

# **Part One: Examining the Health Status & Health Care Experiences of New Permanent Residents in the Three-Month OHIP Wait**

A Scoping Review of the Peer-Reviewed Literature

Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

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Examining Health in the Three-Month Wait | Report  
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This is part one of a three part series about the relationship between the three-month wait period and the health of new PRs, which includes 1) a synthesis of peer-reviewed literature, 2) a synthesis of grey literature, and 3) a theoretical framework.

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## Introduction

Each year over 80,000 new permanent residents (PRs) arrive in Ontario, Canada and are required to wait three months before they are eligible to receive publicly funded health care through the Ontario Health Insurance Program (OHIP)(Citizenship and Immigration Canada [CIC], 2015). While a number of researchers have investigated the health care experiences of new PRs during this wait period, a comprehensive scoping review of peer-reviewed literature has not been conducted.

Health and settlement service providers, academics and new PRs themselves have raised concerns that the three-month wait policy can create a barrier to timely and equitable health care and result in adverse health outcomes (Ontario Medical Association [OMA], 2011). There is evidence that new PRs are seeking health care during the three-month wait; two clinics currently serving uninsured clients in the Greater Toronto Area (GTA) have found that new PRs represent one of the largest uninsured client groups seeking primary health care at their clinics (Access Alliance Multicultural Health and Community Services [AAMHCS], 2015; Shirane, 2009). Existing evidence has found that immediate access to health care services is essential to achieve the best possible health outcomes (Starfield, Shi, & Macinko, 2005). As an important determinant of health (Public Health Agency of Canada [PHAC], 2013), a lack of health insurance could have negative implications on health and well-being (Baker et al., 2001). This review addresses this gap in the literature by providing an overview of existing evidence on the health status and health care experiences of new PRs in the three-month wait. It also identifies opportunities for research and policy regarding the three-month wait.

### Overview of the OHIP Three-Month Wait Policy

The three-month wait policy was implemented in 1994 and also applies to temporary foreign workers and returning Canadians who have been out of the country for five months or longer within a 12 month period (Ministry of Health and Long-Term Care [MOHLTC], 2016). British Columbia, Manitoba, New Brunswick and Quebec are the only other Canadian provinces that also have a waiting period for new permanent residents (British Columbia, n.d.; Manitoba, n.d.; MOHLTC, n.d.; Regie de l'assurance Maladie Quebec [RAMQ], n.d.). The policy does not apply to refugees and refugee claimants who receive health care coverage through the Interim Federal Health (IFH) program.

New PRs in the three-month wait are part of a larger group of uninsured Ontario residents who do not have OHIP coverage due to a number of other reasons: lost or lack of identification, lack of immigration status, and lack of coverage for temporary visa holders. Midwives, community health centres (CHCs), and some volunteer clinics receive some compensation to provide care to uninsured populations (Toronto Public Health [TPH], 2013). Most health care organizations and providers (e.g. hospitals, physicians, walk-in clinics) do not receive OHIP compensation to provide health care to new PRs in the three-month wait and can therefore charge clients out-of-pocket for incurred health care costs.

### Aim of This Review

This scoping review aims to gather existing peer-reviewed evidence to answer the following research questions:

- What is the health status of new PRs during the three-month wait for OHIP?
- What are the experiences of new PRs in the health care system during the three-month wait for OHIP?

In this review, we define health status as the state of physical, mental, and emotional health (World Health Organization, n.d.). If an individual is seeking health care service, we consider this to be indicator of their health status. Health care system experiences are defined as a patient's experience when he or she is seeking or receiving health care (Canadian Institute for Health Information [CIHI], 2016). Permanent residents (PRs) are defined as individuals who have immigrated to and been given permanent resident status in Canada, but are not Canadian citizens (Government of Canada, 2015). In Canada, PRs have the right to receive health care coverage, to live, work and study, to apply for citizenship, and to protection under all Canadian laws (Government of Canada, 2015).

## Methods

We conducted a scoping review of the peer-reviewed literature relating to the three-month wait. This review incorporated the following five steps: 1) identifying the research questions (i.e. What is the health status of new PRs during the three-month wait for OHIP? What are the experiences of new PRs in the health care system during the three-month wait for OHIP?); 2) searching for relevant studies; 3) selecting studies based on inclusion and exclusion criteria; 4) charting the data; 5) collating and summarizing results (Arksey & O'Malley, 2005; Daudt et al., 2013; Levac et al., 2010). The following protocol for this scoping review was developed by the four authors (DK, RC, NH, JS) and reviewed by Wellesley Institute staff.

### Search strategy and study selection

We consulted with a librarian at the University of Toronto to develop the search strategy. We searched the following scholarly databases: MEDLINE, PsycINFO, CINAHL, and Scopus (see Appendix A for database-specific search strategies). Studies were screened and selected based on the following inclusion criteria: published between 2005-2015; English language publication; peer-reviewed studies; collected primary data (i.e. interviews, focus groups, administrative data); study population must have included new PRs in the three-month wait in Ontario (including studies that are aggregated results with uninsured populations more broadly).

Although the aim of this scoping review was to find evidence about new PRs in the three-month wait, evidence focused specifically on new PRs was limited. Due to insufficient data specifically for this population, we included studies that measured the health status and health care system experiences of a larger uninsured cohort (in which new PRs were included). There are a variety of reasons why a patient accessing health care could be defined as uninsured. In most uninsured clinics in the GTA, 27-30 percent of uninsured patients were in the three-month wait (Bunn et al., 2013; AAMHCS, 2011). We hypothesize that these two groups may have similar experiences and characteristics due to their shared experiences of being uninsured and lacking health care coverage in Ontario. However, we are aware that the uninsured population may be different in some capacity than the three-month wait population: they may have been uninsured for a longer period of time, may be living with an increased fear of being non-status, or may have had different migration experiences (Steele Gray et al., 2010). This evidence provides the opportunity to better understand the experiences of new PRs in the three-month wait as one sub-group of a larger uninsured population. Any studies on uninsured populations that did not include new PRs within the study population were excluded.

### Data extraction and synthesis

A total of 299 articles were retrieved, of which five articles were included in the review (see Appendix B for a flowchart on selection of article). The title, abstract and full-text screening of the articles were conducted by all four researchers using Covidence systematic review software; each article was reviewed independently by at least two of the four researchers and all four researchers resolved any conflicts collaboratively. Data was extracted from each article by one of the four researchers using a data extraction sheet, which included a summary of the main results which answered the research questions, the study aim, the research design and methods, participant characteristics, and the study setting and location. Researchers met periodically to discuss and ensure consistency in screening, reviewing and extracting the included studies. After data extraction, researchers collaboratively synthesized extracted data by theme, type of evidence and type of population.

## Findings on New PRs in the Three-Month Wait

### Description of Studies

Two articles presented evidence on new PRs in the three-month wait (Asanin & Wilson, 2008; Goel et al., 2013). All studies included participants in the GTA and were qualitative studies. Refer to the Summary of Findings table for more information about each study (Appendix C).

## Health Care System Experiences

Two studies explored the qualitative experiences of recent immigrants (new PRs) accessing care during the three-month wait, and found that new PRs in the three-month wait experience economic barriers to accessing health care (Asanin & Wilson, 2008; Goel et al., 2013).

Goel et al. (2013) interviewed new PRs in the three-month wait and their caregivers who had accessed health care services at a Scarborough volunteer medical clinic. They found that most participants were unaware of the three-month wait policy until arrival at an OHIP office. No participants had purchased private insurance during the three-month wait due to either an inability to pay, lack of knowledge that it was necessary, or denial by insurance companies. All participants delayed seeking health care due to three-month wait and tried to mitigate the costs of health care. Several participants were asked to pay out-of-pocket for health care and tended to not receive care due to these costs. One participant explained, “I feel bad; I feel sad because I cannot afford to pay from my pocket to go to the hospital, to go to the doctor .... I was upset because I said I’m not working .... How can I go to [the] doctor? How can I afford to go to [the] doctor?” All participants expressed emotional hardship, primarily worry and fear, as a result of the three-month wait, and were concerned about the potential for poorer health outcomes as a result of not seeking health care.

Through focus groups with immigrants in Mississauga, Asanin & Wilson (2008) found that recent immigrants to Canada experience three types of barriers to accessing health care: geographic, socio-cultural and economic. Participants highlighted that the cost of paying out-of-pocket for health care or purchasing private insurance during the three-month wait was a significant economic barrier to accessing care (i.e. newcomers did not seek health care services when sick due to a lack of health coverage).

## Findings on Uninsured Populations (in which new PRs were included)

### Description of Studies

This section of the review includes three articles with evidence focused on the general uninsured population (in which new PRs were included). All three articles include participants in the GTA and collected quantitative data through medical chart reviews. Refer to the Summary of Findings table for more information about each study (Appendix C).

### Health Care System Experiences

Two medical chart reviews measured the type of health care that uninsured refugee, immigrant, and migrant residents receive and have received when presenting at hospitals compared with insured residents (Rousseau et al., 2013.; Wilson-Mitchell & Rummens, 2013). Both studies included a subpopulation of participants who were uninsured because they were new PRs in the three-month wait; however findings for this population of focus were not disaggregated.

As part of a chart review which included 982 Toronto paediatric emergency departments’ files, Rousseau et al. (2013) quantified services received by children who were uninsured because they were new PRs in the three-month wait, undocumented or missing documentation. After arriving at the Toronto emergency department, uninsured children received a range of health care services: 9.6% were hospitalized, 43.6% received medication, 11.9% left without follow-up, 32.6% left with follow-up, and 2.3% left before seeing a doctor (Rousseau et al., 2013).

Through a medical chart review of two GTA hospitals, Wilson-Mitchell & Rummens (2013) compared perinatal outcomes between women who were uninsured and women who were OHIP insured who had delivered between 2007 and 2010; the uninsured women included women who were new PRs in the three-month wait, successful refugee claimants not covered by the IFH, denied refugee claimants, and those who were undocumented (women who had IFH coverage, who had coverage from other Canadian provinces, who had private insurance, or who were homeless were excluded). They found significant differences between the amount of prenatal care that uninsured women received compared to insured women. While some uninsured women received no prenatal care at all (6.5%), all insured women received some level of prenatal care. The average number of reported prenatal appointments that uninsured women received (6.04%) was significantly lower than insured women (8.70).

In addition, the type of health care provider from whom women received prenatal care varied by insurance status. Uninsured women were significantly more likely to seek prenatal care from midwives (35% versus 4% of insured women). All midwives can provide publicly covered care to any Ontario resident. Almost all insured women (94%) received health care from an obstetrician during their pregnancy compared with approximately half of uninsured women (55%). Most uninsured women (80%) received less than adequate prenatal care, defined as fewer than nine prenatal visits starting at 21 weeks gestation, which was based on guidelines from the Society of Obstetricians and Gynecologists of Canada.

Once in hospital, both insured and uninsured women had similar rates of intrapartum medical interventions overall (i.e. oxytocin augmentation, epidural pain control, Cesarean section birth, major resuscitation, NICU admission) with some exceptions. Uninsured women had significant increased rates of caesarian sections compared with insured women as a result of abnormal fetal heart rate (35% versus 21.7%), and newborns of uninsured mothers required significantly more major resuscitation than the newborns of insured mothers (9.7% versus 4.3%). Rates of NICU admission were similar between the two groups' newborns. Uninsured women stayed in hospital significantly less than insured women (1.7 days versus 2.4 days), while length of stay for newborns was similar for each group.

## Health Status

Three articles described the health diagnosis of uninsured residents upon seeking health care at a hospital in Ontario (Rousseau et al., 2013; Bunn et al., 2013; Wilson-Mitchel & Rummens, 2013). One study highlighted that the top three medical and surgical issues for uninsured immigrant children at a Toronto pediatric hospital were: injury/laceration/minor trauma (21.7%), respiratory virus (17.9%), and gastrointestinal virus (6.9%) (Rousseau et al., 2013). Depression and anxiety were documented as top mental health issues, experienced by 3.1% of uninsured children in the study (Rousseau et al., 2013). As well, uninsured children had significantly less urgent triage emergency ratings than the mean of the general hospital population (Rousseau et al., 2013).

Another paper described the differences in health status at diagnosis between insured and uninsured groups (due to three-month wait, lack of permanent residency, lost or expired health cards, or visitor status) who accessed primary health care through a Toronto hospital's family and community practice clinics (Bunn et al., 2013). They found that uninsured clients had a significantly higher prevalence of HIV (24%) compared with insured clients (4%). However, they found no significant differences in the prevalence of hypertension, Type 2 diabetes mellitus, tuberculosis, substance addiction and mental health disorders between uninsured and insured clients.

One article described differences in health outcomes among uninsured immigrant, refugee, and migrant mothers in Ontario (which included new PRs in the three-month wait). In a medical chart review for two GTA hospitals, Wilson-Mitchel & Rummens (2013) compared differences in maternal and neonatal outcomes of pregnant patients and newborns after delivery. The authors found that there were no significant differences in the measured outcomes, such as low birth weight, preterm births, overall maternal complications, and breastfeeding rates.

## Discussion

### Summary of Findings

With this review, we examined the peer-reviewed literature on new PRs in the three-month wait for OHIP. We found that during the three-month wait new PRs are seeking health care at clinics and hospitals (Rousseau et al., 2014; Bunn et al., 2013; Wilson-Mitchel & Rummens, 2013) and that new PRs are experiencing financial barriers to accessing health care (Goel et al., 2013; Asanin & Wilson, 2008). Three medical chart review studies found that new PRs are seeking health care at clinics and hospitals (Rousseau et al., 2013; Bunn et al., 2013; Wilson-Mitchel & Rummens, 2013); however, there was limited evidence on the diagnoses of new PRs in the three-month wait. Two qualitative studies found that new PRs are experiencing financial barriers to accessing health care during the three-month wait (Goel et al., 2013; Asanin & Wilson, 2008). We found no evidence

describing the health status and outcomes of new PRs in the three-month wait.

We also included evidence about the health status and health care experiences of uninsured immigrant populations to supplement the limited evidence specific to new PRs (Rousseau et al., 2014; Wilson Mitchell & Rummens, 2013; Bunn et al., 2013). Uninsured children arriving at a Toronto pediatric emergency department received a range of health care responses; most commonly they received medication or left without follow-up (it is unclear how this compares with the general hospital population) (Rousseau et al., 2014). Pregnant uninsured women at a Toronto hospital received significantly different care from insured women: uninsured women received less prenatal care and were more likely to receive inadequate prenatal care; uninsured women were more likely to see a midwife and less likely to see an obstetrician; and uninsured women had shorter postnatal hospital stays (Wilson Mitchell & Rummens, 2013). Evidence about the health status of these uninsured clients was limited: uninsured children presented with a range of health issues and their health issues were triaged as less urgent than those of the general hospital population (Rousseau et al., 2014); uninsured clients at a Toronto hospital's community clinics had higher HIV prevalence than insured clients (Bunn et al., 2013); and uninsured moms and babies did not have significantly different health outcomes from insured populations (Wilson Mitchell & Rummens, 2013).

## **Interpretation of Findings**

We hypothesize that the financial barriers to health care experienced by new PRs may have negative implications for their health. This is because financial barriers may lead to stress-related poor health outcomes (Turunen & Hiilamo, 2014), decisions to not seek health care (Goel et al., 2013; Asanin & Wilson, 2008), and inadequate health care (Wilson Mitchell & Rummens, 2013). This may contribute to inequities between new PRs and insured populations.

The stress of being in debt from paying out-of-pocket health care and private health insurance costs could pose significant challenges to new PRs' health. Our review highlighted that some new PRs in the three-month wait experience difficulties paying out-of-pocket health care or private health insurance costs (Goel et al., 2013; Asanin & Wilson, 2008). In some cases, new PRs are left with large debts due to health care costs (Goel et al., 2013), which is related to serious effects on health, including suicidal ideation, depression, and poorer health behaviours (Turunen & Hiilamo, 2014).

When experiencing financial barriers to health care, some new PRs with health needs decide to not seek health care or they receive non-comprehensive health care (Goel et al., 2013; Asanin & Wilson, 2008), which may influence their health negatively. Access to timely and comprehensive health care is an established determinant of health (Starfield et al., 2005; PHAC, 2013). In the case of HIV, early diagnosis and treatment of HIV infection is essential to ensuring prompt evaluation, referrals to counseling, and related support services to reduce the risk of disease progression and transmission to others (Centres for Disease Control, 2011). Without these preventative services, the health of new PRs and other populations may be compromised.

This review found that pregnant uninsured women receive inadequate and inequitable prenatal care compared to insured women (Wilson Mitchell & Rummens, 2013). This finding is further supported by authors from other jurisdictions in Canada. For instance, Jarvis et al. (2011) found that uninsured women in Canada received higher levels of inadequate prenatal care compared to insured women. Similar trends have been found in other jurisdictions, where health care coverage has been associated with early prenatal care initiation amongst low income women (Rosenburg et al., 2007) and a lack of health care coverage has been associated with inadequate prenatal care (Delvaux et al., 2001).

Due to the similarities in experiences of being uninsured, we expect that new PR women who are pregnant during the three-month wait may similarly not receive comprehensive and adequate prenatal care. A lack of adequate prenatal care may negatively influence the health of new PR women and their babies. Although our review found no differences in maternal and neonatal health outcomes between insured and uninsured women at a Toronto hospital (Wilson-Mitchell & Rummens, 2013), other studies have found that babies of mothers who do not receive prenatal care are more likely to have worse neonatal outcomes (Vintzelious, Ananth, Smulian, Scorza, & Knuppel, 2002; Patridge, Balayla, Holdcroft, & Abenheim, 2012).

## Three-Month Wait and Health Inequities

New PRs' limited ability to access health care during the three-month wait could contribute to longer-term disparities in access to and utilization of health care, and health outcomes between Canadian-born and immigrant populations. As explained by the healthy immigrant effect, while immigrants generally arrive in Canada healthier than the Canadian-born populations, the physical and mental health status of immigrants declines with the length of time they spend in Canada (Gushulak et al., 2011; Kennedy, McDonald & Biddle, 2006). It is possible that this decline in health status may be in part due to the barriers that new PRs face in accessing health care, including the three-month wait for OHIP. For instance, when newcomers have poor access to care, they may become more distrustful of the health care system, may be less able to navigate it, and may delay accessing care in the long term (Ahmad et al., 2013; Lebrun, 2012). As an important determinant of health, poor access to health care could lead to a decline in the health status of new PRs in the three-month wait, contributing to differential health outcomes between long-term immigrants and Canadian born populations.

## Limitations

While this review provides a comprehensive exploration of peer reviewed literature that examines the health status of new PRs and their experiences in the health care system, there are some limitations to consider. The main limitations of this review are related to the small size of this body of literature and the nature of the current evidence.

All of the studies reviewed were cross sectional, which prevents us from drawing causal links between the three-month wait and health status or health care experiences of new PRs. Also, due to the lack of control groups, we were unable to compare findings between new PRs in the three-month wait and insured populations. Due to limited research specific to new PRs, we included aggregated evidence from uninsured populations in general which include new PRs. While the included findings from uninsured populations may suggest that new PRs who are uninsured in the three-month wait also have a range of health concerns, unmet health needs, and receive inequitable and inadequate prenatal care, we cannot confidently extrapolate these findings to new PRs due to the diverse experiences of uninsured populations.

Additionally, no quality assessment of the documents was conducted as this is not a necessary step of a scoping review (Arksey & O'Malley, 2005). Scoping review methodologies suggest conducting consultations with practitioners to identify potential reports and sources of information which could be useful. Although we engaged with practitioners we did not systematically connect with them to identify relevant resources. Some resources could have been missed. Due to time constraints, we did not reach out to authors of the documents or clinics to verify whether they had disaggregated data for new PRs in the three-month wait.

## Research Gaps & Next Steps

This scoping review has identified a significant gap in the evidence on health care experiences and health status of new PRs in the three-month wait. Although we found that new PRs experience financial barriers during the three-month wait (Goel et al., 2013; Asanin & Wilson, 2008), we need a stronger evidence base to understand the scale and depth of this issue. This will help us better understand the impact of the three-month wait policy on the health of new PRs.

Additional research is needed to quantify the health status of new PRs at a population level and to compare those needs with insured populations in Ontario. As well, research is needed to compare the type and adequacy of health care received by new PRs with insured Ontario populations to determine if differences exist. Ultimately, longitudinal studies examining the relationship between the three-month wait and the health outcomes of new PRs would be beneficial to illuminating the impact of this policy on health. Furthermore, it is important that when possible, researchers disaggregate the findings of new permanent residents who are uninsured due to the three-month wait from findings of uninsured populations in general who often have very different demographics and migration experiences.

## Policy Recommendations

This scoping review found that new PRs in the three-month wait experience an economic barrier to accessing health care, which may result in unmet health needs, inequitable access to health care, and worse health outcomes. Researchers and health care providers have raised concerns about the policy and recommended to end the three-month wait.

In addition to a lack of health evidence in support of this policy, the three-month wait policy does not make financial sense. First, removing the three-month wait would not burden the health care system. The estimated cost of removing the three-month wait would be \$60 million (AAMHCS, 2011), which is approximately 0.1 percent of Ontario's total health care budget (\$51.8 billion)(Ontario, 2016). Second, rather than reducing overall health care utilization and cost, there is evidence that new PRs use health care services significantly more in their fourth month in Ontario, suggesting that they delay seeking health care during the three-month wait (DesMeules et al., 2004). This delay in seeking health care for chronic or acute care issues may worsen their health conditions and ultimately drive up the cost of health care delivery in the months following the three-month wait.

In Canada, we value the inclusion of newcomers and the universality of our health care system. The majority of Canadian provinces provide immediate access to health care for new PRs. The three-month wait policy contradicts these values as well as the internationally recognized right to health by creating financial barriers to immediate and comprehensive health care for newcomers in Ontario. Based on this review, we argue that the three-month wait is not supported by good health evidence; indeed because the policy creates a financial barrier to care, it may merely serve to delay new PRs from seeking care until they have OHIP coverage, and could worsen the health of new PRs. For these reasons, we recommend that the three-month wait policy should be reconsidered and eliminated.

The Ontario Ministry of Health and Long-Term Care has prioritized equity, access and universality of the health care system (MOHLTC, 2015). This is an important step towards improving the health care experience and health outcomes of Ontario's population. The evidence presented in this report suggests that the three-month wait for OHIP creates barriers to accessing care and could potentially have negative implications for health.

The government has committed to evidence based decisions and putting patients needs first. The MOHLTC should consider the lack of evidence for the utility of the three-month wait policy. Ending the three-month wait policy would ensure that newcomer patients can access the right care when they need it and could improve health outcomes.

## Conclusion

This paper provides a comprehensive review of all available, peer-reviewed research about the health status and health care experiences of new permanent residents during Ontario's three-month wait period. The review found that new permanent residents experience financial barriers to accessing health care during the three-month wait. We argue that these barriers could potentially contribute to inequities in access to and utilization of health care, and health outcomes between new permanent residents and Canadian-born populations. Due to the financial barriers that new permanent residents experience during the three-month wait, and the lack of utility of this policy, we recommend that three-month OHIP wait policy be reconsidered.

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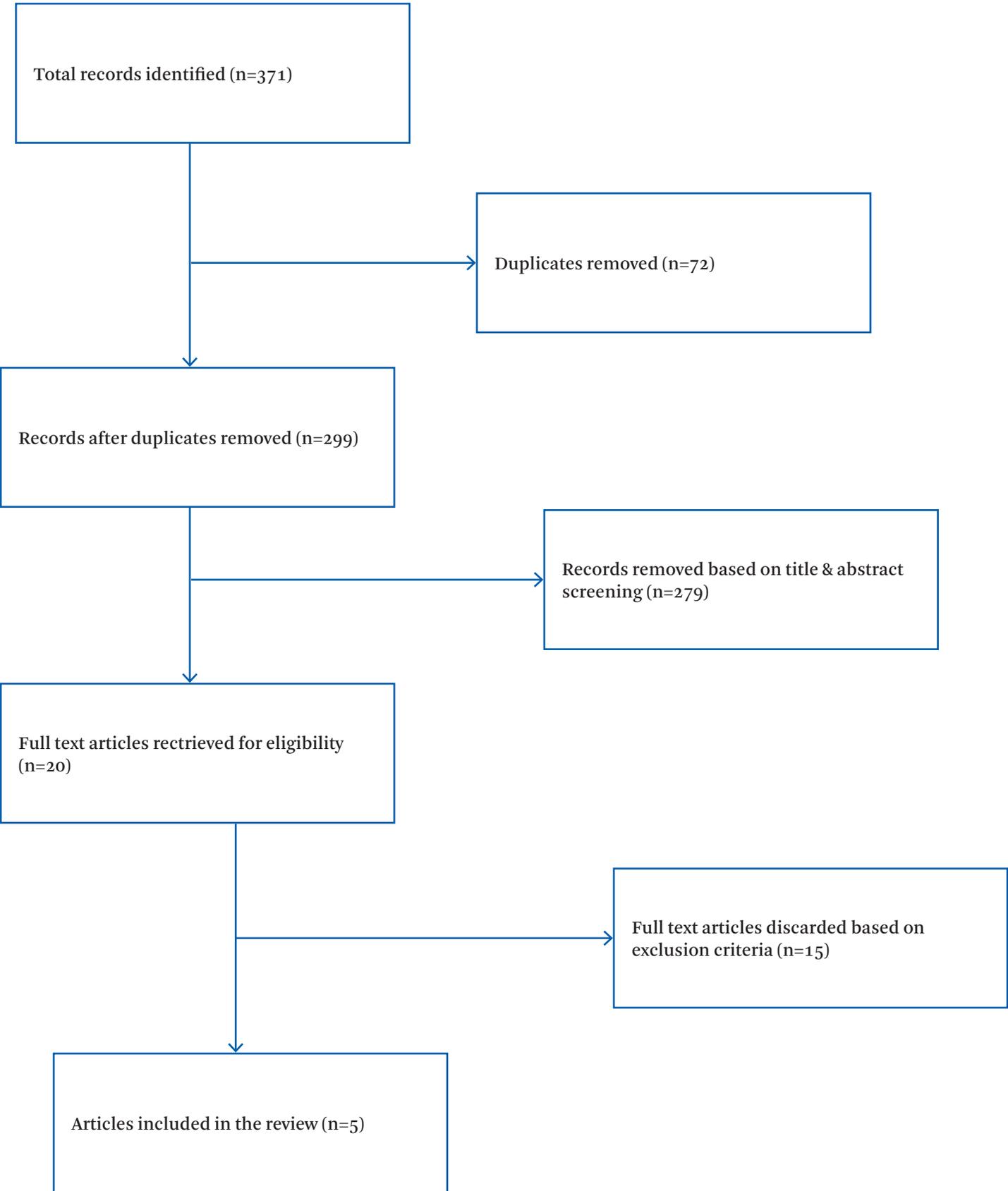
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## Appendix A: Search Strategies

Database	Records	Search Strategy	Limits
MEDLINE	129	exp Health Services Accessibility/ OR exp Insurance, Health/ OR (OHIP or “Ontario Health Insurance Plan” or “Health Insur*” or “Acce* Adj3 Health” or “Health Adj3 Servic*” or uninsured).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] AND (Ontario or Canada or Toronto).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] AND [exp “Emigrants and Immigrants”/ OR (Immigrant* or Newcome* or “permanent residen*”).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] ]	limit to (English language and humans and yr=”2005-Current”)
PsycINFO	78	(exp Health Care Utilization/ or exp Health Care Services/ or exp Health Care Policy/ or exp Health Care Delivery/ or exp Health Insurance/ or exp Immigration/ OR OHIP or “Ontario Health Insurance Plan” or “Health Insuranc*” or “Acce* Adj3 Health” or “Health Adj3 Servic*” or uninsured) AND (exp Immigration/ and (Immigrant* or Newcome* or “permanent residen*”)) AND (Canada or Ontario or Toronto)	limit to (human and English language and yr=”2005-Current”)
Scopus	131	( ohip OR “Ontario Health Insurance Plan” OR “Health W/3 Insur*” OR “Acce* W/3 Health” OR “Health W/3 Servic*” OR uninsured ) AND ( ontario OR canada OR toronto ) AND ( immigrant* OR newcome* OR “permanent residen*” )	(LIMIT-TO (PUBYEAR , 2005 -2015 )) AND (LIMIT-TO (LANGUAGE , “English” )) AND (LIMIT-TO (AFFILCOUNTRY , “Canada” ))
CINAHL	33	( “immigrant*” OR “newcome*” OR “permanent resident” OR (MH “Emigration and Immigration” ) ) AND ( (MH “Health Services Accessibility+”) OR (MH “Insurance, Health+”) OR (MH “Medically Uninsured”) OR (OHIP or “Ontario Health Insurance Plan” or “Health N3 Insuranc*” or “Acce* N3 Health” or “Health N3 Servic*” or uninsured ) AND ( (MH “Canada”) OR (MH “Ontario”) OR (MH “Toronto”) )	Limiters - Published Date: 20050101-20151231 Narrow by SubjectGeographic: - canada Narrow by Language: - English

**Appendix B: Flowchart of Articles**



## Appendix C: Summary of Findings Table

Author and Year	Sample Information	Research Design	Main Findings for New PRs in the Three-Month Wait	Main Findings for Broader Uninsured Population (including those in Three-Month Wait)
Asanin & Wilson, 2008	Type of participant & setting: Immigrants who were part of various classes and groups at a community organization Location: Mississauga Sample Size: 53	Method: Qualitative Design: Cross-sectional Collection: Focus Groups Analysis: Grounded theory coding	<ul style="list-style-type: none"> <li>• The cost of paying out-of-pocket for health care or private health insurance was a significant barrier for participants seeking care in their first three months</li> <li>• It was a significant concerns for family with young children</li> </ul>	None
Bunn et al., 2013	Type of participant & setting: Uninsured and insured patients Location: Toronto Sample Size: 52 uninsured and 52 insured patients	Method: Medical Chart Audit Design: Retrospective Collection: Hospital client charts Analysis: Statistical	<ul style="list-style-type: none"> <li>• In a subgroup analysis of HIV-infected uninsured patients at the hospital, 18% of patients in this group were uninsured immigrants due to the three-month wait</li> </ul>	<ul style="list-style-type: none"> <li>• Prevalence of hypertension, type 2 DM, TB, substance addiction, or mental health disorder were similar between uninsured and insured</li> <li>• No significant difference between the groups in the proportion of patients seeking prenatal or routine pediatric care</li> <li>• Significant difference in the proportion of HIV-positive patients between the uninsured and insured groups</li> </ul>

Goel et al. (2013)	<p>Type of participant &amp; setting: new permanent residents and their caregivers in the three-month wait  Location: Toronto  Sample Size: 7</p>	<p>Method: Qualitative  Design: Cross-sectional  Collection: Semi-structured, in-depth interviews  Analysis: Qualitative analysis (phenomenological framework)</p>	<ul style="list-style-type: none"> <li>• Most participants were unaware of three-month wait policy until arrival at OHIP office, found OHIP officials unhelpful</li> <li>• None had private insurance due to lack of knowledge that it was necessary, inability to pay, or denial by insurance company</li> <li>• Most participants described poor social situations (housing, finances, employment) when arriving in Canada, expressed emotional hardship, and confusion about the three-month wait</li> <li>• Most participants were afraid of financial harms of accessing health care services, and all delayed seeking care owing to the three-month wait</li> <li>• Several were asked to pay for care, some paid, some did not get care due to cost</li> <li>• Participants were concerned about potential for poor health outcomes resulting from not seeking care</li> </ul>	None
Wilson-Mitchel & Rummens, 2013	<p>Type of participant &amp; setting:  Location: Toronto  Sample Size: 435 (175 uninsured and 278 insured)</p>	<p>Method: Quantitative  Design: Medical record review  Collection: retrospective chart reviews of hospital records  Analysis: quantitative analysis</p>	None	<ul style="list-style-type: none"> <li>• Health insurance status was found to be related to the amount of prenatal care, type of health care provider, reason for caesarean section, neonatal resuscitation incidence, and maternal length of hospital stay</li> <li>• Where 6.5% of uninsured women received no prenatal care at all, all insured women received some prenatal care</li> <li>• Uninsured women had received a greater number of inadequate prenatal care and fewer numbers of prenatal visits than insured women</li> <li>• Uninsured women had a significantly higher rate of caesarean sections, higher incidence of major resuscitation, and significantly fewer days of hospital stay than insured women</li> <li>• There were no significant differences between the insured and uninsured groups with respect to low birth weight rates, pre-term birth rates, overall maternal complications, or breastfeeding rates</li> <li>• The two groups also had similar rates of intrapartum medical interventions.</li> </ul>

Rousseau et al. (2013)	<ul style="list-style-type: none"> <li>• Most participants were unaware of three-month wait policy until arrival at OHIP office, found OHIP officials unhelpful</li> <li>• None had private insurance due to lack of knowledge that it was necessary, inability to pay, or denial by insurance company</li> <li>• Most participants described poor social situations (housing, finances, employment) when arriving in Canada, expressed emotional hardship, and confusion about the three-month wait</li> <li>• Most participants were afraid of financial harms of accessing health care services, and all delayed seeking care owing to the three-month wait</li> <li>• Several were asked to pay for care, some paid, some did not get care due to cost</li> <li>• Participants were concerned about potential for poor health outcomes resulting from not seeking care</li> </ul>	<p>Method: Medical chart audit  Design: Retrospective  Collection: Hospital client charts  Analysis: Descriptive and bivariate analysis</p>	None	<ul style="list-style-type: none"> <li>• Top three medical and surgical issues: 21.7% injury/laceration/minor trauma. 17.9% respiratory virus, 6.9% gastrointestinal virus</li> <li>• Top mental health issue: 3.1% depression or anxiety</li> <li>• Top social problem: 4.8% reported family or conjugal violence</li> <li>• the mean triage emergency ratings (urgency of issues) for all uninsured (new PRs, undocumented, and 'grey zone') and refugee claimant children was significantly higher than the overall hospital pop at Toronto hospital but uninsured children had significantly more urgent and more urgent issues than refugee claimant children</li> <li>• Other uninsured kids at Toronto hospital: 9.6% were hospitalized, 43.6% received medication, 11.9% left without follow-up, 32.6% left with follow-up, 2.3% left before seeing a doctor</li> </ul>
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