for new immigrants affected by the wait period.

A political economy theoretical framework was also used to analyze access and utilization of health services among recent Canadian immigrants. Szreter and Woolcock (2004) state that the political economy “approach sees the primary determinant of poor health outcomes as the socially and politically mediated exclusion from material resources” (p. 650). Through a political economy frame, the differential circumstances and resources available to immigrants and how these may constrain their experiences of health were examined and brought into focus during this project. Viewed as a resource, health and access to it are experienced unequally because of policies, which are informed by those with social, economic, and political powers. Health services are rationed, as every resource is, perhaps especially in Canada’s nationally government-sponsored insurance system. In a public health system that is constantly cited as being “in crisis” (Raphael & Bryant, 2010, p. 83), there is a disparate distribution of health services in which segments of the population continue to be underserved.

A political economy lens helped elucidate the processes that produce and contribute to the highly inequitable systems related to health care access. In this study the three-month wait period, as well as other recent policy changes, were found to systematically exclude certain immigrant groups from access to health services and produce inequitable health outcomes. Healthcare providers also explained the differential treatment some clients without OHIP experienced at different points of care, particularly
hospitals. They described how clients were more vulnerable to financial burden because of the three-month wait due to the lack of standardization of costs for services. They explained how clients in the wait period could be charged varying rates for the same services across different points of care because of the lack of standardization of costs for services, further excluding them from accessing care. The dynamic interaction between health care and immigration systems, especially as they operate on different political levels including the municipal, provincial, and federal stages, became evident and more clearly articulated through the use of the political economy theory.

3.5 Methods

3.5.1 Research Site

The primary destinations for 90% of Canada’s immigrants are our country’s major metropolitan areas, located primarily in Ontario, Quebec, and British Columbia (Cymbal & Bujnowski, 2010; Milan, 2009; Waylan, 2006). Ontario welcomed 39.9% or 99,435 of the nation’s new permanent residents in 2011, down from 42.1% or 118,112 of new permanent residents in 2010 (CIC, 2011). Of the new permanent residents arriving in Ontario in 2010, 58.8% were economic class immigrants and 31.3% were principal applicants from the economic skilled workers category (CIC, 2011).

Located in eastern Toronto, the municipality of Scarborough had a population of 602,575 in 2006 and two thirds of the population self-identified as a visible minority (City Planning, Policy & Research, 2008). The city of Scarborough has become known for reflecting the wider immigration patterns of Toronto since the 1970s, when families began to move from the city to the suburbs to pursue more feasible home options and land ownership (Schofield, Schofield & Whynot, 1996; Seward & White, 1996).

This project took place in the Scarborough CVC, established in 2000 by a joint coalition group of Scarborough healthcare providers, including family physicians, public health nurses, hospital administration, as well as other settlement and social services agencies. Previous contact with the CVC from a separate project facilitated my ongoing relationship with the CVC staff. At the time of data collection, the clinic was one of
Canada’s only four volunteer clinics for those without publicly-funded health insurance, with the other three located in western Toronto, Kitchener, and Montreal. The CVC provides accessible primary health care for the residents of Scarborough who do not have health care coverage, including examinations, treatment, vaccinations, and counseling. They operate on a drop-in basis, so no appointments can be made, and they are open for limited hours from 4 to 8 pm on Tuesdays and Thursdays. A small team made up of one volunteer doctor, one public health nurse, one registered nurse, and a medical school resident run the clinic (although they have recently increased nightly staffing to meet the community’s overwhelming demand). By 2006, the volunteer clinic recorded 7000 visits by 2000 patients from over 85 countries of origin (Caulford & Vali, 2006).

3.5.2 Data Collection

Data collection was conducted from August to November 2012 on Tuesday and Thursday evenings for three hours each night while the CVC was open. The volume of clients during the summer months increased drastically, with as many as 30 clients being seen within the four-hour drop-in time. Working with the CVC public health nurses as gatekeepers, the staff members helped with recruitment and were provided with informational flyers to distribute to clients who fit the inclusion criteria (see Appendix B). The flyer included information about the study’s purpose, benefits, and any risks associated with participation. After weeks of not receiving any responses, it was suggested that I stay at the clinic during their operating hours as a visible reminder to the CVC staff during their fast-paced nights spent serving the increasing number of clients.

My physical presence at the CVC proved to be imperative for both the staff and potential participants. I planned to begin my research with a focus group of four to six participants, followed by individual interviews. As a result of being newly settled in the region and needing health care, which was understandably more important than taking part in a focus group, several potential participants who expressed an interest in participating in the study were not able to come back to the clinic for the group discussion. Additional obstacles during this point in the research process regarding client participation was that it would take time away from work, arranging childcare and
translators for those requiring them, and the time and costs of travel to the CVC, especially if they lived outside of Scarborough.

Taking these lessons into consideration, clients who fit the inclusion criteria were then asked if they would like to participate in the study through an individual interview while they were at the clinic. The CVC staff introduced me to clients in the three-month wait after they checked into reception, as they waited to be triaged by a nurse, or following triage as they waited to see the doctor. These waiting times varied anywhere from five to 45 minutes. It was during these moments that I had the chance to explain the study, determine if they were willing or able to participate, and if possible conduct the interviews during their waiting time (in a separate, private room at the clinic). This strategy helped me complete the interviews, and while not resembling “ideal” research conditions they do reflect the reality of my participants’ lives at the clinic and also my ability to be a “researcher-on-the-spot” as the field demanded.

Inclusion criteria and recruitment

The original inclusion criteria for immigrant participants was; that they were economic skilled immigrants; between the ages of 19 to 70; currently in the three-month wait period or previously in the three-month wait period in the past five years. The only inclusion criteria that was adjusted was to allow new permanent residents from both the economic skilled category and family-sponsored categories to participate in the study. New permanent residents from only the economic skilled category was originally proposed because family-sponsored immigrants would already have established family support in Canada that could assist them through settlement challenges and navigating services. During recruitment, participants from the economic skilled category were also found to have family support in Canada, so the ways in which they experienced the three-month wait period and navigating services was not necessarily unique to that of family-sponsored immigrants. Two returning Canadian citizens in the three-month wait period were also included in the study because they still offered valuable insights into the level of awareness people had about the three-month wait period as well as their experiences of navigating health services without OHIP.
Clients were referred to the study as soon as staff members, mainly nurses, learned that they were in the three-month wait period. The public health nurses would briefly introduce the researcher to the client and their family and then leave me to explain the study and what would be involved in participating in the study. This immediate and face-to-face explanation of the study proved very valuable in establishing rapport with the participants, as they often disregarded the flyer provided to them and preferred to ask me questions directly. The flyer seemed to be an ineffective method to deliver information about the study because it failed to stand out from the rest of the forms and papers new immigrants are forced to sort through during the application and settlement process. English comprehension also varied greatly between clients, so the flyer may have been difficult to read and understand for some.

Similar to experiences described above regarding the challenges to recruitment for the focus groups, suitable clients at the clinic identified several issues that prevented them from taking part in the individual interviews. Some expressed a lack of interest, but more often language was a significant factor because some did not speak English. A number of people needed a family member or friend to translate for them, and I also depended on a translator to explain the study. Those who did not have a strong command of English may not have fully understood the explanation of the project and sometimes had difficulty reading through the informational flyer, while others also mentioned they felt uncomfortable about answering questions for a prolonged time without a translator. Telephone interviews were also offered as an option to take part in the individual interviews, which was not successful because some clients did not have an established phone line yet, were unavailable, or failed to answer calls during the scheduled interview time.

The interviews

All interviews were conducted in English and the duration of each interview was heavily dependent on the participants’ waiting time, which averaged around approximately 20 minutes. As I conducted the interview, I had to be very cognizant of the time so as to not delay or impede their care. Despite this impediment, I felt as though I was able to capture
many of the aspects of the experiences they chose to focus on and share with me. I managed my interview time by prioritizing questions directly related to my study objectives, while allowing participants to still tell their stories as they wished. Collecting data when participants are in the process of seeking care meant that the full impact of the policy on their health was unknown, as they waited to see if they would indeed get the level of medical attention they required at the CVC or elsewhere. Getting medical attention for their health concerns, which they often still had not received at the time of the interviews, was also evidently and understandably their main focus; so their responses may have been influenced by their state of stress. For some participants who only required a prescriptions refill or specialist referral, their visit to the CVC was meant to be quick, although the wait at the clinic may have kept them there for longer than expected. Prolonging these clients’ time at the clinic with an extended interview was another consideration when conducting these interviews. Interviews with healthcare providers also followed a narrative approach and were semi-structured, using a separate set of questions as an interview guide (see Appendix C).

All interviews were digitally recorded and conducted in private rooms at the CVC, and often affected by various interruptions like nurses checking in to clarify details of the participants’ medical information, family members or friends coming in and out of the room. Many times the entire family participated in the interview, as the participants cared for their young children or infants who had trouble sitting through the interview either because they were fussy, hungry, or restless. Another consequence of interviewing families together was also that the perspectives of each family member might not have been shared if they felt uncomfortable about sharing their personal views on topics other family members may have been sensitive to.

A total of ten interviews were conducted with 14 new permanent residents, with four of the interviews being with two spouses. All interviews varied in length, ranging from 15 to 50 minutes. There was an even gender distribution across the interviews with seven male and female participants in total. Across immigration categories, there were five interviews with new permanent residents admitted through the federal-skilled worker
stream and two that were family-sponsored. There were also two returning Canadian citizens and one returning permanent resident.

With respect to data gathered with the CVC staff, four individual interviews were carried out. The gender representation was even, with two female and two male staff members interviewed. Three interviews were with public health nurses and one was with a volunteer doctor. Work experience at the CVC differed between staff participants as well, with some being there since the clinic’s inception and others for only a few months. While the perspectives of all types of healthcare and social workers who engage with immigrants in the three-month wait period may not have been captured, the sample selected offered valuable in-depth insights regarding the many complicated challenges with providing care to this population. Unlike quantitative research, the goal of narrative inquiry and qualitative research generally is not to reach generalizable conclusions based on a randomized and representative study sample of a population, but to garner information-rich cases and the lived experience of a phenomenon (Chase, 2005; Morrow, 2005).

*Description of participants in, or previously in, the three-month wait period:*

*Kavi*

Kavi is a pharmaceutical technician who arrived from India to Canada through the Federal Skilled worker category with his wife who was a physiotherapist in India. At about 30 years old, Kavi and his wife were expecting their first child in about a month. They came to Ontario about two months before they sought help at the CVC for his wife who was eight months pregnant at the time. Kavi spoke of how helpful his uncle and aunt had been by warning them about the three-month wait period and helping them decide if they wanted to purchase private health insurance before they came to Canada. With advice from his uncle and aunt, Kavi did purchase private health insurance for his wife in case of any complications during the pregnancy. Once they arrived in Ontario, they immediately began to call community health centres and midwives in Brampton, although none were available. They decided to seek advice at a Salvation Army centre in Scarborough where they were referred to the CVC. After their first visit to the CVC, one
of the public health nurses helped put them in touch with a midwife in Scarborough. To be closer to the midwife, Kavi and his wife moved to Scarborough and arranged for the delivery to be at one of the local hospitals. They were told the delivery would cost about $1100.

**Larry, Marie, and Lucas**

Larry came to Canada from the Philippines in 2005 as a live-in caregiver and after two years of working in Ontario, he became a permanent resident by 2008. When he first arrived in Ontario, he was not aware that he would not have provincial health insurance coverage for three months, so he decided to restrict his activity to avoid getting sick or injured during this time. He sponsored his wife, Marie, and son, Lucas, by 2010 and after almost two and a half years, they joined him in Ontario in July 2012. Within two months of them landing, Larry needed to get a prescription for his eight year-old son who has a congenital heart condition because the medications they packed had run out. Larry luckily bumped into one of the CVC nurses at a Service Ontario centre and she told him that he should bring Lucas in to see one of the doctors at the clinic to get the prescription.

**Niraj and Rajni**

Niraj was a nurse in India before coming to Canada as a federal skilled worker with his wife, Rajni, and two year-old daughter. Before coming to Canada, the family purchased private health insurance even though they knew it would not cover any maternity services. Niraj was eight months pregnant when they arrived in Ontario, so they immediately attempted to seek care at several CHCs around Toronto. None of the CHCs they contacted were accepting new patients, although one CHC recommended they go to the CVC. Within two weeks of arriving in Ontario, they came to the CVC.

**Rafa**

Rafa came to Ontario from Jordan with her four young children and husband, about two months before coming to the CVC. Rafa’s husband applied to come to Canada as a federal skilled worker because he was a physiotherapist in Jordan, while Rafa was a nurse. Rafa explained that they had received their visas a year ago, but they had delayed
landing because she was eight months pregnant at the time and she knew that she would not be covered for maternity because of the three-month wait period. After commuting for two hours, Rafa came to the CVC with her 9 year-old daughter because she had a urinary tract infection. Rafa was frustrated because she had originally sought care at a CHC closer to her house, but she was denied care there because they were full and had been for four months already. Rafa found this especially difficult because she was also dealing with other settlement stresses, particularly finding a new place for her family to live in because they could no longer afford their house. With only one income from her husband, while he was in school to get certification to practice physiotherapy in Ontario, they felt they needed to find a less expensive living situation. Rafa also anticipated going back to school for nursing after her husband started practicing physiotherapy.

**Harry**

Harry had come to Canada from India in the 1970s, but left again in the 1980s to be with his wife who had found a good job as an obstetrician in Dubai. While in Dubai, Harry had met with various specialists and had undergone several tests confirming that he had prostate cancer at about 60 years-old. Following the discovery of his diagnosis, Harry decided to move back to Canada to get treatment because he felt Canada has one of the best healthcare systems in the world. He felt that the three-month wait period was unreasonable though and there should be exceptions made.

**Yamuna**

Yamuna is a returning permanent resident in her late twenties who just graduated from medical school in China, after moving there from Pakistan. Yamuna explained that there had been a four-year delay processing her family’s application, so she applied to medical school while they waited for approval. Just before receiving their visas, however, she received acceptance to medical school in China, so Yamuna landed in Canada just before going to China for medical school. After her mom, dad, and brother had already been living in Canada for over four years, she decided to move back to Canada after graduating in order to be with them. Yamuna was preparing to take her medical school examination to practice in Canada when she decided to volunteer to get Canadian
experience that she could add to her application. In order to volunteer, however, Yamuna discovered she would need immunization shots. Yamuna learned of the CVC at a volunteer fair at a public library a few blocks from the CVC, so she considered herself very lucky to have learned about the clinic.

**Diane**

Diane is twenty year-old college student and she immigrated from the Philippines about five months before the interview. After Diane’s mom worked as a live-in caregiver for two years and became a permanent resident, she spent her savings sponsoring Diane and her father and brother to join her in Scarborough. Diane expressed her disappointment that she had to leave her grandmother and older sister in the Philippines because she was too old to be sponsored and they also did not have enough money to sponsor both of them. Diane did not need any medical attention during the three-month wait period and she received her health card after two month without any complications. Her father, however, sprained his collarbone two month into his three-month wait period and he was forced to quit his job from the pain. Her brother also had difficulties getting his health card because the bank would not provide him with a statement and Service Ontario would not accept any other proof of residency. Diane still thought of her family as extremely lucky to be in Canada, despite the three-month wait period. She also spoke about her feelings of depression and social isolation from being away from her friends back in the Philippines and not knowing many people in Scarborough.

**Kamal**

Kamal is a returning Canadian citizen whose health card expired while he was in India for six months after his father died. Kamal learned about the CVC at a Service Ontario centre and he came to the clinic after having a persistent fever for a few days. Kamal originally immigrated to Ontario from India in 2007 as a federal skilled worker because he was a physiotherapist in India. Kamal described the anxiety he felt when he first landed and learned about the three-month wait period, even though he never needed to seek medical attention. Almost seven years later, as a practicing physiotherapist and Canadian citizen that also sponsored his wife to come to Canada, he still could not see the
purpose of the policy. He explained that he experienced profound settlement stresses when he first arrived as he tried to find work and finish school and that the three-month wait period was an additional, but unnecessary stressor.

**Harshad**

Harshad was previously a nurse in India, until he immigrated to Canada with his wife and eight-month old son in September 2012. Harshad’s family immigrated to Canada with the assistance of an agency that told them about the three-month wait period and after learning about the policy, the family decided to purchase private health insurance. Within two months of arriving in Ontario, they found the CVC after learning about the CVC at a Service Ontario centre and from a friend. Harshad’s family presented at the CVC seeking care for his wife, who was three months pregnant. Harshad explained that when they first received their visas in December 2011, his wife was seven months pregnant so they decided to delay landing because they were aware of the three-month wait period and did not want to travel when she was so far along in the pregnancy. After adding their newborn to their application, they were able to immigrate to Canada as a family seven months later. Harshad expressed his frustration with having to work at Tim Hortons while he went to school to get certified to become a nurse again and felt there should be a better process in place, such as having the program offered in India while he could still work as a nurse.

**Lalit and Pritha**

Lalit and Pritha were both physiotherapists in India before immigrating to Canada through the federal skilled worker category in July 2012. After trying to conceive for months, the couple were excited to find out Pritha was pregnant just one month before they were planning to immigrate to Ontario. While they were aware of the three-month wait period, they did not purchase private health insurance and explained that they were ready to pay for any necessary health services with their savings. They first arrived at the CVC a few weeks before the interview and returned to get an x-ray referral.
Description of healthcare providers:

Dante

Dante is a public health nurse in his early thirties and has worked at the CVC for about a month. Dante spoke highly about the resourcefulness and level of knowledge his colleagues at the CVC had, which he observed over the short time he had been there. Dante described how he enjoyed working at the CVC because he had always wanted to give back to and contribute to the community of newcomers he felt he was once a part of.

Elaine

Elaine is a nurse who has worked at the CVC for almost nine years and throughout the community for over 30 years. Elaine also described herself as an immigrant and described how she loved working at the CVC because she identified so much with the struggles of settlement that she saw so many of the clients going through. Elaine also felt that the job was one of the most fulfilling that she has ever had because of their ability to provide continued care for some clients and be able to see these cases through to healing.

Joan

Joan is a public health nurse who has worked at the CVC since it was established in 2000. Joan is responsible for triaging most patients and coordinating care for referrals outside of the CVC. Since Joan works with health and social service providers outside of the CVC often, she emphasized the importance of advocating for clients without publicly-funded healthcare.

Fred

Fred is a family physician who has volunteered at the CVC since it was established as well. Fred stressed the importance of providing equitable access to care, regardless of immigration status. He was also very politically aware of policy developments and politics surrounding access to care for immigrants between the MOHLTC and CIC.
Field Notes and Observations

Field notes were also taken as a supplementary form of data collection to record my observations throughout the recruitment and data collection process. Reflexive journal entries were made each night at the clinic, after every interview, during conferences, at meetings with community organizations, and at a documentary film screening. I also kept press releases, newspaper articles, and blog entries on immigration policy changes made, which affected access to care for various immigrant groups.

Journal entries at the clinic allowed me to capture in situ notes about the environment of the CVC, including the types of clients that presented at the clinic, the pace at which the staff could attend to them, and the nature of the interactions between clinic staff and clients. Field notes taken after each interview also helped me to reflect on observations made during the interview related to participants’ body language, their hesitations, points of discussion they emphasized or were of particular concern, members of the family who were present for the interview, and how the family dynamic may have influenced their responses. Any interruptions that arose from interjections from the CVC staff or reasons for ending the interview abruptly were also noted. These field notes were helpful in contextualizing data throughout transcription, data analysis and interpretation.

Journal reflections were also important in tracking the development of immigration policy development and how it affected access to care for various groups of newcomers. Observations made at the clinic often seemed to reflect the immigration health policy changes that took place during the course of my fieldwork, which significantly increased the demand and delivery of care at the CVC. In February 2012, I attended the Seeking Solutions Symposium in Toronto, which focused on research on access to care for the uninsured in Canada. At the symposium, I was able to learn about and speak with other healthcare providers and researchers who worked with medically uninsured populations throughout Canada. This opportunity helped to give me insights into the national and international landscape of provision of health services for those without medical insurance. In September 2012, I was also able to attend a Centre of Excellence for Research on Immigration and Settlement (CERIS) panel discussion on the
introduction of Bill C-31, the *Protecting Canada’s Immigration Act*, as well as a Scarborough Civic Action Network (SCAN) forum also dealing with the impacts of Bill C-31. The CERIS panel, which included two Toronto doctors and a hospital community engagement director, provided an informative discussion on their experiences dealing with the effects of Bill C-31. The SCAN forum also included a panel of lawyers, policy analysts, immigration consultants and government officials who clarified the meaning of Bill C-31 and addressed the concerns of community members. The observational notes taken throughout these meetings allowed me to capture the perspectives of the diverse group of stakeholders affected by these policies.

Attendant community projects related to the three-month wait period were also valuable sources of information. In October 2012, I attended a meeting held by the Right to Healthcare Coalition, which aims to advocate for the elimination of the three-month wait period. During the meeting, the coalition attempted to strategize their next steps, considering the effects of the work they have done to date and the response they received from the ministry. This meeting, as well as the news and media releases on the recent immigration policy changes, gave me valuable insights into the political climate the coalition faced and the discourse used by the ministry in discussing the three-month wait period. In November 2012, I was also able to attend the screening of the documentary film “Your Money or Your Life”, which takes a critical look at access to care for newcomers to Canada and follows the stories of a few clients from the CVC. The documentary as well as the question and answer period with the director, doctor and public health nurse from the CVC, and a father and son who were treated at the CVC, also gave me a unique look into the lives of those without publicly-funded medical insurance in Canada.

### 3.6 Data Analysis and Interpretation

I transcribed all 14 digital recordings to ensure a very close and thorough understanding of the data, and to assist in the narrative and thematic analysis of the interview texts. Initial coding and analysis of data followed the transcription of each interview. Transcripts were read, re-read, and after reading through the data multiple times, notes
were taken to identify significant and/or recurring themes (Liamputtong, 2009). Terms were used to label these concepts through coding and as this process developed codes were broken down into increasingly specific categories and sub-categories that reflected information relevant to participants’ evolving expectations and understandings of Ontario’s health care system and their health status. Themes both within and across the groups of immigrants and healthcare providers were more easily distinguishable after each series of coding.

The utilization of narrative analysis across numerous fields of research has produced several differing methods of analysis, with no agreement on a single process. For this study, I utilized the narrative analysis process described by Polkinghorne (1988) and Redwood (1999) as core story creation and emplotment. Core story creation refers to the strategy of reducing full-length stories to shorter stories to focus analysis. Redwood (1999) explains the components of producing a core story by reading the full interview text multiple times, deleting words that detract from the key idea of sentences, reading the remaining text and repeating the previous two steps numerous times to try to capture main themes while referring to the full data text to ensure meanings are not lost. Subplots and themes should emerge and connect with one another to form a coherent core story (Redwood, 1999). Through concentrating the data into core stories, I was able to identify the meanings participants attributed to their most significant life events and those that most closely aligned with my study objectives.

The second step of this narrative analysis is emplotment, which is a process that aims to find the significance of plots taken alone and together (Polkinghorne, 1988). By taking into account the historical and social contexts in which events take place, complex stories can be understood in their significance. Moving between analysis of events and plots in this dialectical nature illustrates how the two contribute to each other and to the whole story, over time and between places, for each participant.

During analysis, it became evident certain participants spoke in greater length and detail. Considering the “researcher-on-the-spot” approach taken, some participants’ circumstances were more conducive to longer interviews, which allowed for more
extensive discussions. Kavi and Joan figured prominently in the themes presented due to some of these realities, although I was cognoscente of issues of participant representation when selecting participant data to present in the findings.

3.7 Quality Criteria

Reflexivity and authenticity are the primary quality criteria through which to evaluate this critical narrative. Reflexivity was practiced by maintaining an audit trail throughout the research process (Ballinger, 2006; Morrow, 2005). This was achieved through keeping a research diary or self-reflexive journal, including my initial thoughts and reflections prior to and following interviews. By sharing my in-field reflections with my advisory committee bi-weekly, I was able to discuss my findings with my supervisory committee as peer de-briefers (Ballinger, 2006; Morrow, 2005). The insights and responses offered by my supervisory committee assisted me in identifying themes and to think critically about key themes and other research considerations.

Authenticity is an important consideration when carrying out any kind of research, including narrative inquiry. Whittemore et al. (2001) define authenticity as, “the portrayal of research that reflects the meanings and experiences that are lived and perceived by the participants” (p. 530). Authenticity has been demonstrated through triangulation, providing thick description, and providing evidence that supports my interpretation (Ballinger, 2006; Whittemore, 2001). Triangulation refers to gathering data from different data sources, including interviews with both new permanent residents, a range of health care providers from the CVC, fieldnotes, and attending meetings and the film screening. Thick description refers to providing context to evidence drawn out from data, such as extended excerpts of interviews quotations. Using observational field notes and other supplementary sources of data with my interview findings, I attempted to produce thick description in the present text. Through the use of these different techniques I trust, and hope, that I have provided accurate representations of my participants’ stories and experiences.
3.8 Ethics

Ethics approval for the study was received from the Non-Medical Health Sciences Research Ethics Board full review prior to recruitment and data collection (see Appendix D). Process consent was ensured throughout data collection by securing informed consent at the beginning of each interview, and reviewing the purpose of the project and telling participants that they could withdraw at any time. Maintaining the privacy and anonymity of participants was a priority for the study as informants, especially those awaiting approval for OHIP, were wary of jeopardizing their chances for approval by participating in the study. No names were used during data collection or in the presentation of findings. All participant names were removed and replaced with pseudonyms.

To help mediate confidentiality concerns, the contact information of the interviewer was given at the outset of each interview in case any participant wanted a copy of the interview transcript or to withdraw any information from being included in the final presentation of findings. A copy of the letter of information and consent was given to each participant to keep and the rights, risks, and benefits of participating in the study were also verbally described (see Appendices E and F). I ended each interview by asking each participant how they felt about the experience and invited their reflections about being a part of the research process as a form of debriefing (Josselson, 2007). It was also expressed that participants could request a copy of the final findings and results from the study, which will also be shared with the volunteer clinic and disseminated through presentations at conferences and through publications.

3.9 Conclusion

This chapter attended to issues related to methodology, data collection methods, and data analysis and interpretation. As discussed, I situated the study through the use of a critical theory paradigm, and used a narrative inquiry methodology and the frameworks of social capital and political economy theories. Qualitative data were collected from semi-structured interviews with ten participants in, or previously in, the three-month wait period, four healthcare providers from the CVC, and from field notes taken at the clinic
and at various presentations. Data were transcribed verbatim and analyzed using core story creation and emplotment as outlined by Polkinghorne (1988) and Redwood (1999). The quality of the study was evaluated by examining its reflexivity and authenticity. Ethical considerations were also highlighted, especially concerning confidentiality.
Chapter 4

4 The Three-Month Wait Period: Exploring New Immigrants’ Experiences

4.1 Introduction

Each year, Canada attracts nearly 250,000 new permanent residents who apply to come to Canada for various reasons, including but not limited to: employment opportunities, the education system, the high standard of living, low population density, the healthcare system, and Canada’s reputation as a welcoming country. Dominant portrayals of Canada often frame it as a nation with a reputation for human justice and equity and one that is rich with opportunities and natural resources. For new immigrants, the ways in which Canada is represented within international newspapers, immigration agencies, settlement consultants, and Canadian friends and family, impacts in profound ways their expectations of the country and imaginings of what life will be like here.

For many participants, the decision to immigrate to Canada is based on the belief that it will be a better place to raise their children and build their families. The lifestyle, health care, education, and work are the most common reasons participants provided when asked why they chose to come to Canada. The weather and draw of the large, metropolitan city of Toronto also figured into their decisions to come to Canada and Ontario, specifically. As Kavi said, “I heard that Ontario is the best place to be especially because I am going around areas you can have good community, a good weather, each and everything.” Yamuna, who returned to Canada after completing medical school in China, described why she thinks her family decided to settle in Toronto:

I like the people it’s the largest and there’s more opportunity so I like it in Toronto so I don’t actually know the reason why my parents applied but maybe this might be the only reason... Yeah good lifestyle like we find it’s good part of Canada more opportunities.
This chapter features the data gathered from the interviews I conducted with participants who were in, or previously in, the three-month wait period for OHIP. My discussion centers on the role of the three-month wait period in shaping the participants’ settlement experiences, and how these experiences aligned with or were in contrast to their initial visions and expectations of Canada.

I begin with data that reflects my participants’ perspectives on the three-month wait period itself, which has been a source of significant frustration for many of them. The remainder of the data are presented in such a way that they follow the arc of the participants’ immigration experiences, beginning with pre-migration planning. Here I discuss the various decisions participants faced when they immigrated to Canada and the factors that affected their pre-migration experience, including: the unpredictability of the application process, awareness of the wait period, purchasing private health insurance, and preparing for the three-month wait period. The second major theme relates to the processes the participants went through to access health services upon landing. In this section I examine the various approaches to and avenues of healthcare sought during the three-month wait period, including: delaying care, community health centres (CHCs), midwifery services and clinics, and the CVC. The third main theme explores the impacts of the wait period on participants’ abilities to access health services during and after the three-month wait, including the effects of delayed care, out-of-pocket fees, stress, and exacerbating existing barriers to care.

Opening Perspectives on The Three-Month Wait

I begin by sharing some of my participants’ general thoughts on the three-month wait period. Although their perspectives about the wait period varied, they shared some similar sentiments, including feeling that the process is unfair, confusion as to the policy’s purpose, and a negative impression of Canada because of the policy. For instance, knowing that other provinces provided provisional healthcare coverage to landed immigrants upon arrival, Harshad felt that that the treatment new permanent residents in Ontario experience was unfair or not justified. His awareness of the policies of other provinces added to his frustration with the wait period. He said:
The health system the card in other states of Canada they are receiving in two weeks, three weeks time, not months, but now here it’s three months but we cannot get sick in three months, what is this? It’s not economical or safe.

Kamal resented the three-month wait period because of the vulnerable position he believed it put new permanent residents in. He describes the lack of control he experienced over his health, “Yeah but this three months waiting period is very sick from what I see…we are here new and…suppose anything happens to our health we couldn’t take the treatments we see fit, that’s the problem.” Another participant, Kavi, described how the three-month wait period negatively affected some of his views of Canada. He explained, “I heard that like this system here is really like first class for landed immigrants and their citizens it covers all the costs, I mean it was really surprising…I think the three-month waiting period is the most concern[ing] thing.”

4.2 PRE-MIGRATION PLANNING

4.2.1 Awareness of Three-Month Wait Period

Most participants were aware of the three-month wait period for OHIP prior to their arrival in Canada. The level of awareness varied and was dependent upon their source of information, which was primarily family, friends, settlement agencies and the Internet. This section features data about these sources of information among participants, beginning with family and friends.

Participants who learned about the policy from relatives or friends had a better understanding of it than those who only read about the policy on the Internet or were informed by a settlement agency. The social networks of family and friends applicants had established in Canada before migrating were crucial in helping them plan and prepare for living in Canada. When speaking about how she came to find out about the three-month wait period, Rafa commented, “From friends, from the Internet.” Kamal had his brother explain the policy to him:
Only through my brother, [who] was an immigrant here in Canada, and he told me before you come to Canada if you get the PR [permanent residency] for three months you have to wait…

Diane learned about the three-month wait period from her mother. “Yeah my mom told me, told us about it, that um once we landed she told us to apply right away for our um…health card so that the three months wait is um going already.”

Settlement agencies and immigration consultants and lawyers were the second main source of information that participants learned about the three-month wait period from. Some found the information from settlement agencies unhelpful because their descriptions of the policy were brief and only stated that they would not have provincial healthcare coverage for a few months. Niraj echoed these sentiments, “We applied through the agency and they have the notification that like um it may take a few months to get the health card…It was just a notification like, it was not clear.” Larry, who did not receive any information from the agency helping him arrange his immigration through the live-in caregiver program, was unaware he would be without healthcare coverage before coming to Canada:

When we arrived they just told us ‘Oh you need to go to the Ministry of Health to get your card,’ and we are at the Ministry of Health they told us ‘Oh you can get your card after three months.’ Then I asked the lady, ‘Oh so we’re not insured?’ and then they told me ‘Yeah you have to wait another two months.’

As a result of his experiences, when he sponsored his wife and son to come to Canada Larry made sure they knew about the three-month wait period. Knowing about the lag in access to health care was of particular importance to the family as they planned to come to Canada because of their son’s congenital heart disease, which requires daily medication.

The Internet was the other most commonly utilized source of information for participants. The CIC website served as the main portal of information about the immigration process, including all of the necessary forms, applications, and documents.
Interestingly, during their searches on the Internet and the CIC website the three-month wait period information was often overlooked by participants because their main concern was ensuring that their application packages were complete. This was problematic for participants who relied solely on Internet sources, versus settlement agencies or consultants, because they did not always feature extensive information about the three-month period. Kavi also explained that only learning about the three-month wait from the Internet is challenging because of the limited time they can spend on the Internet:

I don’t think I would know anything about that before coming to Canada. If my wife was not pregnant then who knows…at the time I got a look at those rules but who cares at that time. Yeah it was there on the…government Canada website (cic.gc.ca). I think each and everything is there, but…more the thing is you use Internet so much, but back home in India no one can.

4.2.2 Unpredictability of Application Process

After determining eligibility to immigrate to Canada, the next step in the immigration process is submitting an application. The processing times of immigration applications can vary depending on the type of application (e.g. skilled workers, provincial nominees, investors), the Canadian visa office the application is submitted to, and can range from six months to five years (CIC, 2013). Participants planned for their immigration according to these processing time estimates and they also checked the status of their application online to time their preparations for emigration. On the CIC website, some points of consideration for preparing to live in Canada are suggested, including: finding work, preparing financially, choosing a city, learning English and French, getting to know Canada, learning what to bring, including proper documents, and finding help adjusting to Canada (CIC, 2013). The CIC website, however, does not include an in-depth discussion of what to do in case of any health concerns, such as pregnancy; which was a life event shared by half of my participants and one which profoundly impacted their application process.
In many ways, for these participants (5/10) the unpredictability of pregnancy was exacerbated by the unpredictability of the application process. Study participants used the processing times estimates, updates, and their knowledge of the three-month wait period to plan for their pregnancy. They found that the processing times estimates were inaccurate and that their application status updates were vague and infrequently revised on-line. This made planning for their pregnancies, while taking into account the three-month wait period, nearly impossible. Upon receiving their visas, the participants managing pregnancies were faced with the decision to either immigrate to Canada immediately or delay their landing. How they came to their decision to deliver their baby in Canada or delay their immigration to have their baby in their country of origin will be discussed in the following section, as well as the implications of these decisions.

The choice to immigrate to Canada immediately upon receiving visas during the late stages of pregnancy was made by three families interviewed for the study, including Kavi and his wife. They tried to make plans for a smooth immigration and a safe pregnancy and delivery, despite the lack of information and application updates they could access online from the CIC website. After their immigration medical examination, they did not receive any updates from the CIC for six months, until they received their visas. At that point Kavi’s wife was five months pregnant and they felt they had to make the calculated decision to immigrate to Canada as soon as possible:

Everybody was saying that if your medical examination was ok then you’ll get Visa in one or two months. So I thought it might be March or April to get the Visa and then we can move here in maybe June, then there was enough time for us to get covered then because my wife was due in uh September. So I thought that would be ok we will get coverage, but that didn’t happen and everything was postponed.

The risk of having their family separated or facing further delays in submitting another application for their newborn factored into their decision to immigrate immediately, deliver during the three-month wait period, and their willingness to pay for any necessary services:
I don’t know what we do so we thought that it might be the cost of something like um five to ten thousand dollar maybe or whatever…we find out later, but the baby will be with us.

In coming to terms with their lack of control over their circumstances with the timing of the pregnancy and the policy, Kavi said, “No one can control that, it was just a matter of fate or something like that for us. So the government can’t control that and we can’t control that, it’s just a matter of destiny”.

Niraj and Rajni also tried to prepare for their immigration and pregnancy simultaneously, although the unpredictability of both resulted in them landing in Ontario when Rajni was eight months pregnant. Faced with the same difficult decision Kavi and his wife experienced, and being aware of the three-month wait period, the family decided to immigrate to Canada immediately after getting their visas. They arrived in Canada in September 2012 and within a week sought care at the CVC. Niraj explained how he and his family tried to plan the time of their landing and their delivery around the three-month wait:

They told us it [their visas] will come in like ten months [from September 2011], right….but it was postponed… meanwhile our planning was right…so we move here in seven months [when Rajni would have been five months pregnant] and then the three months [of the waiting period from June to August, 2012] and after four months [in October 2012 when Rajni is due] it will do…that was our plan, but it takes time.

Rafa and Harshad also received their visas during the late stages of their pregnancies, however, unlike the families above they delayed immigration so they could deliver their babies in their home countries. Rafa, a dependent applicant of her spouse, was about seven months pregnant when they received their visas. The family realized that this meant they would have to deliver the baby during the three-month wait period if they immediately left for Canada, so they chose to delay their departure. Rafa explains:
I think I was seven months...I cannot come to Canada to deliver even if you have
the visa...because there is this three-month waiting period, so something really
difficult because of this with no insurance.

Harshad’s family also made the choice to deliver their baby in their home country
because they did not want to put the mother or baby’s safety at risk by traveling late in
the pregnancy. By waiting until after their son was born, the family had to then add their
baby to their application package and wait for the new package to be reviewed. In total,
the process took ten months, from the time the couple received their visas to their time of
departure with their son. He explained the process:

We all three got together because everything was ready for us by the time he was
born. We are already approved and then we added him at the end...because she
was pregnant, she was pregnant for seven months. How can we take her on the
plane at eight months?

4.2.3 Private Health Insurance

Information about the three-month wait period distributed by CIC includes their advisory
for all new migrants to purchase private health insurance before arriving in Canada. The
CIC does not, however, provide details on the types of private health insurance plans
offered, which can differ depending on one’s country of origin. Private health insurance
plans available for new permanent residents are usually in the form of travel insurance
plans and can vary in the duration of the coverage. While private insurance covers new
permanent residents for the three-month wait period, participants regarded these services
as limited and less comprehensive than publicly funded health insurance. Private health
insurance plans purchased by participants did not cover any pre-existing conditions,
including pregnancy and other chronic illnesses, or any care not requiring hospital
admission. This section features data from three of my participants (out of 10) who chose
to purchase private health insurance, all of whom were seeking either prenatal or
obstetrical care at the CVC for their pregnancies.
Purchasing private health insurance to cover complications throughout the pregnancy or during delivery was one reason these families decided to purchase coverage. For those who immigrated late into their pregnancies, private health insurance plans were of little use because maternity is considered a pre-existing condition. Kavi and his wife decided to immigrate to Canada immediately after receiving their visas, while Kavi’s wife was in the late-stages of her pregnancy. Aware of the three-month wait period and the possibility of incurring out-of-pocket costs to pay for the delivery and prenatal care, they chose to purchase private health insurance to safeguard the family in case of any complications with his wife. He elaborated on his choice saying:

First of all, I got the information of the private company in India when I got the Visa. I went to the consultants, I was taking advice, so then I contacted them and they told me of the way of insurance and what it covered and everything. Then I asked my uncle here [in Canada] because I know they are doing the same thing, ‘Is this beneficial or should I take it or not?’ They told me, ‘That’s fine you don’t need to, but if your wife is pregnant we’ll have insurance in case we have difficulty or something like that, anything can happen.’

While in the late stages of pregnancy, and during the three-month wait period, Harshad’s family purchased private health insurance. Without any primary care options covered by their private health insurance plan and none publicly available, Harshad’s family found themselves in a difficult position with respect to obtaining or accessing prenatal care without accumulating significant debt. Their family attempted to access care at CHCs, but they were informed that they would be placed on a waiting list and it would likely be a month until they could be seen by a doctor. Harshad explains their difficulties:

Yeah we were aware, I took my health insurance from my country when we came. It’s only for admittance, …but like if you’re not very sick the hospital will not make you admit, so only you have to go to the clinic. The clinic I will have to pay [for] from my pocket and it will not be covered by the insurance.
4.2.4 Preparing for the Three-Month Wait Period

Some participants employed strategies other than or in addition to purchasing private health insurance to prepare for the three-month wait period, such as packing medications, and limiting their physical activity. This section discusses the plans participants devised to avoid seeking care during the three-month wait period and the extent to which these approaches were successful in preventing them from needing medical help.

Packing medications before migrating was a common strategy used by participants to avoid seeking care during the wait period. This was especially the case for the participants who previously worked in health services, such as nursing and physiotherapy, who had professional knowledge about and experience with treating various health issues. Kamal, a physiotherapist in Canada and former physiotherapist in India said “So what I did is I packed some of the medications, the basic medications from India, in case of any problems [because I knew] I cannot go and see any doc.” Rafa, a nurse in Jordan before migrating to Canada, was aware that her daughter’s urinary tract infection (UTI) required a physician’s medical attention and could not be treated with the medications she packed. Even after packing medications to try to circumvent having to see a doctor, her daughter’s urinary tract infection was unexpected and beyond her control. Rafa said:

Actually I tell you the truth because I’m a nurse, I take some medications with me um, but um…now I’m asking, I need a physician for my daughter, you know. I cannot treat her with medications that I have for something like for fever, something simple. But now she’s having infection UTI and, you know, I need a physician…I’m trying to manage the kids but this is something I cannot control.

Limiting physical activity to avoid injury or sickness during the three-month wait period was another strategy used by a participant to prevent needing any medical attention while they did not have OHIP. Larry described how he used this strategy:

Yeah I was also in the three-month wait period, so I was so careful not to hurt myself. I just sit because we don’t have OHIP from that time and I don’t know if
there is that thing [the Scarborough Community Volunteer Clinic], but I didn’t know that then.

4.3 UPON LANDING

For the participants of this study and their family members, finding medical help during the three-month wait period was met with challenges, even among those with private health insurance. The barriers to care at various points of service will be discussed here, including: community health centres, midwifery services and walk-in clinics, and the Scarborough CVC. The participants’ experiences with the process of applying for OHIP following the three-month wait period will also be reviewed.

4.3.1 Community Health Centres (CHCs)

Community health centres (CHCs) in Ontario provide primary care, as well as other health promotion resources and activities. They receive varying amounts of funding to provide care for residents who are uninsured and who reside within the defined geographical area of their community or catchment area. Although those in the three-month wait are among the uninsured populations served by CHCs, issues arose for my participants that prevented them from accessing care. The two barriers explored here are refusal of care at CHCs because the centres were full and being outside of an available CHC’s catchment area.

All participants (3/10) who sought care at their local CHC were told that they were full and already operating beyond their capacity. At some CHCs, participants were also refused up front because the CHC waiting list was already too long. One participant shared her experience trying to get a physician for her daughter’s UTI, saying:

We tried to look around the area and the system we could really not understand. Community centers, there is two nearby, but they told me that they are full and they are not taking any new patients right now. We ask what to do because she’s not accepting us, and she told me since May [for five months] she’s not receiving any new patients, since May! (Rafa)
Participants with pressing health concerns, such as a late-stage pregnancy, were persistent in their search to find care. After two weeks of several failed attempts to seek care at several CHCs, for his pregnant wife, Niraj finally found the CVC. He described their experience saying, “We heard a lot like community centres that does a lot for newcomers and immigrants who doesn’t have this health card and there are many who we called, so many but I didn’t hear any replies from them...They said it would be a month”.

The unequal distribution of resources and demand between CHCs serving different catchment areas and neighbourhoods greatly impacted these participants’ ability to access care during the three-month wait period. Several participants who struggled to find services at their local CHC looked outside of their catchment area to get care from other clinics. In his search for prenatal care for his wife, Kavi was desperate and tried to find help “Anywhere in Toronto region just anywhere...we visited so many community centres in Brampton and we called surrounding areas everywhere.” Some CHCs with the capacity to accept new clients still refused the participants because they were not living within the CHC’s catchment area. One participant described her family’s difficulty with this systemic requirement, “Now who gets help, they told us that they have services for newcomers and that’s fine and I have talked to the community health centres and they have told us it’s not in our geographical area” (Rajni).

4.3.2 Midwifery Services and Walk-In Clinics

Midwifery services in Ontario are funded by the MOHLTC to provide services to pregnant residents in Ontario, and they do not require OHIP or out-of-pocket costs. One participant still encountered difficulties accessing midwifery services for prenatal care because the midwifery services in their catchment area were full. They visited the Salvation Army for help, where the Salvation Army staff directed them to the CVC. With the help of a public health nurse from the CVC, Kavi spoke glowingly of this nurse who advocated on their behalf as he spoke of his family’s experience:

It was a great story when Joan…referred us to the midwife service centre. But I called them and they said they are full and can’t help us. They referred us to
another midwife, and we call them, and they said ‘We are almost full, but maybe I can write down your information and we will call you back, but that might be small chances that you get admissions.’ But then we called the nurse Joan and I don’t know what she did, but she called them and she call us back and she said ‘There is a good news for you and you can get admission there.’

Walk-in clinics were another point of care that one family in the study attempted to access. After only being in the country for two weeks, Niraj and Rajni began searching for a physician because Rajni was eight months pregnant. They first presented at a walk-in clinic and paid for services out-of-pocket so that they could get immediate medical attention. The fear of debt from continuing to access and pay for services at walk-in clinics caused the family significant anxiety. His wife, Rajni, spoke of their experience at the walk-in clinic:

They tell us we can come here [to the walk-in clinic] but the problem is that we have to pay for the check-up, but the check-up costs a lot for us and the problem is that we are unemployed for the time and that is a big problem for us and um…Now the first thing is the baby and preparing for that.

4.3.3 Finding the Scarborough Community Volunteer Clinic (CVC)

Participants were referred to the CVC by family and friends, community organizations, and various health and social service agencies. Family and friends were a key link as participants tried to navigate health services, including the CVC. They helped to connect participants either directly to the CVC or to another community organization that then referred them to the CVC. Kavi described his family’s process of gathering information from different resources before eventually finding the CVC:

My uncle, one of his family is here in Scarborough, so they contacted him and reference him to the Salvation Army here in Wood Centre I think...Yeah so we got an appointment with her and then she direct us to here the volunteer clinic.
Another participant, Harshad, learned about the CVC from a friend and at a government service centre, known as ServiceOntario. He explained how he was hesitant to tell the CVC staff that he had private health insurance because he knew the clinic was only for those who did not have medical insurance and thought that his family would not qualify for care at the CVC. He said:

One of my friends who came here, she just let us know to come here because we were not aware. Last week we went to Service Ontario and they give me a paper also...because I told them about my insurance [which] is only valid if I’m admitted…. So I did not tell anyone [at the CVC] because if I tell them [the CVC staff] they will think I have got the [provincial health] insurance.

Community organizations and services also helped direct participants to the CVC. One family mentioned learning about the CVC from an ethnic community organization and another participant learned of the CVC at a volunteer fair at the public library.

4.3.4 Applying for the Ontario Health Insurance Plan (OHIP)

None of the participants experienced difficulties when applying for OHIP, which was an unexpected finding given the dominant portrayal of confusion and significant delays regarding immigrants’ experiences related to OHIP featured in the research literature. One participant described his experience as “Quite easy, everything is there and all the information. So I just signed there and everything was supported, so it was easier not that difficult” (Lalit). This finding is contrary to previous studies (Caulford & Vali, 2006), which cite administrative delays of up to 2.1 years for processing OHIP coverage (Caulford & Vali, 2006; Elgersma, 2008; Goel, 2013). The OMA (2011) also presented conflicting estimates of processing times for OHIP approval as anecdotal evidence from a physician working at a tuberculosis clinic who claimed that some immigrants got OHIP coverage quickly.
4.4 IMPACTS: Effects of the Three-Month Wait Policy on Accessing Care

While applying for OHIP did not present study participants with the difficulties I anticipated, navigating Ontario’s health care system can still be a frustrating and time-consuming experience for newcomers to Ontario; which can have significant impacts on their health. The participants in this study identified a number of health issues they experienced during and associated with the three-month wait period, namely burden of debt, and stress; each of which will be discussed below.

4.4.1 Out-of-Pocket Cost of Care

The most frequent and expensive service participants feared having to incur debt for was pregnancy related costs, such as prenatal and obstetrical care. As previously mentioned, the availability of midwifery services in the Greater Toronto Area (GTA) has been extremely limited with many new permanent residents unable to get even prenatal care for their pregnancies. One participant’s experience paying for the cost of labour and delivery at a Scarborough hospital will be discussed.

Kavi and his wife planned to deliver their baby in-hospital because they believed it would be the safest option. Even with private health insurance, this family also had to pay the full cost of an in-hospital delivery. Kavi explained that even though they were prepared to absorb the cost of the delivery with their life’s savings to protect the well-being of the mother and child, the costs were very high:

If everything goes right…then um…maybe just the one day charge that you have to pay, that’s about $1100 and then the $50 extra for the laboratory charges and then that’s it… we tried to ask if there is any discount or installment plan or anything and they said you have to pay all here.
4.4.2 Stress

Combined with settlement stressors, such as finding employment, housing, and adjusting to a completely new way of life, some participants experienced high levels of stress that impacted their mental health. The effect of these stressors on participants, including their feelings of vulnerability related to their limited access to publicly funded health services, will be examined.

Participants who were in the late-stages of pregnancy upon arrival to Ontario experienced profound stress as they tried to learn about and navigate Ontario’s health system for prenatal and obstetrical services. Kavi’s wife was due one month before the end of her three-month wait period for OHIP, so their family dedicated all of their time and resources to ensuring a safe pregnancy and delivery. The family based all other settlement decisions on how it would affect the pregnancy and getting care. Kavi described how the family’s main priority was managing the pregnancy:

I was just worried about the pregnancy and where will we get the service for my wife, and then we can decide what to do then after, like how to run our household, do volunteer work and then apply [for jobs] hopefully.

Kavi’s extended family helped to relieve some of the couple’s stresses by assisting them in finding health services for the pregnancy during the three-month wait period. He explained the crucial role his extended family played:

It was a stressful one month actually, we are contacting everyone we already know. Actually my aunt is here and she’s [working] in Toronto health service. She was a lot [of help], she’s helping each and everything for us, for all possible way to cover the cost or to get decision done. It was stressful, but still we got to make the decision.

In some instances, the pressures and challenges of getting care during the three-month wait period exacerbated other settlement stresses participants experienced. The early settlement period is often new permanent residents’ first exposure to Ontario’s
environment, which is drastically different from their countries of origin, Rafa explains the difficulty her family had:

Everything got changed and my daughter having a UTI, everything there’s stresses in everything and it [our health] has been compromised… three months, what to do and this system even if you have the card and the notice, they will not accept us at our community centre…we would have to go find physician and this is another issue…I find it very difficult and thank to God that no one get sick but the winter is coming and snow and everything like that and we have never had that.

Participants also expressed fear about not being covered for any primary care needs. Kamal’s knowledge of the three-month wait policy as well as the limited services covered by private health insurance plans, rather than relieve his concerns, only contributed to his heightened awareness of his vulnerability during the wait period. Five years after being in the three-month wait period, he vividly described the anxiety he felt during the three-month wait period, even without any chronic or emerging health concerns:

Yes I felt sick, not regularly but occasionally once a year or two times maximum. That’s all, but that’s just to say when they said we had to wait three months automatically we become sick [laughs] that’s just how it works [laughs] oh they say we have to wait three months so my mind is all the time scared to get sick so automatically I get sick.

4.5 Conclusion

In this chapter I explored the effect that decisions made at different times during the immigration process had on my participants’ ability to access health services during the three-month wait period. In trying to understand the expectations and understandings participants had of Ontario’s health care system and the wait period prior to arrival, the data presented here demonstrate varying levels of awareness and understanding of the policy. Most participants were aware and well-informed of the process and what was
required to get OHIP, as well as other health insurance options during the three-month waiting period. This is an important finding because it illustrates how these participants were conscientious of and continuously attempted to manage the effects of the policy on their health throughout the immigration process. It is also contrary to most literature citing the difficulty new permanent residents had in applying and getting their OHIP cards (Caulford & Vali, 2006; Elgersma, 2008).

Participants dealing with pregnancies faced a series of especially challenging situations, particularly as they tried to juggle the equally unpredictable and stressful events of having a baby and immigrating to Canada. They were very active in trying to learn more about the policy and their health care options before choosing to immigrate. The data illustrated, however, that their research and plans, were very dependent on the timing of their immigration, which was largely out of their control because of the unpredictability of the processing times of applications. Other precautions exercised by participants before arriving in Canada consisted of packing medications and purchasing private health insurance. For some participants, these safeguards were still minimally effective in helping them to avoid seeking and securing primary or prenatal care during the three-month wait period.

The extent to which participants could draw on informal resources, such as social networks, greatly impacted their ability to find the CVC and access the care they needed. Participants’ choices for seeking care during the three-month wait period were constrained by their ability to pay for health services directly because of the limited availability of publicly funded health services for the uninsured at CHCs and midwifery services. To varying degrees, delayed care, out-of-pocket costs, and stress were the main impacts of the policy on participants, but could be mediated by informal networks, such as family and friends, as they could assist in finding care faster, minimizing expenses, and thereby also relieving some stressors.
Chapter 5

5 The Three-Month Wait Period: Exploring the Perspectives of Healthcare Providers

5.1 Introduction

This chapter focuses on three main themes that arose from the four semi-structured interviews I conducted with three public health nurses and one doctor from the CVC. The first theme explores the participants’ experiences with advocating for their clients within a health care system that, at times, constrains their duties to serve their clients. These situations raise a series of ethical considerations related to the tensions they experience in their attempts to coordinate care for vulnerable clients within a structural setting that does not always make room for them. The second theme illustrates the types of partnerships developed to facilitate care for clients without public health insurance, both between and across health and social services. It also discusses the challenges that can arise between providers who disagree about the level of access these clients should have to various services. The third theme explores the influence of politics on the provision of care to those in the wait period, specifically the Ministry of Health and Long Term Care’s response to those advocating for an end to the three-month wait period, and the effects of political discourse surrounding recent immigration policy changes. Specifically, these immigration policy changes include cuts to the Interim Federal Health (IFH) program and the introduction of Bill C-31, Protecting Canada’s Immigration Act (2012).

5.2 ADVOCACY

5.2.1 Ethics

Ethical principles, such as respect for the autonomy of the patient, beneficence, non-maleficence, and justice, guide the work of healthcare providers as they seek to protect and promote their clients’ well-being. Healthcare providers in my study had difficulty fully providing and negotiating these duties to those in the wait period because of the
ways in which the policy excluded these people from the care they needed and put providers in emotionally and professionally untenable situations. With recent immigration policy changes that further restricted some migrants’ access to care, serving those in the three-month wait period has become even more challenging. CVC staff indicated feeling like they still have a responsibility and professional duty to serve patients in need of care, no matter what other providers do or the kinds of coverage policies or conditions their patients had. They were very hesitant to deny care and part of the ethical approach to advocating on their clients behalf, for instance in situations where they could not accept or serve certain clients for various reasons, was to refer them to other healthcare providers who they knew would accommodate clients without OHIP. One nurse, Elaine, explained:

At the point we see it...who will help him if not for us? Right, because he will be scared to go to the hospital if he does not have enough money, right, like if they charge him where will they get the money from? Right...how can you turn them away especially like if the child will come here?

Advocating for clients’ access to care, regardless of immigration status or ability to pay, was an ethical matter related to social justice for healthcare providers at the CVC because they realized the potentially catastrophic health consequences of refusing people care. Thankfully, at the CVC, staff were not forced to deny care on the basis of immigration status or ability to pay, although they did have to become more selective about who to treat because of the increased demands placed on the clinic. Advocating for client care grew more important, not only for services beyond the CVC, but between members of the CVC care team. Due to increasing caseloads, working together efficiently by clearly outlining and advocating for their client’s needs to each other was essential for the staff to continue to be able to serve all of them. The staff’s sense of duty to help everyone who presented at the clinic became the most evident in the face of increasing caseloads. One of the public health nurses at the clinic said:

I think that’s what keeps me going because we see it’s tough but it’s crazy for people they can’t manage if we stop and I think that’s why the doctors come, it’s
not so much the care they’re giving but the alternative for people we can’t imagine it (Joan).

In February 2012, I attended the Seeking Solutions Symposium in Toronto, on access to health care for the uninsured in Canada, which acted as a supplementary form of data collection and an opportunity to sit in on current debates and discussions directly related to my research. At the symposium, I learned about a meeting between several health services stakeholders and the MOHLTC that was planned for March. The doctor I interviewed at the CVC clinic, Fred, attended this meeting and explained during our interview that the goal of the meeting was “Advocating for the end of the three-month wait because of the various reasons that would be ethically inappropriate from a healthcare perspective.” He discussed the challenges encountered when weighing the ethical issues of basing care on the ability to pay or denying care, as posed by the three-month wait policy. He saw this as a matter of social justice and he felt a strong obligation to express his concerns regarding the adverse health consequences of the policy at the meeting with the MOHLTC. The negative effects of the policy, which he witnessed on a daily basis in his practice, included progressed diseases and acute episodes from delays to care. He described the three-month wait period as part of a set of “very regressive policies of not treating patients who are, you know, even acutely ill. The inhumanity of that is obscene and it’s a gross injustice”. He explains that anything less than the full coverage of OHIP that all other residents of Ontario receive is unacceptable:

It would really mean a system of health care far less than you and I experience. So it becomes a second-tier, another apartheid approach to healthcare um…it becomes a set of artificial rules so… it remains unethical… what we’re interested in is equality.

5.2.2 Coordination of Care

The CVC played a significant role in helping those without OHIP, not only through providing primary care, but also by referring clients to other healthcare providers or services throughout the community. The healthcare providers at the CVC found that
advocating for care beyond the CVC for those in the three-month wait was especially difficult because of the way the policy systematically limited access to health services to only those who could pay for it. Connecting them to points of service that are publicly-funded was also challenging because of the overwhelming demand placed on them to serve those who are uninsured for various other reasons, such as no longer qualifying for the IFH program, being non-status, or having a lost health card. Whether paying for services or accessing publicly-funded care, CVC staff still had to advocate for their clients and make a case for each of them to get care because of the level of resistance they encountered from other institutions and service providers. One public health nurse described the situation:

     It affects everybody it’s just a matter of now you have to be thinking that much more about finding help for that person um…It’s a lot more work, so I guess in a sense it could be burdening us as well because you have to do more outreach you have to advocate for the client more and you have to see you have to work for the system as well as against it to find a way around the loopholes so it’s affecting everybody (Dante).

Another public health nurse illustrated how other healthcare providers throughout the community were also being affected by the three-month wait period. She explained how hesitant some healthcare providers were to accept her referrals because of the overwhelming demand they were also trying to cope with. She explains the importance of advocacy when she makes referrals for her clients to other services because she is often met with such resistance. She says:

     If I have to turn someone away I have to try and find them some other options and do some advocacy to try to get them into another CHC… You have to go through the clinical or medical director and make a case for it…It’s all about advocacy for either the client to be able to advocate for themselves or someone to advocate for the client to get them into the clinic, but it won’t happen any other way (Joan).

     The same participant described how coordinating referrals to social services, such as shelters, has also become more difficult following immigration changes introduced
earlier that year, particularly the cuts to the IFH program and the introduction of Bill C-31. Changes to the IFH program significantly limited services or completely removed any health insurance coverage for different categories of refugee claimants. The enactment of Bill C-31, among other changes, meant the implementation of the Designated Countries of Origin (DCO) refugee claimant category. This refugee claimant category is made up of claimants from countries on the DCO list, which is comprised of countries CIC considers “safe” and unlikely to produce refugees (CIC, 2012). Refugee claimants from any country on the DCO list will have their claims processed faster and their hearings scheduled sooner, during which time these claimants will not have any healthcare coverage (CIC, 2012).

The impacts of these recent immigration policy changes further limited access to care for several categories of immigrants and compounded the challenges frontline providers in health and social services sectors were already facing. These changes had the effect of making access to services systematically more inequitable and required staff to advocate for their clients more. Joan said:

It’s very, very hard, very hard because now with all the changes in health and immigration the shelters are full and they’re not moving out fast so when we try to get someone in there it’s taking a lot longer so all systems are pretty much over burdened with changes coming now.

Joan described the stress and pressure she experienced trying to get her clients care working within these health and social service systems that were already overwhelmed. She explained the barriers she faced advocating for her client’s care beyond the CVC and how compromised their situations could become if they had time-sensitive issues, such as pregnancy or an advanced illness. The longer it took for her to get them help, the more complex their situations would become through the progression of their conditions and, in turn, so too would the challenge of getting them care. She remarked:

Yeah so it’s exhausting, it’s exhausting because I think before the refugee cuts and changes I knew I could work with the number of referrals but now I’m getting more referrals and they’re more complex and the system and the pathway is less
assistant to my referrals so it’s really hard…I’ve got time constraints with the situation people are in so on my end it’s pretty hard.

5.2.3 Outcomes

Two healthcare providers also discussed the burden the three-month wait policy poses to not only health services staff, but also to the healthcare system as a whole. Both of these participants explained that although the nature of the healthcare needs of those in the wait period are the same as other clients, the policy produces different outcomes for those in the wait period; including forcing people to have no choice but to delay seeking care. The decision to delay care can have the indirect impact of increasing their vulnerability to the progression of their condition. Two of the healthcare providers explained how treating advanced conditions increases the possibility of an acute episode requiring emergency care or increases the risk of complications if clients affected by the policy chose to seek medical attention after the three-month wait. Fred explained that the risks generated by delaying getting care can result in increased use of emergency care services or tertiary care:

They present with the same problems, they present with common colds to cancer…they pose the same risk to themselves of ending up in hospital and end up getting worse with complications. They pose the same potential of unmet needs they, they remind me of Canada before there was OHIP people just scrambling for care almost like a medical hazing that they have to go through to prove that they belong here.

The three-month wait period leads to delays in seeking and accessing health services, and these delays can translate into health conditions that are more serious and require treatments and services that are more costly for the healthcare system. Increased use of emergency and tertiary services, in turn, have the combined impact of costing the healthcare system more on an even larger scale because of the systematic barriers the three-month wait policy creates for primary and preventative care. The inequitable health outcomes the policy may have for new permanent residents can also, in turn, have
negative consequences for all residents of Ontario because of the way in which it can endanger public health, drive up healthcare system costs, and place an additional demand on healthcare providers both during and after the three-month wait period. Dante elaborated on the potentially negative effects the policy can have for the providers trying to find these people care and the healthcare system as a whole:

People will be keeping their disease or illness to the point where they’ll need to be hospitalized and that’s a burden on health care that’s a burden on everybody really because that’s a case where it could have been prevented… there’s going to be consequences and we’re seeing the consequences now.

5.3 COMMUNITY COLLABORATION

5.3.1 Partnerships and Coalition Mobilization

With limited resources dedicated to serving those without publicly-funded health insurance, health and social service providers throughout the city of Toronto have developed both informal and formal partnerships to secure resources to treat these clients. Informal partnerships consist of agreements healthcare providers made between their colleagues and professional networks, usually for consultations or referrals. Formal partnerships are mainly made up of contracts for material resources, such as funding, staffing, and space. In the following section the establishment of the CVC and the experiences of staff members interviewed, many of whom were integral in this process, will be used to demonstrate ways in which such partnerships were created.

The impetus for the establishment of the CVC (c.2000) grew out of the collaboration between health and social service providers, who identified the unmet needs of the medically uninsured populations in Toronto as a significant problem throughout the community. Frontline providers became more aware of the growing population of the medically uninsured populations in Toronto and the problems associated with getting them care through existing points of service, which many of them worked in and witnessed the problems those who were uninsured presented with. Frontline providers were also aware of how some CHCs throughout the city were overwhelmed trying to
serve the uninsured population, and in some cases were unable to. Part of this problem was the unequal allotment and distribution of resources and funding between CHCs to serve the uninsured population in different areas of the city. One of the public health nurses refers to this as she discussed the situation CHCs throughout Toronto were in before the CVC was established:

We were realizing there was a three-year wait with the only CHCs in Scarborough for someone who didn’t have a health card to [see] a doctor, three years! [Now] Heritage is probably like two years, Bell View is closed, so a lot of the CHCs are closed. Then some of the other CHCs are in areas where they don’t have a lot of need and some of them were sending back money to the Ministry, so that’s why Central Centre, they’re trying to pull together and work together with the CHCs because some of them are just so overwhelmed (Joan).

After coming to this stark realization of the potential scope of the problem throughout the community, Joan partnered with the current Scarborough CVC Medical Director and a member of the Patient Services team at a local hospital to determine the extent of the problem and the best way to address it. During discussions with the other frontline providers they got to be involved, the types of conditions people without OHIP presented with at their respective settings, and the growing magnitude of the medically uninsured population in Scarborough were prominent issues. They found that medically uninsured community members presented at the hospital frequently and shelters were also seeing numerous clients in need of medical care, but without OHIP. Discussion then grew around developing an alternative point of care that would deliver the same quality of care that anyone with OHIP would receive. Joan described the range of the problem within Scarborough and Toronto:

There’s this big problem in the community, and there’s a big problem with the hospitals. For someone to be sitting and waiting in the waiting room and not seeing the doctor, but having a problem. We were concerned that this is one person, but if there’s more than this is a really big problem… so we pulled
together a small group at the table with him [the CVC Medical Director] and he said yeah the problem is definitely overwhelming and it’s huge in the community.

They sought to establish a clinic, and did so via the CVC, that would deliver the same quality of care as any other primary care facility in the community. Various stakeholders serving those who were medically uninsured came together to form a coalition that would share resources, including professional networks, staffing and funding. These coalition members consisted of representatives from the local hospital, shelters, settlements agencies, and midwives. Joan explained:

Well we had formed a committee and the shelters were on that committee, we had community services on board, so we had a network, oh and settlement service agencies were at the table, so we could get referrals for them.

The CVC was established in 2000 after coalition members secured a clinic space for one volunteer doctor and two public health nurses to serve residents of Scarborough without OHIP. Coalition members leveraged various resources by working within their professional networks and organizations to get dedicated staffing, funding from community organizations, and developing agreements to refer clients to other healthcare providers outside of the CVC. With very limited funding, and a clearly defined need within the community, the Medical Director began by recruiting volunteer doctors from within his group of medical colleagues. Joan recalled:

He pretty well begged his friends, like you know, his other family physician friends to volunteer one week once a month. And in the beginning we had like ten doctors who volunteered once or twice a month.

She went on to elaborate on other favors and agreements they managed to get for the clinic. One of these included a partnership with a diagnostic lab, which was crucial to managing their budget and saving their funding. Joan said, “We were really getting favors all the way along and Dr. X asked a favor of the diagnostic lab he refers his clients to and he got six months of free diagnostics which is really amazing.” To assist them with referrals, particularly for pregnancies, and to have support staff during regular clinic
hours, other community organizations committed portions of their funding and some of their staff to the CVC. Joan clarified:

A lot of our money was just going to getting obstetrical care…that’s why with midwifery they can have the baby at home so um that’s one of the coalitions we have, and with Community Services they give us a nurse…that comes and helps us and that’s part of their homeless budget with Holy Spirit so that’s amazing for us to have that.

Hospital administration staff members were also part of the initial CVC coalition, and they assisted clients from the CVC by working with colleagues to develop payment plans for clients without OHIP and training their staff in how to assist this unique group of clients. While the partnership ceased a few years after the establishment of the CVC, Joan spoke of the significance of the support they had previously provided:

She [Patient Care staff member from the local hospital] sat and helped us with training with the staff on the needs of the uninsured and creating some awareness on the issue in the community. And she worked on getting a lot of more concessions from the hospital…they would have payment plans with people, which was quite a feat for the hospital at that time. And the hospital helped with organizing some of the doctors so we had some administrative support.

After thirteen years of managing the CVC, Joan reflected upon some of her concerns with maintaining the partnerships the clinic was built on. Given the substantial increase in patient volume following recent immigration policy changes, sustaining the support of the volunteer doctors was one of her main priorities. She reasoned:

Since our numbers have been increasing, I have to be a little tougher because we don’t want to burn out our doctors. You know they’re working from 7.00 or 8.00 in the morning and they’re exhausted and this is really complex. We’ve had some of these doctors from the beginning, I mean it’s been thirteen years and it’s not getting better, it’s getting worse with the volume! So it’s just we want to give some support to our doctors and help them out.
5.3.2 Inter-Professional Tension

Ideas held by other health and social services staff about which immigrants deserve which kinds of health services often informed the manner in which CVC staff were treated when they advocated for their clients. Negative attitudes from staff at other healthcare facilities, particularly providers and administration staff, were issues that one public health nurse encountered frequently. From the perspectives of these study participants, such sentiments were related to the increasing number and frequency of migrants without OHIP presenting at the hospital seeking care. Joan described one phone call during which a hospital staff member directly attributed abuses of the healthcare system to the CVC because of his/her belief that facilitating care for those without OHIP was encouraging people to take advantage of the healthcare system. She said:

We’ve had healthcare providers who don’t think we should be doing this and we’ve had them say ‘we’re more burdened’ and ‘more people are coming to the hospital’ because we’re doing this, you know…They won’t work with us and they have that attitude towards people and working with them...One woman said ‘more people are coming to Canada because they know the clinic is there’.

Joan felt that the work of the CVC actually helped people to avoid presenting at the hospital, and that their clinic was actually saving hospitals time and money. She went on to say:

They’ll probably be coming to emerg you know we’re saving them work actually because if the clinic wasn’t there, they’d probably just present at emerg with worse conditions...Yeah but that happens a lot that kind of sentiment.

Joan worried about the long-term effects of the IFH cuts and Bill C-31 impacts, which both left several categories of refugee claimants without any healthcare coverage and significantly increased the CVC’s client volume. She anticipated that relationships between healthcare providers serving the uninsured population will become more strained in the future:
I think there’ll just be a lot more clients and I know and I think the anger towards the community helping them will grow and why am I supposed to see them, that feeling will grow and it’ll be harder to get their services and maybe healthcare providers…It’ll be harder to get understanding from the community that we’re in.

She went on to say that budgets will likely only become more heavily prioritized, especially over the needs and special requests made by those serving clients without OHIP. With the uninsured population already rising from the recent immigration policy changes made, Joan was skeptical that relations between hospital staff and those advocating for care for the uninsured would improve. She thought that the frequency of special requests they would have to make for their clients would increase significantly as a result of the policy changes and hospitals would grow more opposed to accommodating their referrals. From her past experiences, Joan also observed that her requests for services were more often met with a negative sentiment during times of financial difficulty for hospitals and this would only be made worse due to their rise in client caseloads at the CVC. She explains:

It happens more when there’s a big deficit and those institutions are under a crunch somehow and we try to get some leniency for a bill somehow we get that kind of talk yeah…finance is about money and dealing with the deficit and the bottom line at the end of the year.

The pressures hospitals face to meet tight budgets can influence attitudes within medical settings and the levels of accommodations hospitals can or are willing to make, and for whom. Some CVC clients were denied services or charged differential rates for services between hospitals as a result of the varying policies and attitudes hospital management teams could have towards those without OHIP. Joan explained that her clients could be treated differently in the rates they were charged for services because of the lack of standardized costs for procedural and registration fees between hospitals. She explained how the three-month wait period leaves clients vulnerable to excessive debt for services not covered by private health insurance, such as obstetrical care. Joan illustrated how these differential rates were borne out by hospitals:
If you deliver at the hospital they can charge you between $800 to $1200 per day...And that’s just at some places, others can charge $1800 a day...Well it depends on if they can pay it but if they overstay and they can’t pay it, they can be really nasty, you know.

The reservations other healthcare providers have about treating clients without OHIP stemmed less from their opposition to helping those in the wait period, but from how much they believed they could help a client if he or she did not have access to diagnostic tests or necessary medications. Joan described how some doctors were concerned about the extent to which certain clients could follow their treatment plans, and how they would be compromising their quality of care if they provided an alternative treatment plan to accommodate for their lack of access to diagnostics and medications. Restricted by their patient’s ability to pay and their practice’s resources to provide for any necessary medications or diagnostic tests, these doctors were hesitant about providing a standard of care lower than those with OHIP receive. Joan said:

There are doctors who try to do their part in their own family practice if there is a patient with no health coverage and that’s why they would send them to us…I think it’s really not because they don’t want to help but it’s like if I order blood work, who’s going to pay for that blood work? You know as a doctor, if I have this care plan…it compromises their care if there isn’t an ability pay, like if I order blood work, who’s going to pay for it? It’s sporadic care.

Specialists who Joan reached out to for assistance with some of her cases were limited in their capacity to help because of hospital policies and regulations, as well as the difficulties with arranging the required healthcare teams to assist them through certain procedures. For some specialists, having to work within and for the hospital’s system restricted them from being in a position to offer any help to some of Joan’s clients. Joan illustrated how this affected her situation for one client:

It’s getting very, very hard like right now we’re looking for an obstetrician because we have a high-risk pregnancy situation because you know who’s going to pay the obstetrician and the obstetrician has a surgical assistant and an
anesthesiologist and they all need to get paid and the liability insurance is high because they only have four high-risk pregnancies they’re doing so it might not work for them.

5.4 POLITICS

5.4.1 Ministry Response

In March 2012, healthcare providers and other front-line workers who witnessed the negative consequences of the three-month wait policy had the chance to bring their concerns about the policy to a meeting with the MOHLTC. The CVC doctor interviewed (Fred) participated in this meeting and his thoughts on the Ministry’s response to the policy will be outlined here to provide first-hand insights on current debates and discussions about the policy and its effects for immigrants and practitioners. During the meeting, front-line providers, researchers and a CHC director presented the problems they and their clients had experienced in light of the three-month wait policy. Among the most discussed issues was increased client vulnerability to potentially catastrophic health outcomes related to delays regarding care that are being brought about by the policy. During our interview, Fred said that the post-meeting communications between these providers and the MOHLTC were very strained, with minimal response from the MOHLTC and a lack of willingness on the Ministry’s part to continue discussions regarding the policy. He summarized the outcome of their communications with the MOHLTC:

There’s been no response, no and this has been a fairly typical approach that the Ministry does…it’s what I would call a fairly deflecting attitude and approach. We’ve run into the same level of resistance on the three-month wait as we’ve run into on any other discussion of social justice… so you’d think we had some sort of opportunity on the three-month wait to make some head way but it hasn’t happened (Fred).

The recently introduced IFH cuts and Bill C-31, as previously discussed, have left the issue of responsibility for healthcare coverage in a contentious and ambiguous state.
Fred described how the policies introduced between the CIC at the federal level and the MOHLTC on the provincial level had direct and differential impacts on the services frontline providers could provide for their clients. The combination of these two policies has had the compounded effect of further limiting resources available for the increasing population of those without public health insurance. The arguments posed by the Minister of Health and the Minister of Immigration regarding the responsibility of healthcare coverage between the federal government and the provinces are, in his mind, hypocritical:

Ontario’s Health Minister Matthews had taken Kenney to task as well over this downloading to provinces. The irony of that is that the Ontario Ministry of Health and Deborah Matthews is downloading to us the three-month wait so I don’t quite get where she’s demanding from Mr. Kenney that he not do this to her, but she’s quite willing to do this to the patients and the system and us as the providers…she’s making a huge burden to us to provide this care without resources.

5.4.2 Political Discourse and Ramifications

On July 1, 2012, CIC introduced Bill C-31, which resulted in the loss of all health coverage for some categories of refugee claimants, as well as substantial cuts to services for others that were previously covered by the IFH program for refugees. These changes were then followed by the implementation of the DCO list in December 2012, which effectively removed IFH coverage for refugee claimants from any of the “safe” countries included in the list. In lieu of these changes, the CIC announced that these changes would serve to prevent “bogus claimants” from “taking advantage” of the Canadian healthcare system (CIC, 2012). Interestingly when Health Minister Ruth Grier introduced the three-month wait policy in 1994, she provided the same rationale for the changes as current Immigration Minister Jason Kenney, which was “To protect Canada’s health care system from being abused” (CIC, 2012).
Joan commented on the profoundly negative effects that this official discourse, including its emphasis on ‘blaming the victim’, has had on her relationship with clients, who feel they are being targeted as a group and held responsible for immigration problems beyond their control. Joan found that the CIC’s message sent a negative message to immigrants, regardless of status or length of residency and across migrant categories. She described the ways in which this made her work of helping these people more difficult, particularly when trying to take her clients’ medical histories. She went on to explain how they were hesitant about trusting her and disclosing their information, from fear of deportation:

Most people are scared. They look at me like I’m going to report them because I’m asking them questions to see their eligibility for the clinic or you know what areas they’re at and they look at me like oh why is she asking me these questions and I’m just asking to see where they can get help like are they in a compromised position… people are really, really scared in a climate of um blaming really poor people for the economy or the immigration problems we have you know.

Joan elaborated on how her delivery of care was directly affected by the discourse used by the government to rationalize their health and immigration policy changes. This language produced fear among her clients, especially in the face of controversial cases of deportations and detainments. From her perspective, this leads to a heightened sense of anxiety among her clients when seeking care, particularly in light of highly publicized and more frequently reported incidents where the government criminalizes or deports immigrants in an effort to discourage abuses of the immigration and healthcare systems. She says:

Every time there is an incident, like this person was deported, you can feel in the community that people are like, ‘You know we’re not bad people’ because you know, there’s people saying they’re trying to mooch off the system and they’re causing this problem and people are kind of you know, all getting painted with the
exact same brush. But it’s been more because you know, the government is cutting down on the number of immigrants.

Joan, who works within and throughout Toronto’s migrant communities, spoke of the direct impact the CIC’s new policies has on community members and the way in which it makes many of them feel like they are being targeted. She explains:

That discussion influences the mood and how people feel and you know there’s been a lot of people deported, and when people were getting stopped and people were asking them to show their ID, that was really, really scary for them.

She went on to say that she saw no medical benefit to the policy and without such, it continued to needlessly differentiate new permanent residents’ entitlement to health services from what other residents of Ontario have complete access to. She felt that while the policy has no medical value, it works to take advantage of new permanent residents who cannot influence its reform because of their lack of political power. Joan argued that the three-month wait, together with the CIC’s requirements for three years’ residency for citizenship and voting rights, systematically exclude new permanent residents from the health services they pay into through taxes. She shared her thoughts on the policy saying:

It’s a very discriminating kind of a policy. For someone who is in Canada here and they have to go through three months, I mean they are a new landed resident as soon as they come…and they’re not entitled to healthcare, they’re not entitled to vote to change the policy, and they have to wait three years to become a Canadian citizen, so they don’t actually have any voice but sure yeah we’ll take their tax money.

5.5 Conclusion

This chapter presented the insights regarding the impact of the three-month wait period on the abilities of healthcare providers, in this instance from the CVC, to provide care for this unique group of clients. These data contribute to understanding the lived experiences of those in the wait period, and also offer in-depth insider perspectives on the challenges
faced by providers who struggle against the same structural impediments—via the policy—that their clients do when it comes to finding and distributing healthcare services.

The ways that professional ethical obligations were constrained by various aspects of the wait policy, and thus contributed to significant professional and personal strain, figured prominently in their discussions. These issues also directly affected their decisions regarding how to provide care, which often required them to advocate on their clients’ behalf for care beyond the CVC. Other health and social service providers’ attitudes towards the uninsured population were a significant challenge to helping their clients access services throughout the community. With very limited funding available, building partnerships and leveraging professional networks were key to working within this healthcare system, where CVC staff were often met with negative responses from other service providers. The government’s response to concerns raised about the dangers posed by three-month wait period, as well as other immigration policies that limit access to care for immigrants, had various effects on immigrants’ decisions to seek care and trust healthcare providers. While the government’s rhetoric contributed to the lack of receptivity from other frontline providers to assist the uninsured, it also had the consequence of discouraging the uninsured from seeking the care that they needed.

The challenges and the extent to which these healthcare providers could help clients in the three-month wait period demonstrated the impact of the policy on accessing care. The barriers faced by these CVC staff members advocating for the care of those in the three-month wait illustrated the profound ways in which the policy significantly limits new permanent residents’ access to resources and services. The government discourse used to support the maintenance of the three-month wait policy also negatively affected new permanent resident’s views of the Canadian healthcare system during their initial period of settlement.
Chapter 6

6 Discussion

6.1 Introduction

The primary goal of this qualitative study was to explore the effect of the three-month wait period for OHIP on new permanent residents’ experiences of accessing health services in Ontario. The project’s aims were also to better understand the expectations and understandings new permanent residents have of the policy and Ontario’s health care system upon arrival, its impacts on the lives and health status of new permanent residents, and the kinds of informal resources or strategies they used to cope with their health issues while they waited for coverage. Using a narrative inquiry approach, data were collected from a total of fourteen interviews conducted at the CVC, whose staff provided invaluable insights, time, and access to all of the participants for this study. Ten semi-structured interviews were done with new permanent residents in, or previously in, the three-month wait period who presented at the CVC. Narrative interviews were also conducted with four healthcare providers from the CVC to capture a richer understanding of the effects of the policy on their work and their clients’ experiences of accessing health services. The specific research questions that framed this inquiry were:

1) What expectations and understandings do new permanent residents have of Ontario's health care system upon arrival, including the three-month wait period?

2) How does the three-month waiting period impact the lives and health status of new permanent residents?

3) In the face of the structural challenges created by the three-month wait period, what kinds of informal resources or strategies do new permanent residents draw upon to cope with their health issues?
6.2 Main Findings from the Study

The findings from this study provided answers to the research questions that guided this project and contributed to understanding the effects of the three-month wait period throughout the stages of immigration. The aim of the study was to garner answers to the question of what expectations new permanent residents have of Ontario’s healthcare system and the three month wait period; how the policy impacts their lives and health; and what informal resources or strategies they draw upon to cope with their health issues. The social capital and political economy theoretical frameworks applied to the study also informed my understanding of the data as it related to the objectives of the study.

Both forms of social capital, linking and bridging, were crucial to mitigating the effects of the three-month wait policy as it impacted participants’ lives and health. Before immigration, linking social capital was instrumental for participants as family and friends helped to make them aware of and understand the policy. Bridging social capital was also important upon landing because participants depended on information between their family, friends, and service providers to find the CVC and navigate health services. Healthcare providers also utilized bridging social capital when advocating for their clients, attempting to build partnerships with providers throughout the community, and managing tensions that arose between providers.

Ideas inherent to political economy theory emerged as central to healthcare providers’ understandings of the policy. These participants felt that the maintenance of the policy was motivated by political efforts to control access to health resources, and they found no medical benefit to the policy. They contended that the systematic inequalities produced by the policy only led to inequitable, and increasingly negative, health outcomes for their clients as they often decided to delay care. These structural barriers created by the policy were also seen as having various detrimental consequences, including endangering public health, costing the healthcare system more, and constraining their ability to deliver quality care.
In exploring the expectations and understandings that new permanent residents have of Ontario’s healthcare system and the three-month wait period, the findings from this study have shown that their level of awareness depended heavily on their source of information. Participants mainly learned about the three-month wait policy from family, friends, the Internet, and immigration agencies. Those who were informed about the policy from family and friends had the best understanding of the meaning of the policy and its consequences for their family. Participants who learned about the policy solely from the Internet or an immigration agency were aware of the policy, but had a minimal understanding of how exactly it would affect them. The unpredictability of both the immigration process and health concerns, particularly pregnancy, figured prominently into participants’ plans for immigration as well as their experiences accessing care upon arrival. For the three participants who purchased private health insurance, their health needs were not met by the services covered by their coverage plans. Accessing prenatal and obstetrical care for pregnancies was particularly problematic for these families because all of their health insurance plans considered pregnancy a pre-existing condition. Participants also planned for the three-month wait period before immigrating by packing medications to try to mitigate their need to seek medical attention.

Participants were able to mediate the policy’s effects through leveraging informal resources and strategies to varying degrees. An important issue that figured prominently in participants’ experiences of accessing care was the difficulty they encountered getting care at alternative points of care, specifically CHCs, midwifery services, and walk-in clinics. Accessing care at a CHC was especially challenging for three participants who were refused care because of long waiting lists or because they lived outside of the CHC’s catchment area. Participants seeking care from midwifery services were also denied care because of capacity issues. Walk-in clinics were another point of care that one family sought care from, although they found that paying for continued care out-of-pocket would not be financially sustainable for them. In the face of these structural barriers to care, participants found the CVC through the help of family and friends who were instrumental as the primary step to connecting participants either directly to the CVC or to services within the community. Community organizations, such as the Salvation Army and ethnic community organizations were key for referring participants
to the CVC. Participants without any social supports often initially presented at walk-in clinics, Service Ontario centres, or CHCs where service providers would recommend they visit the CVC.

The findings from the study have also shown that upon arrival, immigrant participants’ settlement experiences were greatly impacted by the three-month wait policy because of the financial burden and stress it created for them. Costs associated with pregnancy, including prenatal and obstetrical care, were the most expensive that participants incurred. Existing settlement stresses were also exacerbated by the policy because of the ways in which it served to produce additional anxiety over accessing care. The stress participants experienced from the challenges they faced attempting to navigate care was compounded by their fears of accumulating debt from paying for services out-of-pocket, while simultaneously trying to find services for potentially time-sensitive conditions, such as pregnancy.

The four interviews conducted with healthcare providers from the CVC also provided important insights into the nature of providing care for their clients in the three-month wait period and the unique challenges they and their clients face due to the policy. Advocacy was a central issue they discussed in terms of the ethical obligations they felt to advocate for their clients both at the CVC and beyond because of the potentially catastrophic consequences of not helping them get care.

The study also found that relationships between frontline providers were complex and could serve as both a pathway and impediment to care. Partnerships developed between health and social service providers, as demonstrated through the establishment of the CVC, were crucial to getting those in the three-month wait care. Getting care for clients beyond the CVC, however, was often problematic because of the inter-professional tension that could exist between providers and the resistance some had towards accommodating care for those in the three-month wait. Differences in the priorities and pressures that these providers experienced, as a result of the systems they worked in and were accountable to, further complicated the challenge of helping those in the three-month wait access care.
The CVC staff also framed the political response, or lack thereof, to the three-month wait and the political discourse used to support recent immigration policy reforms, importantly Bill C-31 *Protecting Canada’s Immigration System Act* and cuts to the IFH program, as directly impacting their delivery of care to those whose access to healthcare has been limited by these policies. Since the meeting between the MOHLTC and service providers advocating for the end of the three-month wait, discussion from any level of government on the three-month wait has been minimal. The official discourse used by the CIC to support the implementation of their recent policy reforms was also described by one of the service providers as unjustly targeting immigrants for abuses of the immigration and healthcare systems. She explained how this negatively impacts their delivery of care because of the way it has had the damaging effect of discouraging immigrants from seeking needed care and trusting service providers.

### 6.2.1 Relationship of Findings to the Current Research Literature

Several findings from this study are consistent with previous literature on the wait policy as it pertains to the experiences of those attempting to access care during the three-month wait. Existing research has predominantly referred to the policy as a major barrier to care for new permanent residents during their initial period of settlement because of the various ways in which it can create financial hardship, negatively impact mental health, and limit access to publicly funded health services to alternative points of care, despite having private health insurance (Asanin & Wilson, 2008; Elgersma, 2008; Toronto Public Health & Access Alliance Multicultural Health and Community Services, 2011). Participants in my study who purchased private health insurance found that, while reasonably affordable, the plans were limited in coverage and did not cover services for primary care or pre-existing conditions, including pregnancy and chronic diseases.

Previous studies on the three-month wait period that have included perspectives of healthcare providers feature similar findings to this study, as they also highlight the various ways in which service providers’ delivery of care are constrained by the policy (Gagnon, 2002; Sylvain, 2005). Healthcare providers, across several professional organizations including the OMA, the RNAO, and AOM, have all commented on the
ways in which the policy endangers their clients’ health by delaying their access to early, preventative care. They also assert that the inequitable health outcomes of the policy, as they have witnessed in their daily practices, does not save Ontario’s healthcare system money but instead can result in greater systemic expenditures due to complications from delayed care. Health and social service providers also spoke of the profound ways the policy restricts their ability to treat clients in the wait period because of the limited resources and capacity they have to serve the growing demand for their services. The policy significantly complicates and problematizes their delivery of care as they experience considerable stress and require additional time to find services for these clients within a system that has become increasingly resistant to assisting those without OHIP.

This study also included unique findings about the ways in which participants became aware of and understood the three-month wait policy, as well as how they navigated services during the wait period. The findings of the study illustrate the importance of social supports, such as family and friends, to new permanent residents’ planning for the wait period and also how they manage the effects of the policy on their access to healthcare. This study contributes to the understanding of how those affected by the policy come to understand it, but importantly when this happens throughout the process of immigration. Contrary to previous literature (Elgersma, 2008; Goel, 2013), the findings from this study demonstrate that nine (out of ten) of the participants were aware of the policy to varying degrees prior to arrival. Depending on their level of understanding of the policy, participants also actively tried to prepare for the wait period through various strategies, such as purchasing private health insurance (three out of ten) and packing medications (four out of ten).

Despite these strategies, however, participants were still forced to seek care during the three-month wait period because they could not control for the unpredictability of the timing of the immigration process as it coincided with the development of their health concerns, particularly pregnancy. Participants who were previously in the three-month wait period also expressed the ease with which they were able to apply for and get...
their OHIP card, which is contrary to previous studies that have cited delays of up to two years for OHIP approval (Caulford & Vali, 2006).

Findings from the four interviews with healthcare providers from the CVC also garnered rich data that provided unique insights into the important interprofessional dynamics that are involved and must be considered in an analysis of the impacts of the policy. As CVC staff advocated for their clients’ care with other providers, health services staff’s decisions were often constrained by their at times conflicting responsibilities to their clients, professional duties, and the pressures of the systems in which they work. Conflicts in attitudes and the compromised position many healthcare providers were put in as a consequence of the policy created tension between providers that further complicated the challenge of getting care for those in the three-month wait. Unlike previous research on health care providers’ experiences in relation to the wait period, specifically those that do not provide in-depth accounts of the political implications of the policy (Steele et al., 2002; Ter Kuile et al., 2007), this study includes data from healthcare providers related to the influence of politics on their delivery of care. Political discourse on policy reforms was found to have both direct and indirect impacts on delivering care to those in the three-month wait and the experiences of those attempting to access care in the wait period.

6.3 Limitations

The limitations of this study pertain mainly to methodological issues, namely the sample size and issues of recruitment. The sample size of 14 may have prevented gathering really in-depth understandings, although I was still able to gather information-rich cases from both sets of participants’ experiences. Another limitation of the study is that purposive sampling was used, which limited the sample to only those either seeking care at the CVC (n=10) or those employed at the CVC (n=4). However, given the aim of the study to understand how the experiences of these two participant groups, and the tremendous support and insights offered through and within the CVC it was an ideal locale from which to select my participants. The experiences of those who may have accessed care at
a different point of delivery, were unable to get care, or did not require any medical attention during the wait period were not exclusively captured in this sample.

The main challenges with regard to recruitment were not only in identifying clients who fit the inclusion criteria, but to find those who were interested in and capable of coming back to the CVC to participate in an interview. Attempts to schedule interviews for a later date were problematic for various reasons, including a lack of resources potential participants had in terms of time, child care, and transportation as well as language difficulties. Given these considerations, participants who presented at the CVC and fit the inclusion criteria were then approached about participating in the study while they were at the CVC. The spontaneous nature of conducting interviews as participants sought care at the CVC was a unique aspect of recruitment, which meant that the duration of interviews varied greatly and depended on their waiting times between triage and seeing the doctor or how much more time they could afford to speak with me after receiving care.

A separate issue connected to recruitment, but also the reality of who goes to these clinics together, was that participants often presented at the CVC with their families and took part in interviews together. Participants who were in the three-month wait period at the CVC were also often caregivers of a family member, also in the wait period and in need of care, which meant that entire families presented at the clinic together and participated in the interviews with all family members in the room. Having entire families together during the interviews may not have allowed for or been conducive to allowing each family member feel open to sharing their views. While not the focus of the study, the link between culture and gender was an important consideration during the interviews. Future research can look into the complex implications of these cultural dynamics of families and how they may affect experiences of health and accessing health services.
6.4 Recommendations

Several recommendations can be made from the results of the study for both policy and clinical considerations. There are four main recommendations that can be made from the findings of this study, which include continuing discussions between frontline providers and stakeholders, resuming discussions with the MOHLTC, a review of private health insurance plans currently offered, and standardizing costs for services between points of care. The first recommendation, drawing upon my data that highlighted the clinical importance and effectiveness of partnerships developed through community collaboration, such as the establishment of the CVC, points to the need for more sustained and supportive dialogue between health and social service providers. As the healthcare providers in this study anticipated the increased demand for health services for those without OHIP, increased discussion between providers will be critical to foster understanding about the nature of serving this population to maintain and develop partnerships throughout the community.

The second recommendation, specifically with respect to policy considerations, is resuming discussions between the MOHLTC and healthcare providers regarding the potential benefits and dangers of the policy. The potential adverse health consequences of the policy, such as complications from delays to care as described by the study’s participants, highlights the need for an evaluation of the maintenance of the policy. Data regarding any benefits to the maintenance of the three-month wait policy should be made available by the MOHLTC in light of the concerns raised by healthcare providers regarding the adverse health outcomes the policy continues to have for their clients.

The third recommendation, with regard to policy, is a review of current available private health insurance plans for those in the three-month wait period. The findings from the study illustrate the challenges associated with the limited services covered by private health insurance plans currently offered for new permanent residents. Exclusion of coverage for services involving prenatal and obstetrical care as well as primary care, were of particular concern.
The fourth recommendation, from the study’s findings on interprofessional tension, is to work towards the standardization of fees for services between and across various delivery points of care. Data from the study show that those in the three-month wait period who access care by paying for services out-of-pocket are unaware of the differential rates and costs they are charged between points of care, especially at hospitals. The development and implementation of standardized costs for services would assist in protecting those paying for services out-of-pocket from incurring additional and unnecessary financial burden as well as remove geographical barriers to more affordable care.

6.5 Future Research

The findings from this study raise many interesting and, as of yet, unexplored questions for future research that explores new immigrants’ utilization of and access to health services. This is particularly the case for women and children and how they may be impacted by recent immigration policy changes. While primary applicants for the federal skilled worker category are assessed according to their anticipated ability to adjust and contribute to Canadian society, relatively little is known about the effects of immigration on their dependent applicants, who are most often women and children. As Canada’s immigration system continues to select individuals to come to Canada, it also has the effect of settling families. The degree to which the process of immigration and immigration status can affect the entire family unit’s experience of accessing health and social services throughout settlement remains to be studied.

Every woman who participated in this study was a dependent applicant of their husband or father, despite their own professional backgrounds, and they often expressed their frustration at the additional delay they faced in getting their credentials recognized in Canada because they had to wait for their husbands to finish their courses and get their credentials recognized first. They were often responsible for childcare, while their husbands were in school, and navigating health services for their children or themselves during the three-month wait significantly contributed to the burden of settlement challenges they faced. The experiences of children and youth throughout the process of
immigration is another important area for future research as several of the participants in this study were seeking care for their children who had various health concerns. The impact of the immigration process and the challenges of adjusting to re-settlement for children at home and in school can have both short and long-term health consequences for their development and well-being.

6.6 Conclusion

The primary aim of this study was to explore the effects the three-month wait policy has on new permanent residents’ experiences of accessing care in Ontario, although in analyzing the many impacts the policy has, I have developed a greater understanding of what the denial of services means to the lives of people hoping to make Canada their home. The policy reflects the deeper inequities that are created by the intersection of structural systems within Ontario that allow immigration status to be a determinant of access to services and, in turn, produce differential health outcomes. New permanent residents’ resiliency to the effects of the three-month wait period proves their commitment to establishing themselves and their families in Ontario, while the determination of the healthcare providers who serve them also demonstrates the profound commitment they have to the values of equity that guide their work.

The direction the CIC has taken with recent policy changes illustrates how limiting new immigrants’ access to services is not just becoming more prevalent, but that it is only another set of policies, much like the three-month wait, that is part of a continuing trend of policies that serves to exclude access to services on the basis of immigration status. Since the three-month wait policy was introduced in 1994, the ramifications of the policy have affected every new permanent resident to come to Ontario since and will continue to impact the approximately 99 000 new permanent residents that Ontario expects to welcome annually (CIC, 2010), as well as the healthcare providers who serve them. The ways in which the policy has shaped these new permanent residents’ experiences of health during their initial time in Canada will continue to have consequences for all residents of Ontario as we build and share our communities with those affected by the three-month wait period.
Bibliography


*Canada Health Act, R.S.C., c. C-6* (1985).


Immigration and Refugee Protection Act, c. 27 (2001).


Appendices

Appendix A: Literature Review by Type of Output

**Group 1: Empirical Findings**

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<thead>
<tr>
<th>Ref. No.</th>
<th>Author</th>
<th>Date</th>
<th>Title</th>
<th>Type of paper</th>
<th>Method</th>
<th>Location</th>
<th>Key findings / opinions</th>
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<tbody>
<tr>
<td>1</td>
<td>Ontario Health Quality Council</td>
<td>2007</td>
<td>Q Monitor: 2007 Report on Ontario’s Health System</td>
<td>Report</td>
<td>Mixed- literature review, expert consultations</td>
<td>Ontario</td>
<td>The province’s health system performance was evaluated using the measures of accessibility, effectiveness, safety, patient-centredness, equity, efficiency, and appropriate resources with a focus on population health. In its assessment of equity for new Canadians, the report found that very new immigrants to Canada who have been in Ontario for less than three months face the additional barrier of the three-month</td>
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Community health centres and a volunteer clinic with the Scarborough Hospital are described as providing some services for non-insured patients. Immigrants within the three-month wait period were found to make up one-third of clients seeking care at the volunteer clinic at the Scarborough Hospital and 90 percent were reported to be approved immigrants awaiting determination of their status.

<p>| 2 | Assanin, J. | 2007 | “Education? It is relevant to my job now, it makes me very depressed…”: Exploring the health impact of | Masters Thesis | Qualitative study using in-depth interviews | Mississauga, Ontario | In discussing the role of employment on skilled workers’ health, access to health care services is described as a more indirect impact on their health. The three-month wait period was seen as an issue impeding access to care as private insurance was extremely |</p>
<table>
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<tr>
<th></th>
<th>Precarious employment among highly skilled recent immigrants in Mississauga, Ontario</th>
<th>Difficult to afford for immigrants without secure employment. Some immigrants had enough savings to purchase private insurance or pay for costs out-of-pocket, while others who could not afford private insurance did not seek care when it was necessary or tried to prevent their family from becoming ill by limiting their exposure outside of the home.</th>
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| 3 | Central East Local Health Integration Network (LHIN) | 2010 | The culture, diversity and equity project: Focus groups | Report | Focus groups with community members | Throughout the three regions of the Central East LHIN, including Scarborough, Durham, and the Northeast (Haliburton,  
|   |   |   |   |   |   | The medically uninsured individuals focus group was carried out with seven participants from the Scarborough area in 2009. Investigating the health-related issues of the uninsured was seen as a critical part of the report’s project to assess adverse health consequences of being uninsured. The three-month wait period was described as a significant |
| 4 | Steele, L.S., Lemiuex-Charles, L., Clark, J.P., and Glazier, R.H. | 2002 | The impact of policy changes on the health of recent immigrants and refugees in the inner city: A qualitative study of service providers’ perspectives | Journal article | Qualitative study- semi-structured key informant interviews | Ontario | financial burden and participants described their experience as feeling ignored by the Canadian health system. Participant recommendations included the immediate elimination of the policy. Using a grounded theory approach, the study analyzes the effects of several health and social policies implemented from 1993-1997 in Ontario. Of ten key informants, six regarded the three-month wait period introduced in 1994 as exacerbating existing barriers to accessing health services for recently landed immigrants. These newly landed immigrants were reported to go to community health centres (CHC) to seek care and health care providers working at CHCs expressed feeling extreme pressures to care for such a
growing community with shrinking resources. The staff mentioned having to compromise time for counseling, preventative care, case-management, and seeing an increased need for patient advocacy. These stresses have also been said to lead to staff burnout. Immigrant women were highlighted as especially vulnerable to these policy changes. The study’s recommendations include ensuring that policy changes introduced promote rather than endanger public health to protect universal and equitable access to health services.

<table>
<thead>
<tr>
<th>5</th>
<th>Elgersma, S.</th>
<th>2008</th>
<th>Immigration status and legal entitlement to insured health services</th>
<th>Library of Parliament Report</th>
<th>Not specific</th>
<th>Canada</th>
</tr>
</thead>
</table>

The report analyzes the *Canada Health Act*’s core principle of “universality” and the degree to which it can be achieved under the current definition of “insured persons” that
includes residents of a province, excluding certain groups, such as the Canadian Forces and Royal Canadian Mounted Police, and those who have not completed a minimum period of residence up to three months. The focus of the paper is immigrants currently residing in Canada and how their immigration status affects their access to publicly funded health care. A review of health services entitled to different immigration categories across jurisdictions is offered and clarifies that new landed immigrants to Ontario, British Columbia, Quebec and New Brunswick undergo a three-month wait period before becoming eligible for provincial health insurance and during this time they are advised to purchase private health insurance.
Problems surrounding being uninsured during this time include limitations of private insurance, inconsistent public services provided, administrative delays, and difficulties for healthcare providers to differentiate different categories of immigration categories. As a consequence of these issues, immigrants were found to delay seeking medical care for financial reasons, thereby increasing risks associated with serious health conditions and even death. Public health is also put in jeopardy by delaying care. The study notes that since these individuals pay taxes, the policy can be seen as unfair and leading to increased long-term costs instead of the suggested short-term savings. The federal government’s
role surrounding these issues is then called for through enforcing and strengthening requirements for private health insurance because of their role in admissions of immigrants.

|   | Toronto Public Health and Access Alliance Multicultural Health and Community Services | 2011 | The global city: Newcomer health in Toronto | Report | Mixed- literature review, key informant focus groups, analyses of existing health and socio-demographic data | Toronto, Ontario | Barriers to accessing health services were identified by newcomers in focus groups conducted for this report and were consistent with findings from other local consultations. Cost and eligibility with those still in the three-month wait period were considered a key barrier and a significant stressor among newcomers trying to access health services. Paying for private insurance was a challenge to afford during initial settlement in Ontario and some newcomers did not qualify for private health insurance because of a pre-existing illness. This forced |
|   | Gray, C.S., Hynie, M., Gardner, L., & Robertson, A. | 2010 | Qualitative research project on health-care access for the uninsured | Report | Semi-structured interviews with key informants from the Women’s College Hospital Network on Uninsured Clients | Ontario | The members defined their uninsured and/or undocumented clients as being within the three-month wait period, those with lost or stolen OHIP cards, and those with no legal status. About 50% of participants defined their clients as being landed immigrants within the three-month wait period. Mental health issues and pregnancy were the most common health issues reported among the health care providers’ clients. Community health centres, hospitals, private physicians, Toronto Public Health, and walk-in clinics were the most frequent points of care accessed by the population. General barriers reported when accessing care was “fear (mainly of
deportation), cost of care (both actual and perceived costs), and lack of knowledge (on the part of the uninsured undocumented regarding what care is accessible and on the part of health-care providers regarding how to treat this population)” (p. 4). The most common policy recommendation from twenty out of the total twenty-four participants was to eliminate the three-month wait period immediately. Health insurance coverage for pregnancy for those within the three-month wait, similarly to Quebec’s exemption, was also recommended. Information needs documented in the report includes cost-analyses, descriptive statistics, and individual stories.

| 8  | Goel, R., Bloch, | 2013 | Waiting for care: | Journal | Qualitative study | Ontario | Using a phenomenological approach, |
seven semi-structured key informant interviews were conducted with participants who needed care during the 3-month waiting period or were caregivers for someone who did. Participants were recruited from the Scarborough Community Volunteer Clinic (SCVC). Main findings included that participants believed there was a lack of clear information and lack of help from officials, poor social situations, financial loss or threat of financial loss, choice to delay seeking care owing to cost, difficulty accessing alternative care, appreciation for those who advocated in their behalf, emotional hardship, poor health outcomes, unpredictability of health, and negative impressions of Canada as a result of negative
experiences seeking care. Given the findings and participants’ overall negative experiences seeking care, the paper argues for the elimination of the policy.
### Group 2: Guidance Material

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<thead>
<tr>
<th>Ref. No.</th>
<th>Author</th>
<th>Date</th>
<th>Title</th>
<th>Type of paper</th>
<th>Method</th>
<th>Location</th>
<th>Key findings / opinions</th>
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<tbody>
<tr>
<td>9</td>
<td>Ministry of Health and Long-Term Care</td>
<td>2009</td>
<td>OHIP coverage waiting period</td>
<td>Fact Sheet</td>
<td></td>
<td>Ontario</td>
<td>States that a three-month waiting period for OHIP applies to most new applicants for coverage and former residents returning to Canada after living in other countries for a long period. Exemptions are outlined for newborn babies in Ontario, OHIP-eligible adopted children under 16, protected persons, and people from other provinces or territories who move directly into a long-term care facility in Ontario or require admittance to a long-term care facility within three months of arrival to Ontario. The three-month wait period also applies to those with a valid Temporary Resident Permit because of changes introduced on April 1, 2009. The fact sheet explains that</td>
</tr>
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if you move to Ontario from another country, the waiting period begins on the date you establish residence in Ontario and coverage begins after three calendar months. For those moving to Ontario from another province with provincial/territorial health insurance coverage, the former province’s health care will provide health insurance until the first day of the third month after establishing residence in Ontario. For those moving to Ontario from another province/territory without health insurance coverage, the waiting period will last three full months after permanent residence is established in Ontario.

| 10 | Ministry of Health and Long-Term Care | 2011 | Health Insurance Act, R.R.O. 1990, Regulation 552 | Legislation | Ontario | Gives statutory authority to the Ontario Health Insurance Plan (OHIP). Under subsection 5(1), “a person shall only start receiving insured services once the General Manager is satisfied that he or she has been |
a resident for three full consecutive months, and has not stopped being a resident since meeting that three-month waiting period requirement”.

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<tr>
<th></th>
<th>Minister of Justice</th>
<th>1985</th>
<th><em>Canada Health Act</em></th>
<th>Legislation</th>
<th>Canada</th>
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<td>11</td>
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Program criteria for each province or territory to qualify for a full cash contribution is public administration, comprehensiveness, universality, portability, and accessibility. Defines “insured person” as “a resident of the province other than…(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services” (p. 4).

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<tr>
<th></th>
<th>Legislative Assembly of</th>
<th>1994</th>
<th>Official Record for 31 March</th>
<th>Hansard transcript</th>
<th>Ontario</th>
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<td>12</td>
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Former Minister of Health Hon. Ruth Grier made an announcement regarding changes
| Page 13 | Ministry of Health Ontario | 1995 | Managing health care resources 1994-95: Meeting priorities | Report | Ontario | The report summarizes progress made by the Ministry of Health through 1994 to 1995. The ministry reported to achieve a decrease of 2.9% in spending between 1994-95 through implementing several measures to control costs. Among these were changes to eligibility, including the three-month waiting period for all new applicants and former residents returning to OHIP to become effective April 1, 1994. Along with ending health insurance coverage for temporary residents in Ontario, the Ministry introduced the three-month waiting period for OHIP, following models from British Columbia and New Brunswick. The change was “expected to save Ontarians about $418 million annually by preventing people from coming to Ontario for the sole purpose of receiving health care, then leaving again” (p. 36). |
Ontario after living outside of Canada. The new eligibility requirement is said to prevent people from coming to Ontario just to receive medical care.

| Ontario | Legislative Assembly of Ontario | 2008 | Official Report of Debates Tuesday 17 June 2008- Standing committee on estimates Ministry of Health and Long-Term Care | Hansard transcript | New Democratic Party (NDP) Member of Provincial Parliament (MPP) France Gelinas questioned former Minister of Health Hon. Ron Sapsford about the cost of the Fairness for Military Families Act, which eliminated the three-month wait period for military families going to Ontario. Since it was passed, approximately 48 families were estimated to have been affected by the Act, although the cost to Ontario was not stated. Mme. France Gelinas suggested that military families can be seen as a test case for the government to observe the cost of eliminating the three-month wait period for all new immigrants to Ontario, which the
<table>
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<th>Source</th>
<th>Year</th>
<th>Description</th>
<th>Source</th>
<th>Text</th>
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<tbody>
<tr>
<td>Ministry of Health and Long-Term Care</td>
<td>2007</td>
<td>Proposed legislation would eliminate 90-day OHIP waiting period for military families</td>
<td>News Release</td>
<td>This text describes the intention of the provincial government, under Premier Dalton McGuinty, to eliminate the 90-day wait period for military families. The proposed legislation is said to give earlier access to care for up to 8500 military family members each year.</td>
</tr>
<tr>
<td>Legislative Assembly of Ontario</td>
<td>2010</td>
<td>Official Report of Debates Thursday 25</td>
<td>Hansard transcript</td>
<td>A motion was put forward by Mr. Peter Tabuns to the Standing Committee on Finance and Economic affairs strongly...</td>
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</table>
February 2010 recommending to the Minister of Finance that in the 2010-2011 budget several changes, including the elimination of the three-month wait period for OHIP coverage for newly arrived immigrants, be made to protect front-line health services. Mr. Wayne Arthurs responded that the government caucus cannot support the motion. Mr. Wayne Arthurs explained that ending the three-month wait period for OHIP coverage is a policy beyond the scope of the government caucus.

<table>
<thead>
<tr>
<th>legislators</th>
<th>committee</th>
<th>date</th>
<th>source</th>
<th>province</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Hansard transcript</td>
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| | | | | New Democratic Party (NDP) Member of Provincial Parliament (MPP) France Gelinas presented a petition of 3000 postcards asking for the elimination of the three-month wait period for all new landed immigrants. Mme. stated the importance of protecting all landed immigrants’ right to access health care free of charge in
accordance with the Ontario Human Rights Code and its principles of equality of services to its residents.
### Group 3: News Releases

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<tr>
<th>Ref. No.</th>
<th>Author</th>
<th>Date</th>
<th>Title</th>
<th>Type of paper</th>
<th>Method</th>
<th>Location</th>
<th>Key findings / opinions</th>
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<tbody>
<tr>
<td>18</td>
<td>Mick, H.</td>
<td>July 6, 2007</td>
<td>Still a long way from home</td>
<td><em>Globe and Mail</em> article</td>
<td></td>
<td>Toronto</td>
<td>Story of an eight-year old girl who was a newly landed immigrant through the family-sponsorship category who came down with chicken pox six days after arriving in Canada and one day after celebrating being reunited with her mother at Chuck E Cheese. After being recommended Aveeno and an oatmeal bath by a doctor at a walk-in clinic, pain in her legs became too much to bear. She was prescribed codeine for the pain at the emergency room, six days later she was admitted to the hospital for observation, during which her lungs collapsed when the chicken pox virus attacked them, she was then sedated to relieve pressure in her lungs</td>
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when she suffered a stroke. Her entire right side became disabled when she was transferred to a rehabilitation hospital where she stayed for two months. By the time she could leave the rehabilitation hospital, the family’s hospital bill amounted to $90,500 because she was not in Canada for three months to be covered by OHIP.

<table>
<thead>
<tr>
<th>19</th>
<th>Sylvain, M.</th>
<th>2005</th>
<th>Caring for the uninsured</th>
<th>Medical Post article</th>
<th>Canada</th>
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<td>Dr. Paul Caulford, chief of family medicine at Scarborough Hospital and founder of the Scarborough Volunteer Clinic for the Medically Uninsured, studied 2000 patient records from the volunteer clinic and found that 90% of the patients reported having credentials to be in Canada permanently. The patients mainly fell into the categories of being within the three-month wait period for OHIP or “navigating” a claim for residency status. Almost 36% of the</td>
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patients were in the three-month wait period. The federal government's plans to expand immigration were anticipated to have a significant impact on increasing the population of the medically uninsured in Ontario and the demand on health care providers who see them. Scarborough alone was reported to accept up to 20% of the national total of new immigrants.

<p>| 20 | Keung, N. | Dec 28, 2008 | Ill nanny inspires push for reform; After beating red tape that called for her removal, immigrant still hopes to beat cancer | Toronto, Ontario | Arriving in 2003 under the federal live-in caregiver program, an ill nanny applied for permanent residency, which is an option for domestic workers who complete three-year assignments and pass medical and criminal record clearances. During her medical examination, the nanny discovered she had cancer and her permanent residence application was rejected twice. She appealed to immigration officials to waive the good-health requirement on |
| 21 | Keung, N. | Mar 9, 2007 | Nanny awarded medical coverage; Cancer treatment was delayed after woman deemed ineligible for OHIP | The Toronto Star article | Toronto, Ontario | After having her story featured in the <em>Toronto Star</em>, a nanny who was twice rejected for permanent residency status received a letter from the Ministry confirming that her case had been reviewed and she would be eligible for OHIP. While her permanent residency status is still not conferred, the Ministry has said OHIP will reimburse outstanding medical claims. Prior to becoming eligible for OHIP, the nanny chose to forego treatment until immigrant advocates, churches, and community leaders raised $1000 for her care, CT scan, and biopsy. |
| 22 | Crawford, T. | Sept 26, 2009 | Special delivery $5000; It’s a ‘half a welcome’ for new Canadians who must drain their life savings for basic health care while on a 3-month wait for OHIP | The Toronto Star article | Toronto, Ontario | Parents admitted to Canada as skilled workers gave birth to their baby at The Scarborough Hospital and were charged $5000 for the delivery. With $16 000 in savings when they came to Ontario from Bangladesh, the financial burden and stress this has created for the newborn’s parents was expressed. The mother refused to get prenatal care from fear of accumulating too much debt, until she fainted and had to be taken to the emergency room where they were asked for $250 up front and then $1100 for a deposit for the birth. During delivery, an emergency C-section was performed because doctors could not find the baby’s heartbeat. Following the delivery, the mother continued to worry about costs during her three-day stay at the hospital. The baby was issued a health card at birth and seventeen days later, following |</p>
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<tr>
<th>No.</th>
<th>Author</th>
<th>Date</th>
<th>Source</th>
<th>Location</th>
<th>Text</th>
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<tbody>
<tr>
<td>23</td>
<td>Javed, N.</td>
<td>Dec 11, 2011</td>
<td>A unique place of healing, help and hope for GTA’s uninsured; A free Scarborough clinic offers health care to new immigrants and others without medical coverage</td>
<td>Toronto, Ontario</td>
<td>The Scarborough Volunteer Clinic for the Medically Uninsured is profiled and cases of some patients are featured while reviewing the medically uninsured population the clinic serves. Advocates have agreed that ending the three-month wait period for landed immigrants is, at this time, the “easier fix”. Dr. Paul Caulford, director and founder of the clinic, contests that at the policy level, the challenge to change the policy comes down to a lack of political will. It is clarified that only Ontario, British Columbia, and Quebec are the only provinces maintaining this policy, while Quebec has exemptions for care provided for domestic violence, maternal care, and infectious disease. Health</td>
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Minister Deb Matthews says they are not considering changing the policy at this time and people coming to Canada know they will be without health insurance for three months and need to purchase private health insurance beforehand. The Gupta family is used as an example of the ineffectiveness of having landed immigrants pay for private insurance because, like the Guptas, private insurance only covers them for emergencies and not pre-existing conditions. The family contends that if they did not hear about the volunteer clinic, where they brought their son to get checked after having a high fever for three days, it would have been cheaper to send their son back to India instead of paying out of pocket for an ambulance, the doctor visit, and potentially a night’s stay at the hospital.
Parents on work permits from India were billed $22,000 for the delivery of their premature twin daughters, who arrived three and a half months early and seventeen days before their mother’s OHIP coverage kicked in. The mother, a post-doctoral fellow at the Centre for Global Health Research at St. Michael’s Hospital, purposely waited until after her first trimester of pregnancy before moving to Toronto because she was aware of the three-month wait period and wanted to be sure her pregnancy was stable. After a week of trying to get private insurance, she was only able to get a limited package because pregnancy is considered a “pre-existing condition”. She spent seven days at Sunnybrook hospital before giving birth and three days after the delivery, during which one of the twins was delivered by C-
section. The father works as an engineer and is trying to reassure his wife about not worrying about the expenses, while he is nervous about the attention the family’s story has received. He hopes to stay in Canada and raise his family here, but fears the media attention will endanger those hopes.

| 25 | Ogilvie, M. | Mar 2, 2011 | Immigrant OHIP wait must end, board says; 3-month delay raises risk for TB, measles | The Toronto Star article | Toronto, Ontario |

Toronto’s Board of Health urged the Ontario Ministry of Health and Long-Term Care (MOHLTC) to eliminate the three-month wait policy for new permanent residents before becoming eligible for OHIP for the second time. They argue ending the policy will help to protect public health by allowing newcomers to receive timely treatments and diagnoses. The Board’s particular focus is the control of tuberculosis, which Toronto gets about 300 cases of each year. Ontario and British
| 26 | Mar 4, 2011 | Three months not that long; Immigrant OHIP wait must end, board says | *The Toronto Star* opinion and editorial | Toronto, Ontario |
| 27 | Feb 4, 2011 | Agencies push Ontario to eliminate wait times; 5000 postcard campaign will pressure Queen’s | *The Toronto Star* article | Toronto, Ontario |

Columbia are noted as the only provinces that will not provide any coverage for newcomers with communicable diseases.

Responses from the feature about the Toronto Board of Health urging the Ministry of Health and Long-Term Care are offered. One reader wrote that people with communicable diseases should not be allowed in the country and three month’s wait is fair. Another argued that OHIP is strained and they should not allow people to be eligible if they do not contribute to it.

In light of the fall election of 2011, agencies forming the Right to Health Care Coalition, which advocates for the elimination of the three-month wait period, launched a postcard campaign. The coalition works to have the wait period eliminated for new permanent residents.
A coalition member remarked that new permanent residents are unlikely to put a strain on the health system because they are required to pass medical examinations before their applications are approved. They only need health coverage for unexpected events. An example offered to illustrate such an instance was the case of a new permanent resident trying to get private health insurance, as they are advised to do so for the three months, but was rejected because her pregnancy was considered a “pre-existing condition”.

The article reviews and agrees with the arguments made against the three-month wait period in a previous article featured in *The Ottawa Citizen*. The excessive demand felt by frontline health care providers serving the uninsured is reiterated. The
potential negative consequences of delaying care are explained, such as latent tuberculosis becoming highly contagious when left undiagnosed. These severe and acute cases are seen as costing the health care system more money and putting public health in danger.

| 29 | Taylor, L. | Feb 28, 2012 | Not worth the wait | Ottawa, Ontario | Ottawa Board of Health joined the Toronto Board of Health, and the Ontario Medical Association in calling for an end to the three-month wait period, especially for patients with tuberculosis. Councillor Diane Holmes, also chairwoman of the Ottawa Board of Health, sent a letter in January to Ontario Minister of Health Deb Matthews to make her aware of the board’s resolution against the policy. |
| 30 | Association of Ontario | | Where the parties stand | Survey of political | Ontario | When asked if their party supports ending the three-month wait period for new |
midwives views on health care issues

permanent residents, Liberals responded by commenting that they are currently doubling the number of community health centres in the province, which is where those in the three-month wait period would be served. They stated they will review the three-month wait period for new and returning Ontarians. The New Democratic Party (NDP) expressed their commitment to collaborating with stakeholders to eliminate the policy. The Green Party stated that the policy is an issue that needs to be reviewed because new residents are subject to the same taxation as everyone else upon arrival. The Conservative Party of Canada had no response.
<table>
<thead>
<tr>
<th>31</th>
<th>Rosenberg, R.N.</th>
<th>May 25, 2011</th>
<th>New health policies for potential immigrants</th>
<th>Canadian Immigrant article</th>
<th>Canada</th>
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<td></td>
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<td>Article highlights changes made by Citizenship and Immigration Canada (CIC) following a Supreme Court decision regarding opening two-tiered medical examinations for permanent resident applicants. Applicants for permanent residence, such as those who are family-sponsored, skilled workers, entrepreneurs or provincial nominees, are found inadmissible if they do not pass their medical exam in full. They become inadmissible because the applicant may pose excessive demands on health or social services in Canada. Under the new guidelines proposed by the CIC, immigration officers must now review all evidence presented by permanent residence applicants, potentially including an applicant’s financial ability to pay for social services required. While the changes</td>
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do not open the door for two-tiered medical services provided in Canada, it does create a two-tier system in medical admissibility evaluation for those who can pay for social services and those who cannot.
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<th>Date</th>
<th>Title</th>
<th>Type of paper</th>
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<th>Location</th>
<th>Key findings / opinions</th>
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<tbody>
<tr>
<td>32</td>
<td>McKeown, D.</td>
<td>2011</td>
<td>OHIP Coverage for New Immigrants with Tuberculosis</td>
<td>Medical Officer of Health report to Toronto Board of Health</td>
<td>Toronto, Ontario</td>
<td>The report served to update the Board of Health of the Toronto Public Health’s submission to the Province of Ontario’s pre-budget consultation calling for the elimination of the OHIP three-month wait period for newly landed immigrants. The focus of the submission emphasized the importance of terminating the three-month wait period to protect public health and prevent communicable diseases, such as tuberculosis (TB). In response to the Chair of the Board of Health’s letter to the health Minister, it was communicated that the TB-UP program, which covers some services for persons with TB, and private insurance are adequate solutions for newcomers. The</td>
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Report outlines that private health insurance companies consider TB a “pre-existing condition” and will not provide coverage. It is also clarified that unlike other health issues, such as diabetes, cancer treatment, or broken bones, it is not legally permissible to defer or refuse treatment for TB. While all landed immigrants to Canada undergo the Immigration Medical Exam (IME) in their country of origin, which screens for TB, the IME is valid for twelve months. Those found with scarring on their chest x-ray are indicated as higher risk for TB and are referred for medical follow-up in Canada under the medical surveillance program of the CIC. Those referred to TPH each year through this program, about 1300 people, are advised to delay the full medical examination with a chest x-ray until they have OHIP. The three-month
| 33 | Right to Healthcare Coalition | 2007 | Backgrounder for Community Members and Policy Makers Advocating an End to the OHIP 3-month Wait Period for Recent Landed Immigrants in Ontario | Report | Ontario | Provides key facts and figures regarding the policy, immigrant health and access to health services in Ontario, and estimated cost savings of the three-month wait period. Highlights effects of the three-month wait period through case studies and analyzes the consequences of maintaining the policy, including compromising Ontario’s ability to fully utilize newcomers’ contributions, putting newcomers in major financial debt during the initial period of settlement, and actually incurring more expenses for Ontario’s health system by delaying care for new landed immigrants. The report estimates it wait period is recognized as a serious barrier to initial diagnosis of TB and a threat to public health as TB becomes more infectious as the disease progresses and treatment is delayed. |
|   |   |   |   |  
|---|---|---|---|---|
| **34** | **Right to Healthcare Coalition** | **2011** | **Investing in health, economic settlement and integration outcomes: A business case for eliminating the three-month wait period for OHIP for new Ontario residents** | **Report** | **Ontario** | Offers an analysis of the elimination of the three-month wait period as an investment for the Ontario government. An estimated $60 million per year or 0.1% of the total provincial budget for health care and 0.05% of the province’s total budget would be the cost of eliminating the policy. Its rationale as an investment is based on maintaining Ontario’s competitive edge in recruiting and retaining newcomers, savings costs by not delaying care, providing the services recent immigrants pay for through provincial sales taxes, and costs on average $81 million per year to provide hospital-based care to immigrants following their three month wait versus providing less expensive preventative care if primary health care coverage for landed immigrants began immediately upon arrival. |
as basic human equity as supported by the Canada Health Act, The Ontario Human Rights Code, The Canadian Charter of Rights and Freedoms and the United Nations International Covenant on Economic, Social and Cultural Rights. As an investment, the termination of the three-month wait period is said to produce dividends in improved health outcomes, help newcomers be more economically effective, allow children to receive vaccination so they can register for school immediately, and help new permanent residents contribute their skills to Ontario’s labour market.

<p>| 35 | Ontario Medical Association (OMA) | 2011 | Reviewing the OHIP Three-Month Wait: An unreasonable barrier to | Policy review | Literature review, interviews with physicians | Ontario | The OMA’s review of the three-month wait policy finds no evidence to suggest the delay to OHIP coverage, from the three-month waiting period, actually saves the health system any money. The OMA also |</p>
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<tr>
<th></th>
<th>Association of Ontario Midwives (AOM)</th>
<th>Midwives in Ontario want to protect and expand medicare</th>
<th>AOM Position Statement on</th>
<th>Ontario</th>
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<tr>
<td>No. 36</td>
<td>found no reason to restrict newcomers or returning Canadians from full health insurance coverage upon arrival to Ontario. Their findings also showed that those without health insurance coverage go to hospital emergency rooms for care or delay seeking care, which actually compounds costs as the illness advances. With no medical reasons found to maintain the policy, benefits of removing the policy found by the OMA include allowing people to seek care at appropriate health care delivery points and preventing the spread of infectious diseases. The complete removal of the three-month wait period is advocated by the OMA.</td>
<td>The AOM officially supports the end of the three-month wait for new permanent residents to become eligible for OHIP. The three-month waiting period is seen as</td>
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Publicly-Funded Health Care

exacerbating stress and illness because it is a significant barrier to accessing care. The AOM asserts that pregnant women, children and senior citizens are especially vulnerable because they are excluded from qualifying for private health insurance policies because of “pre-existing conditions” and age-related exclusions. They strongly recommend the termination of the three-month waiting period in Ontario for new residents.

37 Registered Nurses’ Association of Ontario (RNAO) 2011 Letter to Minister Matthews and Minister Duncan Ontario

The RNAO urges the government of Ontario to immediately abolish the three-month waiting period. They outline the benefit of providing early access to health services and preventative care for improved health outcomes and cost-effectiveness. Providing access to care for newly landed residents is seen as a human rights and public health concern by the RNAO. The
An example of tuberculosis is used to illustrate the province’s vested interest in eliminating the three-month wait period. The RNAO recognizes the commitment newly landed residents make to Canada and the immigration requirements they have met to be given immigration approval asserting that they are not medical tourists.

<table>
<thead>
<tr>
<th></th>
<th>Goel, R.</th>
<th>2010</th>
<th>Maintaining Pressure for Equity for Patients at the OMA</th>
<th>Letter to Dr. Suzanne Strasberg, President of the Ontario Medical Association</th>
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</thead>
</table>

The Medical Reform Group (MRG) is a national group of physicians, residents and medical students committed to high quality health care for all Canadians. The letter expresses the MRG’s support for the motion put forth by the OMA to encourage the Government of Ontario to follow the exemptions the government of Quebec made to the three-month waiting period for pregnancy, domestic violence and serious infectious disease, as a first step to eliminating the three-month wait period.
<table>
<thead>
<tr>
<th>39</th>
<th>Sansom, S.</th>
<th>1997</th>
<th>Refugee claimants, OHIP eligibility, and equality</th>
<th>Journal article</th>
<th>Ontario</th>
</tr>
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</table>

The paper examines the changes introduced by Ontario Health Minister Ruth Grier on March 31, 1994, including the end of provincial health care coverage for temporary residents, the introduction of the three-month wait period, and the shift of refugee claimants comprehensive coverage under OHIP to the Interim Federal Health Plan (IFH). The article reviews the history and context in which the new amendments were made and argues they are inconsistent with the Canada Health Act and the Charter under subsection 15(1) and not reasonable enough to justify under subsection 1 through the R. v. Oakes test of proportionality. The possibility of making a successful Charter case is reviewed and it is outlined that where “a benefit has been conferred on a disadvantaged group, and
has subsequently been taken away…discriminatory treatment is easy to see, and easy to remedy” (p. 231).

<table>
<thead>
<tr>
<th>40</th>
<th>Canadian Civil Liberties Association</th>
<th>2010</th>
<th>Who belongs? Rights, benefits, obligations and immigration status: A discussion paper</th>
<th>Discussion paper</th>
<th>Canada</th>
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<td></td>
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<td>The paper reviews Canadian court decisions on cases challenging distinctions made on the basis of immigration status, including the case of <em>Irshad (Litigation Guardian of) v. Ontario (Minister of Health)</em>. It outlines that the Court’s decision to reject the appeal was on the basis that the residency requirement is reasonable and not unchangeable. The court held that the limit on OHIP eligibility is reasonable and does not infringe on the right to equality of any particular group. This decision was unlike that in <em>Andrew v. Law Society of British Columbia</em> where the Court recognized non-citizens who are permanent residents as a “discrete and insular minority” (p. 18) to be protected.</td>
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<tr>
<td>41</td>
<td>Gardner, B.</td>
<td>2009</td>
<td>Welcome to Canada – don’t get sick!</td>
<td>Wellesley Institute opinion piece</td>
<td>Ontario</td>
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<td>Identifies systematic inequities leading to the situation of various medically uninsured individuals in Ontario contrary to popular Canadian belief that health care access is universally available. Lack of awareness of this population, including new legal permanent residents in the three-month wait period, is said to be part of the challenges towards change. Community health centres are discussed as sometimes insufficient to address their health needs beyond primary care, such as diagnostic tests.</td>
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<tr>
<th>42</th>
<th>Gardner, B.</th>
<th>2011</th>
<th>Welcome to Ontario – Don’t get sick!</th>
<th>Wellesley Institute opinion piece</th>
<th>Ontario</th>
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<td></td>
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<td></td>
<td>Three-month wait period for new permanent residents is regarded as discriminatory and dangerous to an already vulnerable population. Support for the Right to Health Care Coalition’s demand to eliminate the three-month wait period is</td>
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</table>
stated. Findings from a research conference at the Women’s College Hospital in Toronto shows that the wait period has a significant impact on new immigrants’ health. Some decide to delay care and only seek treatment after the three months, thereby allowing illnesses to progress and require acute care, which could have been avoided with appropriate preventative care. Women and children are seen as particularly vulnerable within this population. The results of the Right to Health Care Coalition’s business case to eliminate the policy show that it would cost 0.18% of health expenditures at the highest estimate, but this would actually save the health care system money by providing immediate preventative care equitably.

| 43 | Gardner, B. | 2011 | Ontario doctors call for end to | Wellesley Institute | Ontario | An update on the advocacy campaign to eliminate the three-month wait period is |
given as the Ontario Medical Association (OMA) officially joins other health care providers and organizations in their call to end the three-month wait period.

| 44 | Barnes, S. | 2011 | Time to end the 3 month OHP wait period | Wellesley Institute Opinion piece | Ontario | Health professional are reported to be in consensus against that three-month wait period, which can have significant adverse health impacts on newcomers. In response to an article featured in the *Toronto Star* about the Scarborough Volunteer Clinic for the Medically Uninsured, it is estimated that 50,000 new permanent residents are affected by the three-month wait policy each year. The response by Hon. Deb Matthews, Minister of Health and Long-Term Care, is critiqued as the figures contributing to her cost savings estimate of $90 million are not discussed. |
| 45 | Barnes, S. | 2012 | Health care for | Wellesley | Ontario | Canadian and international evidence |
Institute Opinion piece

| the uninsured: why it’s important and next steps | gathered from the Seeking Solutions Symposium in Toronto are discussed regarding accessing care among the medically uninsured. Delaying or foregoing seeking care, being denied care when it is sought, or being discriminated against are among problems reported by individual attempting to access care without health insurance. Negative health impacts include higher rates of disease and infections, serious triage assessments, higher rates of pregnancy and newborn complications, and negative mental health consequences. Doctors were also cited as creating alternative care plans when made aware their patient would not have access to tests, follow-up appointments, or drugs. The three-month wait period for new permanent residents was seen as an opportunity for a more “immediate win” in reforming |
| 46 | Caulford, P. & Vali, Y. | 2006 | Providing health care to medically uninsured immigrants and refugees | Journal article | Ontario | At the Scarborough Volunteer Clinic for the Medically Uninsured, 36% of clients were found to be within the three-month wait period. The paper recommends the elimination of the three-month wait period. |
| 47 | McKeown, D. | 2011 | Letter to standing committee on Finance and Economic Affairs | | Toronto, Ontario | Voices Board of Health’s strong support for the elimination of the three-month wait period for new permanent residents to be included in the 2011 Budget, minimally for communicable diseases. Tuberculosis (TB) is discussed as one such public health concern that can be exacerbated by the policy because of new immigrants delaying seeking care due to the wait period. Private health insurance plans also do not cover care for TB because it is considered a pre-existing condition due to the dormant |
nature of the disease. Initial diagnosis is key to protecting public health because the infection can spread through the air and becomes increasingly infectious as the disease progresses. While all new permanent residents pass a medical exam, the infection can lie dormant and is more prevalent in countries some new permanent residents come from, so a bad cough may go unchecked as many new permanent forego seeking care while in the three-month wait period.

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<tr>
<th>No.</th>
<th>Author/Producer</th>
<th>Year</th>
<th>Title</th>
<th>Role</th>
<th>Location</th>
<th>Description</th>
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<tbody>
<tr>
<td>48</td>
<td>Toronto Board of Health</td>
<td>2011</td>
<td>The global city: Newcomers health in Toronto</td>
<td>Board of Health</td>
<td>Toronto, Ontario</td>
<td>The report was motioned to be sent to the Premier of Ontario to strongly urge the government to eliminate the three-month wait period for OHIP, among other considerations.</td>
</tr>
<tr>
<td>49</td>
<td>O’Keefe, K. (Producer,</td>
<td>2012</td>
<td>Your Money or Your Life: Documentary</td>
<td></td>
<td>Ontario</td>
<td>Investigates the suffering newcomers to Canada experience attempting to access</td>
</tr>
<tr>
<td>Page</td>
<td>Author</td>
<td>Year</td>
<td>Title</td>
<td>Location</td>
<td>Description</td>
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<tr>
<td>50</td>
<td>McKeown, D.</td>
<td>2013</td>
<td>Medically Uninsured Residents in Toronto</td>
<td>Toronto, Ontario</td>
<td>The report identifies Toronto resident groups that do not have access to OHIP funded healthcare, including people who have lost their identification, people in the three-month wait for OHIP, temporary visa holders, some refugees, and undocumented residents. The report describes the health concerns these populations face and also offers several recommendations, such as endorsement from the Board of Health for the elimination of the three-month wait period to the Ministry of Health and Long Term Care.</td>
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</table>
Appendix B: Poster for Recruitment of Interview Participants

Would you like to take part in a study about experiences with the Ontario Health Insurance Plan (OHIP) 3-month wait period?

If you are interested, you can take part in the following activities:
- Focus Group Discussion (60 minutes)
  Discussion with 4-6 participants
- Individual Interviews (60 minutes)
  One-on-one private discussions

The project is open to:
- economic skilled immigrants;
- between the ages of 19-70;
- currently in the OHIP 3-month wait period
- previously in the OHIP 3-month wait period in the past 5 years

Your perspectives and experiences are greatly valued.

If you would like more information about the project and are interested in taking part, please contact:
Andrea Bobadilla at XXX-XXX-XXXX or XXX@XXX.ca. Honorariums will be available for participants.
Appendix C: Interview Guide

INTERVIEW QUESTIONS TO BE USED IN STUDY

Introduction: I am a Masters student from Western University doing a study on the effects of the three-month wait period for OHIP on new permanent residents’ experiences of health and trying to access health services in Ontario. I am working under the supervision of Dr. Treena Orchard, a Researcher and Professor from Western University, as this project fulfills a requirement of the Masters in Health and Rehabilitation Sciences. My interest is in learning about the impact the policy has for new permanent residents and health care providers. The results of the study will help to inform policy makers of the perspectives of those affected by the three-month wait period and the practical consequences of the policy in people’s everyday lives.

Your participation in this project is essential because it is built on the objective of trying to gather the views of those most affected by the policy, which are mainly new permanent residents like yourselves and health care providers. I truly appreciate everyone taking the time to participate in this discussion.

Open-ended, semi-structured interviews with immigrants

1. How did you feel about applying to Canada through the economic skilled immigrant category? What do you think about the classification? What would you prefer to be called?
2. Why did you choose to immigrate to Canada?
3. Before coming to Canada, what did you hear about the country? Where or who did you hear these thing about Canada from? What role did this play in setting your expectations of Canada?
4. Did these expectations match your actual experiences throughout the immigration process? How about while living in Ontario?
5. Do you still think Canada is a good country to live in and make your home?
6. Why did you choose to settle in Ontario?
7. What was your chosen occupation before you came to Canada?
8. From the time you applied to immigrate to Canada, how long did the immigration process to Canada take?
9. How you feel about the services in place to assist you with settling in Ontario?
10. How did you hear about the volunteer clinic/community health centre?
11. Has your health been impacted trying to settle in Ontario?
12. Were you made aware of the three-month wait period before coming to Ontario?
13. Have you considered or tried to purchase private health insurance for the three-month wait period?
14. Have you ever tried to get medical attention at another institution besides the volunteer clinic or AAMCH? If so, can you describe your experiences? If not, how else have you taken care of your health since coming to Ontario?
15. For those awaiting approval: How did you find the process of applying for OHIP? When did you first apply to OHIP? How long have you been waiting for approval?

Open-ended, semi-structured interviews with health care providers

1. How long have you been working at the volunteer clinic/AAMCH?
2. What do you think about the move from your old location? Did the move impact your experience providing care at the volunteer clinic? How do you feel about the environment at the new location?
3. Why did you decide to start volunteering your time and skills to the clinic? How did you come to get involved in delivering care to vulnerable populations at AAMCH?
4. Do you enjoy serving the community you work with?
5. Can you describe any challenges you face working with such diverse and multicultural clients?
6. How do you feel about the three-month wait period and any issues or benefits that have come from it? Do you believe it is a fair time to withhold provincial healthcare coverage to try to protect Ontario’s health care system from being taken advantage of?
7. What do you feel are the most common health issues presented by clients within the three-month wait period?
8. Do you feel that clients within the three-month wait period receive the same standard and quality of care as clients with OHIP?
9. Do you find people within the three-month wait period often present with illnesses or symptoms beyond which the clinic/AAMCH has resources to provide care for? What strategies, such as partnerships or informal agreements, have you developed to get services beyond primary care for those in the three-month wait period?
10. Can you describe how responsive other health care settings or institutions have been in providing health services to those in the three-month wait period?
11. Can you describe any difficulties you may have experienced between health care teams or other health care professionals in trying to provide care for clients within the three-month wait period?
12. Do you find that providing care to those within the three-month wait period presents an extra burden to your job?
13. Do you believe the three-month wait period poses any concerns to public health?
Appendix D: University of Western Ontario Ethics Approval

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Treena Orchard
File Number: 102843
Review Level: Delegated
Approved Local Adult Participants: 15
Approved Local Minor Participants: 0
Protocol Title: A Narrative Inquiry of the Experiences of Economic Skilled Workers to Ontario with the Ontario Health Insurance Plan's Three-Month Wait Period
Department & Institution: Health Sciences/Nursing, Western University
Sponsor:
Ethics Approval Date: June 20, 2012 Expiry Date: October 31, 2012
Documents Reviewed & Approved & Documents Received for Information:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Comments</th>
<th>Version Date</th>
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<tr>
<td>Western University Protocol</td>
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<td></td>
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<tr>
<td>Letter of Information &amp; Consent</td>
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<td>2012/05/30</td>
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This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the University of Western Ontario Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.
Appendix E: Letter of Information and Consent for Participation in Narrative Interviews

July 2, 2012

Letter of Information

A Narrative Inquiry of the Experiences of Economic Skilled Workers to Ontario with the Ontario Health Insurance Plan’s Three-Month Wait Period

For Interviews with Immigrants and Interviews with Healthcare Providers

PRINCIPAL INVESTIGATOR:
Treena Orchard, Ph.D.
Assistant Professor
School of Health Studies
Western University
Phone: XXX-XXX-XXXX

Co-Investigator:
Andrea Bobadilla
Phone: XXX-XXX-XXXX

Purpose of Study: You are invited to take part in the interviews I am doing at the Scarborough Volunteer Clinic for the Medically Uninsured and Access Alliance Multicultural Community Health centre. As a Masters student from Western University (WU), I want to understand the impact the three-month wait period has on new permanent residents’ experiences of health and trying to access health services in Ontario. I would also like to gain insight into the effects the three-month wait period has on healthcare providers in Ontario and the consequences they view the policy has on their clients’ health, public health and long-term costs for Ontario’s healthcare system. Very little has been written about the experiences of new permanent residents and healthcare providers with the three-month wait period for Ontario’s Health Insurance Plan (OHIP). Your experiences and ideas are very valuable, and that is why I am asking you to take part in the project.

The Goal of the Study: Identify the challenges and barriers, if any, the three-month wait period produces for new permanent residents trying to access health services and medical attention in Ontario. The aim of this study is also to understand how new permanent residents respond to the structural challenges created by the three-month wait period and what resources or strategies they use during this time to manage their health. I also want to learn about what information new permanent residents received about the three-month wait period, prior to immigrating to Ontario. This information can be used to inform the current debate surrounding the maintenance of the three-month wait period policy, which is crucial because of the paucity of academic literature currently available regarding the issue. Your experiences, stories, and ideas are very valuable to this study, and that is why I am inviting you to take part in the project.

Participant Initials
Who and What is Involved: The lead researcher is Dr. Treena Orchard who is a Researcher and Assistant Professor at Western University. A total of 15 participants between the ages of 19-70 will be involved in the study to take part in one part of the project: focus group, interviews with new economic skilled immigrants within the three-month wait period, interviews with economic skilled immigrants awaiting OHIP approval, or interviews with healthcare providers. There will be a total of two interviews with each individual economic skilled worker that participates. Each activity will take 40-60 minutes and all activities will take place at the Scarborough Volunteer Clinic for the Medically Uninsured or Access Alliance Multicultural Community Health Centre. You are invited to take part in the confidential, semi-structured interviews and you will be compensated for your time and input.

Focus Group (6 recent economic skilled immigrants): There will be one focus group discussion with 6 recent immigrants who were admitted to Canada through the economic skilled worker category and have a strong command of English. This focus group discussion will be conducted at the beginning of the research project to gain insight into what issues regarding the three-month wait period new permanent residents see as the most important to learn about. The focus group will be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said.

Interviews (3 recent economic skilled immigrants within the three-month wait period): I will interview 3 recent economic skilled immigrants on a one-to-one basis two times to gain a more in-depth understanding of experiences of health and accessing health services during the three-month wait period. Expectations of Ontario’s healthcare system prior to immigrating and experiences during settlement will also be discussed. The interviews will be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said.

Interviews (3 recent economic skilled immigrants awaiting OHIP approval): I will also be interviewing 3 recent economic skilled immigrants one-on-one two times to learn about their experiences during the three-month wait period and applying for OHIP. The interviews will be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said.

Interviews (3 healthcare providers): Three healthcare providers will also be interviewed to gain insight into their experiences serving clients within the three-month wait period, working with health care teams to deliver care, and their interactions with health care professionals from various other health care delivery points. The interviews will be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said.

Confidentiality: Confidentiality of the information you disclose is respected and protected. I will not report any information that identifies you and all information obtained will be made and kept anonymous. This includes any personal names you may divulge during the interviews, which will be changed when your data is incorporated into reports, presentations, or publications. You will be asked to read this information and sign the consent form, and after that a study number will be given to you instead of using your real name during the study. By doing this, information gathered will contain numbers and not names, which means that no one will be able to identify you. Only myself and the lead researcher will have access to the information from the study.

Participant Initials
What Will the Information be Used For: The information from the study, which will not contain any identifiable information, may be used to create reports to be presented at scientific conferences and academic journals. It is also my hope that the information will be used during the development of programs to assist newcomers access health services.

Your Rights: Participation in this is voluntary. You may refuse to participate or refuse to answer any questions or withdraw from the study at any time. If you are not comfortable with having your information included in the study, you can contact the lead researcher or co-investigator and she will destroy your information. You can do this at the time of your participation or after you have finished taking part in any stage of the project.

Risks: I do not anticipate that participation in this study will result in any distress or harm for you. However, some issues may be difficult to talk about and could generate emotional and psychological stress; or they may trigger previously traumatic experiences. If you do experience any discomfort, distress, or other emotional difficulties during the research I will be able to provide you with the name of support staff (off and on-site) and the appropriate referral. In addition, if we find information we are required to disclose in relation to child protection provisions, we cannot guarantee confidentiality.

Benefits: The primary benefit of this study is that it honours and seeks to better understand the experiences of new permanent residents to Ontario with the three-month wait period from their own perspective and in their own words. New permanent residents who are or have been in the three-month wait period have often expressed feelings of being ignored by Ontario’s health system by being denied OHIP upon arrival and this study is an opportunity to validate and consider their views on the policy. Healthcare providers have also described their frustration with the three-month wait period and this study will also collect information on the effects of the policy on their jobs and duties as healthcare providers.

Honorariums: An honorarium will be provided for your time and participation in this study at the end of each activity you take part in.

Who to Contact if You Have Questions About Your Participation in the Study: If you have any questions about your rights as a research participant or the conduct of the study you may contact staff at the Office of Research Ethics at Western University at:

The Office of Research Ethics at (XXX) XXX-XXXX or by email at XXXXXX@XXX.ca.

Signing this information and consent form does not waive any of your legal rights. In order to ensure you fully understand the nature of your participation we encourage you to read through the letter of information and ask us any questions you may have, which will be answered immediately.

We thank you very much for your time, input, and willingness to share your important experiences. If you have any questions about the project you may contact the Lead investigator at:

Treena Orchard, Ph.D.
Assistant Professor
School of Health Studies
Western University
Phone: XXX-XXX-XXXX

Participant Initials
Appendix F: Letter of Informed Consent for Narrative Interviews

Letter of Informed Consent

A Narrative Inquiry of the Experiences of Economic Skilled Workers to Ontario with the Ontario Health Insurance Plan’s Three-Month Wait Period

Consent and Signatures: I have read the letter of information and consent and have had the nature of the study explained to me. All questions have been answered to my satisfaction and I agree to participate. I have been given a copy of this letter of information and consent.

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<tr>
<th>PARTICIPANT</th>
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<td>Name:</td>
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Curriculum Vitae

Name: Andrea Bobadilla

Post-secondary Education and Degrees:
University of Western Ontario
London, Ontario, Canada
2007-2011 BHSc. Hons. (Minor in Sociology)

Honours and Awards:
The University of Western Ontario
Dean’s Honour List
2010-2011

Related Work Experience:
Teaching Assistant
The University of Western Ontario
2011-2013

Health Promotion Practicum Student
Oxford County Public Health Unit
2013

Co-op Student
Canadian Institute for Health Information (CIHI)
2010

Project Coordinator
Canada Health Infoway
2008

Publications:
Locally Driven Collaborative Project Breastfeeding Surveillance Project Team. (2013).