Part Two: Examining the Health Status & Experiences of New Permanent Residents in the Three-Month Wait for OHIP

Scoping Review of the Grey Literature

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Examining Health in the Three-Month Wait: Part Two| Report

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This is part two 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 for 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 grey literature has not been conducted.

Health and settlement service providers, academics and new PRs themselves have raised concerns that the three-month wait policy creates a barrier to timely and equitable health care and can 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 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, Sudano, Albert Borawski, & Dor, 2001). This review addresses the gap in the literature by providing an overview of existing evidence on the health status and health care experiences of being in the three-month wait. It also identifies opportunities for research and policy regarding the three-month wait.

Overview of the Three-month Wait Policy for OHIP

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], n.d.). 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 grey literature to answer the following research questions:

- What are the experiences of new PRs in the health care system during the three-month wait for OHIP?
- What is the health status of new PRs 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 services, we consider this to be an 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], n.d.). 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).

Part one of this series reviews peer-reviewed academic literature on new PRs in the three-month wait. In comparison, this

paper reviews the grey literature including reports by health care organizations and from clinics in Toronto.

Methods

We conducted a scoping review of grey literature relating to the three-month wait. This review incorporated five steps: 1) identifying the research questions (i.e. What are the experiences of new PRs in the health care system during the three-month wait for OHIP? What is the health status of new PRs due to 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. We based our scoping review methodology on the frameworks proposed by Arksey & O'Malley (2005).

The aim of this scoping review was to find evidence about new PRs in the three-month wait. However, evidence relating to our research questions that focused specifically on new PRs was limited. Due to the paucity of data specifically on this population, we expanded our search to include studies that measured the health status and health care system experiences of a larger uninsured cohort (in which new PRs were included). We hypothesize that these two groups may have similar experiences due to their shared experiences of being uninsured and lacking health care coverage. Although they may have similar health care experiences in Ontario, we are aware that the uninsured population differs from the three-month wait population as 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, Hynie, Gardner & Robertson, 2010). This evidence provides the opportunity to better understand the experiences of new PRs in the three-month wait as one component of a larger uninsured population. We would like to note that only studies on uninsured populations that included at least some new PRs within the study cohort were included.

To identify grey literature, a Google search was conducted in January, 2015 using search terms ("OHIP" OR "Ontario Health Insurance Plan" OR "three-month wait" OR "3 month wait" AND "Immigrant" OR "Newcomer" OR "permanent resident" AND Ontario OR Canada OR Toronto) with limits (2005-2015, Canada). The search found 7330 results of which the first 100 were reviewed and assessed based on the inclusion and exclusion criteria. See Appendix A for a flowchart of studies throughout the scoping review process.

A key website search (of terms such as "three-month wait" or "3 month wait" was also conducted on the following websites for grey literature:

- City of Toronto
- Canadian Public Health Association (CPHA)
- Access Alliance Multicultural Health and Community Services
- Toronto Local Immigration Partnerships (LIPS) - North, South, East and West
- Ministry of Health and Long-Term Care (MOHLTC)

These websites include prominent government bodies and service providers related to settlement and health.

All documents were screened and selected based on the following inclusion criteria:

1. Published between 2005 - 2015 (i.e. current)
2. English language publication
3. Grey literature (e.g. reports, conference presentations)
4. Include collected data (i.e. a primary study, case studies, administrative data)
5. Include data about new PRs in the three-month wait, including studies that are aggregated results with uninsured populations more broadly, in Ontario.

Data was extracted from each report by the study team through a data extraction sheet; information was extracted regarding the sample information (participant type, setting, location, sample size), research design (method, design, collection, analysis), population of focus, main findings, type of publication and themes. Researchers met periodically to ensure similar understanding of definitions and codes. Through coding the studies, themes were inductively developed.

Findings

Description of Studies

In total, the review identified five grey literature papers, i.e. reports and studies that have not been published in peer-reviewed academic journals and that have findings on new PRs in the three-month wait (AAMHCS, 2015; Bobadilla, 2013; Shirane, 2009; Steele Gray et al., 2011; TPH & AAMHCS, 2011). Only one article (Bobadilla, 2013) focused specifically on new PRs in the three-month wait, and was a qualitative, cross-sectional study.

The remaining four studies had findings related to the broader uninsured population, but included findings specific to new PRs in the three-month wait or included them as participants (AAMHCS, 2015; Shirane, 2009; Steele Gray et al., 2011; TPH & AAMHCS, 2011).Two of the studies that focused on uninsured populations more broadly are descriptive analyses of medical records (AAMHCS, 2015; Shirane, 2009). Two papers are qualitative cross-sectional studies (Steele Gray et al., 2011; TPH & AAMHCS, 2011).

All studies included participants in Toronto. Refer to the Table of Findings for more details about each study (Appendix B).

1.Health Care System Experiences

The review findings relating to the experiences of new PRs in the health care system are composed of a) issues with accessing health care (i.e. cost of out-of-pocket care, delay in care, denied care) and b) health care received (i.e. limited availability of health care provided, system and provider responses).

a) Issues with accessing health care

i. Cost of Out-of-Pocket Health Care

Two studies found that inability to pay for health care out-of-pocket is a barrier to receiving care for new PRs in the three-month wait (Bobadilla, 2013; TPH & AAMHCS, 2011). Focus groups with service providers by Toronto Public Health & Access Alliance Multicultural Health and Community Services (TPH & AAMHCS) (2011) found that there were economic barriers to accessing health care for those in the three-month wait. For example, a parent who was a new PR in the three-month wait had no job and could not afford the $500 fee for admitting his child into hospital for pneumonia. Additionally, his wife was pregnant and he spoke to how it was “really difficult” (p.103). Bobadilla (2013) found that the most expensive and frequent costs that new PRs feared incurring were pregnancy related costs including prenatal and obstetrical care.

Although private insurance is available for purchase, it was found that some new PRs in the three-month wait cannot afford to pay for it (Bobadilla, 2013; TPH & AAMHCS, 2011). Additionally, those who have a pre-existing illness or condition, such as pregnancy, can be denied private insurance (Bobadilla, 2013; TPH & AAMHCS, 2011). Furthermore, new PRs considered private insurance to be less comprehensive than public coverage (Bobadilla, 2013).

Similarly, Steele Gray et al. (2010) found that cost is a major barrier to accessing health care for uninsured populations. For instance, pregnant uninsured women often face barriers to accessing prenatal care due to cost.

ii. Delay in Care

One article found that new PRs in the three-month wait delay care due to financial reasons (TPH & AAMHCS, 2011). Service providers reported that new PRs are deciding not to seek health care during the three-month wait (Bobadilla, 2013). This delay in health care could result in increased use of tertiary and emergency care because there may be a heightened risk of complications, especially for acute health issues (Bobadilla, 2013).

For instance, pregnancy is one situation where a delay in care is a problem. One health care provider explained, “Sometimes, pregnant women come here six months [pregnant] and then wait three months to get their OHIP. And then they need the doctors right away. It’s difficult to find doctors at that very moment” (Bobadilla, 2013, p.94).

Similarly, Steele Gray, et al. (2010) found that uninsured pregnant women delay prenatal care mostly due to financial reasons.

iii. Denial of Care

One article reported that new PRs were denied care in the three-month wait (Bobadilla, 2013). In this qualitative study, all new PR participants who sought care at their local CHC were denied care due to long waiting lists or limited CHC capacity (Bobadilla, 2013). One of the participants reported challenges accessing midwifery services for prenatal care because the midwifery services in the catchment area were full (Bobadilla, 2013).

In focus groups with service providers who serve uninsured populations, it was found that uninsured pregnant women in need of prenatal care were also refused services even when they were able to pay for these services (TPH & AAMHCS, 2011). No reason was reported for why services were denied.

b. Health care received

i. Limited Availability and Quality of Health Care

One article described the characteristics of health care received for new PRs in the three-month wait. New PRs reported limited midwife availability in the Greater Toronto Area (GTA) and therefore limited access to publicly covered prenatal care (Bobadilla, 2013).

In addition, there were four studies that include findings about quality of health care for uninsured populations (AAMHCS, 2015; Shirane, 2009; Steele Gray et al., 2011;TPH & AAMHCS, 2011). Due to clients' limited ability to pay for health care expenses, and the limited resources of service providers to provide care to uninsured populations, the health care that uninsured populations receive is often not comprehensive, timely, or adequate (Steele Gray et al., 2010). In particular, uninsured pregnant women, often receive inadequate prenatal care (AAMHCS, 2015; Shirane, 2009; Steele Gray et al., 2011;TPH & AAMHCS, 2011).

ii. System and Provider Responses:

One article described system and provider responses for new PRs in the three-month wait. Bobadilla (2013) found that regardless of whether clients were paying for services or accessing publicly funded care, staff at a volunteer clinic in Scarborough, Toronto had to advocate for their clients to receive care because other health care providers were already overwhelmed with the demand. The Scarborough Community Volunteer Clinic (CVC) has had increased demands and consequently has had to be more selective about who to treat (Bobadilla, 2013).

Bobadilla (2013) also reported that health care providers rely on formal and informal relationships between primary and specialist care providers to provide care. As well, staff reported interprofessional tension due to differing opinions on providing care for this population; some health care providers were hesitant about providing a lower standard of care to those in the three-month wait than those with OHIP.

There were two studies that focused on system and provider responses for uninsured populations (Steele Gray et al., 2010; TPH & AAMHCS, 2011). Supporting the findings of Bobadilla (2013), Steele Gray et al. (2010) also found that some health care organizations have developed formal contracts with each other to ensure consistent out-of-pocket health care fees for uninsured clients, or to share space, staff, or funding used to provide health care for uninsured populations. Some hospitals and CHCs in Toronto have developed short-term agreements to provide birthing services, or to harmonize hospital rates for uninsured clients (Steele Gray et al., 2010). These agreements may increase the consistency of health care for uninsured populations, but are limited in their scope of services and funding (Steele Gray et al., 2010).

Limited resources were also identified as a barrier to serving uninsured populations. Providers serving uninsured populations sometimes have limited hours and financial resources to respond to their needs (Steele Gray et al., 2010; TPH & AAMHCS, 2011). In focus groups, newcomers to Toronto describe a number of different barriers to accessing health care including: long wait times particularly at walk-in clinics; being rushed in appointments; not receiving sufficient information about medical procedures; and a lack of understanding from service providers about specific newcomer experiences and challenges (TPH & AAMHCS, 2011).

2. Health Status

The grey literature reviewed had limited evidence on the health status of new PRs during the three-month wait. Health status

is composed of health concerns/range of diagnoses and health outcomes.

a. Health Concerns / Range of Diagnoses

There is no quantitative or qualitative grey literature reporting disaggregated information on the specific health conditions of new PRs in the three-month wait.

Despite the lack of evidence on the specific conditions of new PRs in the three-month wait, AAMHCS (2015) and Shirane (2009) found that new PRs in the three-month wait are either the biggest or second biggest group of the uninsured population seeking health care. AAMHCS (2015) reports findings from the uninsured walk-in clinic in Toronto and Shirane (2009) from the volunteer clinic for the medically uninsured in Scarborough.

AAMHCS (2015) reports that the common health issues of uninsured clients included:

- prenatal care 5.9% (top issue)
- review of test results 4.33%
- special screening including immunizations 4.33%
- hypertension 4.33%
- joint pain 3.17%
- and diabetes 1.7%
- and mental health issues 0.92%

Shirane (2009) reports the most frequent medical needs for uninsured populations from the chart reviews including data from 2000-2008. The main concerns were prenatal care (13%), immunization (11%), upper respiratory-tract infections (33% of acute medical conditions), hypertension (7.3%), and diabetes (5%).

b. Health Outcomes

There is no quantitative evidence and limited qualitative evidence on health outcomes for new PRs due to the three-month wait.

Through interviews with new PRs in the three-month wait and service providers serving this population in Scarborough, Bobadilla (2013) found that service providers were concerned that adverse health outcomes were a potential consequence of the three-month wait, and reported that new PRs in the three-month wait may have differential health outcomes from the rest of the population (Bobadilla, 2013).

In line with the findings related to new PRs in the three-month wait, two studies found that uninsured participants may experience negative health outcomes (Steele Gray et al., 2010; TPH & AAMHCS, 2011). According to nearly half of service provider respondents in a qualitative study, there may be an increased severity of health conditions as a result of delays in accessing and receiving care, which is avoidable (Steele Gray et al., 2010; TPH & AAMHCS, 2011). Uninsured groups experience emotional hardship (including stress, fear, depression and frustration) relating to the inability to meet their health care needs (TPH & AAMHCS, 2011; Steele Gray et al., 2010). Specifically for pregnant women, service providers highlighted that uninsured populations may deal with health conditions in ways that are risky, such as having unsupervised home births. This can pose a risk to both the mother and child (TPH & AAMHCS, 2011; Steele Gray et al., 2010).

Discussion

Although there is limited evidence in the grey literature regarding the experiences and health status of new PRs during the three-month wait, the existing grey literature suggests that new PRs face challenges when they have a health need during the three-month wait. They may face financial barriers when accessing health care such as: costs of out-of-pocket care, or not being able to afford private insurance (Bobadilla, 2013; TPH & AAMHCS, 2011). They also face challenges related to the limited availability of publicly covered health services, such as insufficient prenatal care or midwifery services (Bobadilla, 2013). As well, due to pre-existing conditions, they might not be eligible for private insurance (Bobadilla, 2013; TPH & AAMHCS, 2011). All of these factors combine to create a difficult situation where new PRs might delay care (TPH & AAMHCS, 2011), be denied care (Bobadilla, 2013) or access services which vary in comprehensiveness and quality (Bobadilla, 2013). The literature shows that new PRs presented at clinics during the three-month wait which suggests that new PRs have health needs during the

three-month wait (AAMHCS, 2015; Shirane, 2009). However, there is no strong evidence regarding what type of health concerns people present with or the extent of those needs in the entire three-month wait population.

These findings about new PRs are further supported by research about the health status and experiences of uninsured populations. The literature about both uninsured and new PRs suggests that being uninsured, whether because of the three-month wait or for other reasons, is a challenging situation for both uninsured clients and for the providers who serve them with limited resources. For example, access to adequate prenatal care was identified as an issue for those in the three-month wait and for uninsured populations more broadly (AAMHCS, 2015; Bobadilla, 2013; Shirane, 2009; Steele Gray et al., 2011;TPH & AAMHCS, 2011). The literature suggests that the demand for services for uninsured populations is high. The high demand combined with limited resources creates difficulties for service providers to meet the needs of the uninsured population (Bobadilla, 2013).

The evidence suggests that the three-month wait policy is creating inequities in health care access for those in the three-month wait. The ability to find those few clinics which provide services free of charge or at reduced rates to uninsured populations is another barrier to accessing care that furthers inequities. Those who are not able to access those clinics might not be able to access health care at all, or might have to pay out-of-pocket for health care services. New PRs have varied economic situations and some may not be able to afford private insurance or pay out-of-pocket costs (Bobadilla, 2013; TPH & AAMHCS, 2011). For instance, those who are unemployed or have limited assets would likely pay a larger proportion of their income on health care costs than those new PRs who are in a better economic position.

All of the challenges new PRs experience during the three-month wait, could result in negative health outcomes. By creating a barrier to accessing care, the three-month wait could result in new PRs not receiving care at all, delaying their care or receiving inadequate care (Bobadilla, 2013; TPH & AAMHCS, 2011). All of these situations could negatively affect their health. Literature on the healthy immigrant effect demonstrates that the health of immigrants decreases as they spend more time in Canada (TPH & AAMHCS, 2011). A current systematic review of the healthy immigrant effect suggests that barriers to accessing care could in part affect the health outcomes of immigrants (Vang, Sigouin, Flenon & Gagnon, 2015). Furthermore, it has been established that timely access to health care, especially primary health care, is important for improved health outcomes (Starfield et al., 2005).

The three-month wait policy might also negatively affect the health outcomes of new PRs directly and indirectly by creating additional post-migration stressors (Steele Gray et al., 2010). By being unable to access care, or having to pay out of pocket, the three-month wait could create stress for new PRs when they need to access care (Goel et al., 2013). Research in Canada and abroad suggests that immigrants already face post-migration stressors, such as acculturation or discrimination which creates negative mental health outcomes (Beiser, 2005; Dow, 2011). The three-month wait policy could be an additional stressor for new PRs, as it can create fear due to being unable to access care or being faced with high hospital bills (Steele Gray et al., 2010).

The evidence suggests that the three-month wait is problematic as it can create inequities in access to care, it can create negative health outcomes and it can make the settlement experience more stressful for new PRs. These issues have implications for practice and policy which will be further discussed below.

Limitations

While this review provides a comprehensive overview of the grey literature about the health status and experiences of new PRs in the three-month wait, there are a number of limitations to consider. In part due to the geographic boundaries of this policy and subsequently the scoping review, there is a small body of the literature dealing specifically with new PRs in the three-month wait in Ontario. All of the included studies used a cross-sectional design which does not allow for an understanding of the causal mechanisms or the long-term impact of the three-month wait on new PRs. Another limitation was that some of the studies did not disaggregate data for new PRs in the three-month wait. As such, we were unable to confidently report on the specific health conditions of those in the three-month wait. None of the studies quantitatively examined the relationship between the three-month wait and health outcomes, although it was clear that for new PRs and for service providers this policy was a cause for concern.

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 consultation 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 look for additional 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. Also, by only examining the first 100 results of our Google search we could have missed relevant studies.

Further Research

Given the limited literature on the topic it is not possible to form definitive conclusions about the effects of the three-month wait on new PRs. However the literature does point to issues which might be experienced by new PRs during the three-month wait. This highlights the importance to conduct further research about how the three-month wait affects the health of new PRs, and other health related areas of the immigration experience. Although there is no research linking the three-month wait period to broader health concerns for new PRs, the findings of this review raise interesting research and policy relevant concerns worth analysing.

It is worth conducting further research to address these gaps. This includes developing a better understanding of how many new PRs are in need of health care during the three-month wait and the specific conditions they present with. Further research could explore the impact of the three-month wait to clarify how many new PRs seek health care and for what conditions. Another area of research that could be explored is how the three-month wait is related to the healthy immigrant effect, social exclusion and the settlement period.

No existing research outlined how the three-month wait affects different sub groups, and it would be useful to understand how the policy affects new PRs differently, depending on their age, country of origin, ethnicity, gender identity or if they are part of a racialized group.

Implications for Practice

Some recommendations that would improve practice include:

- Service providers should collect and report on disaggregated data to be better able to provide services to those in the three-month wait. This would also add to the evidence about the health needs of those in the three-month wait.
- As is currently being done, service providers should continue to develop guidelines and share best practices for serving new PRs in the three-month wait to facilitate efforts to connect clients to services.

Implications for Policy

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 policy creates barriers to accessing care and could potentially have negative implications for health.

Since 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. A number of prominent health and public health organizations in Ontario have called for this change, including the Toronto Medical Officer of Health (2013) and the Ontario Medical Association (2011).

Removing the three-month wait would not be costly for Ontario. Access Alliance has estimated that removing the three-month wait would cost $60 million (AAMHCS, 2011), which is approximately 0.1 percent of Ontario's health care budget (Ontario, 2016). Simultaneously, the removal of the three-month wait may prevent poorer health outcomes and therefore costly health care needs.

This range of evidence supports the examination and removal of the policy to enhance access to excellent health care for all Ontarians.

Conclusion

Existing evidence suggests that the three-month wait for OHIP policy is problematic as it creates barriers to accessing care, and could detrimentally affect the health of new PRs. Further research could clarify how the three-month wait affects the health of new permanent resident in the short-term and long-term. Therefore, it is recommended that the policy should be further examined and eliminated.

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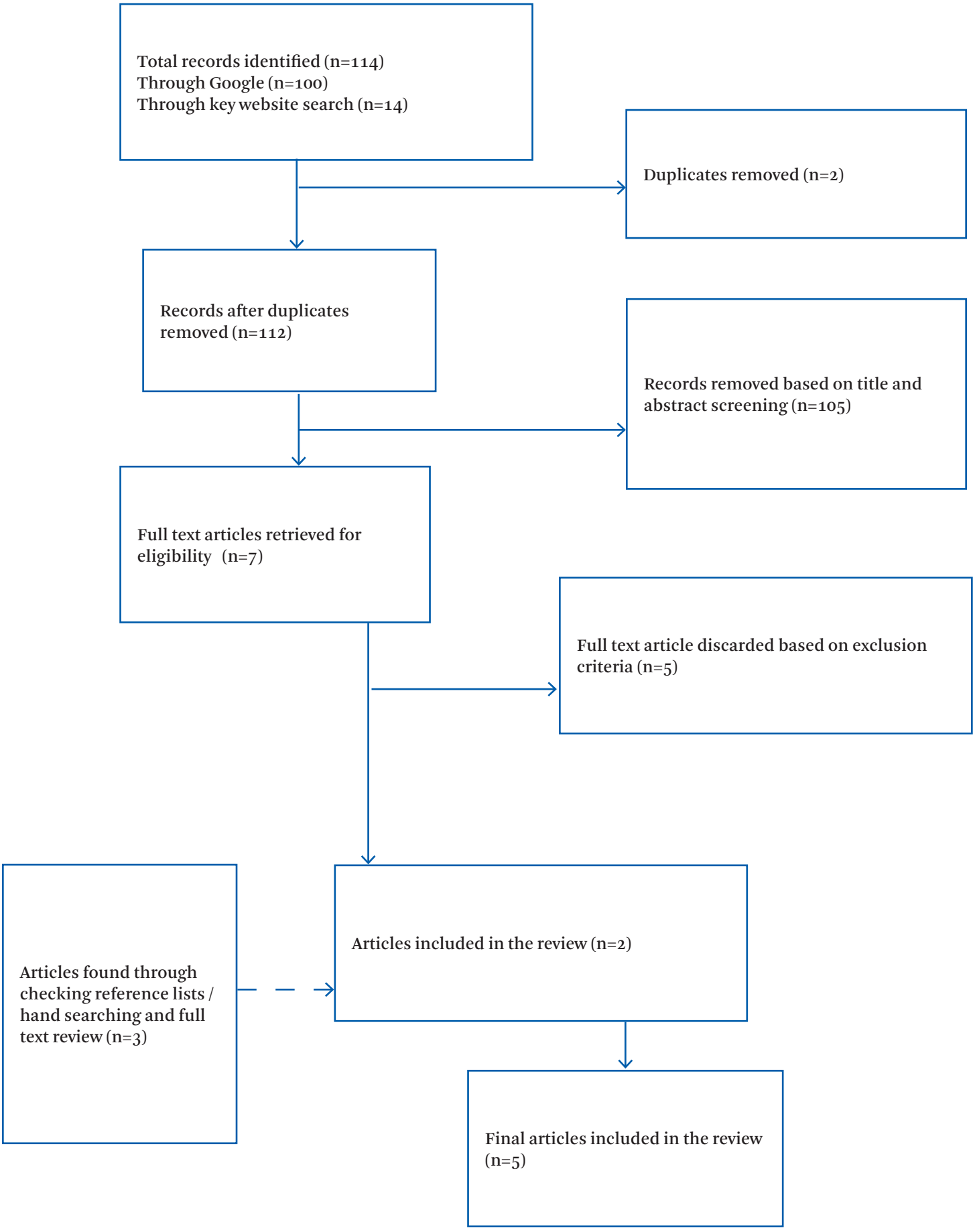
Appendix A: Flowchart of studies



Appendix B: Summary of Findings Table

Author and Year	Sample Information [Type of participant and setting/ Location/ Sample size]	Research Design [Method/ Design/ Collection/ Analysis]	Main Findings for New PRs in the Three-month Wait	Main Findings for Broader Uninsured Population (including those in Three-month Wait)
AAMHCS (2015)	• Type of participant & setting: Non-insured persons living in Toronto who do not have a primary care provider (PCP). Toronto, West End Non Insured Walk In Clinic(NIWIC) • Location: Toronto • Sample Size: 393	• Method: Quantitative • Design: Descriptive statistics • Collection: Administrative data • Analysis: Descriptive	• 23.7% (93/393) of clients at the clinics were permanent residents in the 3-month wait period (the second biggest group after 38.4% (151/393) non-status	• Health issues that clients come in with include: - prenatal care: 5.9% (top issue) - review of test results: 4.33% - special screening including immunizations: 4.33% - hypertension: 4.33% - joint pain: 3.17% - hypertension (4.33%) and diabetes (1.7%) were the most prevalent chronic disease - mental health issues: 0.92% • Healthcare services offered to clients include: - preventative health care: 30.76% (top service provided) - addressing symptoms: 25.97% - musculoskeletal concerns: 7.9% • 24 referrals made to specialist physicians - ophthalmology (top referral made) - ongoing prenatal care: 57 - 12 to obstetrician and 45 to midwife clinics - 36 referrals to primary care providers at partner CHCs - 25 were successful - Only 33% of high risk referrals made within the specific time frame (1-3 weeks) - 71% of medium risk referrals made in the target time frame (4-8 weeks)

TPH & AAMHCS (2011). The Global City: Newcomer Health in Toronto	• Type of participant: Service providers serving non-insured clients; non-insured immigrants using health services in Toronto • Location: Toronto • Sample Size: 75	• Method: Qualitative • Design: Cross-sectional • Collection: Focus groups • Analysis: Thematic Analysis	• Some participants delayed care due to the three-month wait • Participants spoke about the negative impacts of the three-month wait for themselves and, in the case of service providers, of their clients • Participants were worried they would get sick during the three-month wait • Participants faced increased stress due to payments • Cost can be a barrier to accessing health care for newcomers, especially for those with limited financial resources and for those in the three-month wait for OHIP period	• Lack of access to a regular doctor (accessibility to primary care) • Without a regular doctor, newcomers tend to rely on walk-in clinics, which may negatively affect continuity of care • Concern about the quality of care received • Barriers faced: being rushed in medical appointments; not getting adequate explanations about medical procedures; doctors being quick to prescribe medication; and experiencing a lack of empathy from services providers about their particular circumstances as newcomers • Many newcomers lack private insurance benefits that would cover such services, and cannot afford the cost of paying out of pocket • Need for - Mental health care - Affordable health care - Access to dental care - Access to vision care - Culturally and linguistically appropriate health services - Improving access to preventative care and screening, and to promote and offer free mobile screening clinics for adults in community settings - Services outside of the health care system/ cost due to other settlement barriers because newcomers are less likely to be employed. - Prenatal services. Instances where non-insured pregnant women in need of prenatal care were refused services even when they were able to pay for these services • Long wait times for health services (especially walk-in-clinics) is a barrier to access • Issues with authority (including health service providers) based on their experiences in home country • Prefer to access services or medications that they are familiar with

Bobadilla, A. (2013). "Oh, so we're not insured?": Exploring the impact of Ontario's Health Insurance Plan on new permanent residents and healthcare providers	• Type of participant & setting: New permanent residents and healthcare providers who serve new immigrants who are not insured at Scarborough Community Volunteer Clinic • Location: Scarborough, Toronto • Sample Size: New permanent residents (n=10) and healthcare providers (n =4)	• Method: Qualitative • Design: Cross-sectional • Collection: Semi-structured interviews • Analysis: Narrative and Thematic Analysis	NEW PR INTERVIEWS: • New PRs felt that the three-month wait policy in Ontario is unfair and unjustified • Most participants were aware of the three-month wait period for OHIP prior to their arrival in Canada • Participants regarded private insurance as limited and less comprehensive than publicly funded health insurance • Other strategies include packing medications from home country and limiting physical activity • Local CHCs were full and already operating beyond their capacity and denied care • Example of midwifery services in the catchment area being full • Prenatal and obstetrical care is most frequent and expensive service participants feared having to incur debt for • High stress levels that impacted mental health due to combination with settlement stressors, such as finding employment, housing, and adjusting to a new way of life STAFF INTERVIEWS: • Staff feel obliged to serve patients in need of care • Staff had to advocate for clients, in both cases of paying for services or accessing publicly-funded care because of resistance encountered from other institutions and service provider (who also may have overwhelming demand) • Policy poses a burden to not only health services staff, but also to the healthcare system as a whole • The healthcare needs of those in the wait period are the same as other clients, the policy produces different health outcomes for those in the wait period • Policy forces people to have no choice but to delay seeking care	• There are broader settlement issues. For instance, 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

Shirane (2009). Inequity in access to Canada's health-care system: Medically uninsured, legal residents of Canada suffer from preventable and manageable conditions.	• Type of participant: Medically uninsured migrants presenting at a volunteer clinic • Location: Scarborough, Ontario • Sample Size: 200 medical charts	• Method: Quantitative • Design: Statistical Analysis • Collection: Medical Chart Review • Analysis: Descriptive statistics	• 47% of sample of 186 (n=88) from uninsured volunteer clinic population were new PRs (landed immigrants or family sponsored immigrants) without OHIP coverage [the largest group]	• Most frequent medical diagnosis or assessment: acute conditions (32%), chronic condition (27%), and reproductive health concern including prenatal care (21%) • 23% had multiple medical conditions • Most frequent medical problems or needs: prenatal care (13%), immunization (11%), upper respiratory-tract infections, hypertension (7.3%), and diabetes (5%) • Gender: acute conditions were most common type of medical diagnoses for males (57%), repro health concerns for females (44.5%) • Age: 0-16 years had highest health promotion needs, 60+ years had highest chronic conditions • Mean gestation age at first presentation from sample of 26 women was 25.5 weeks • Hypertension (7.3%) and diabetes (5%) were the two most prevalent types of chronic conditions in the study group

Steele Gray et al. (2010)	• Type of participant: Health care professionals from various health care organizations who are part the Network for Uninsured Clients • Location: Toronto • Sample Size: 24	• Method: Qualitative • Design: Cross-sectional • Collection: Interviews • Analysis: Qualitative Analysis	• Fear was experienced differently by different groups in this population, specifically that individuals without status experienced greater fear than those in the three- month wait period (who do not fear	• Mental health and pregnancy identified as most prominent health issues for uninsured clients • Settlement stress and potential health care bills cited as threat to health as well as social isolation • Women often access prenatal care late in pregnancy due to expense and fear of being reported (sometimes arriving at ER in labour), miss important prenatal screening, might seek alternative and risky care • Formalized agreement between CHCs and hospitals often cover straightforward labour but not complications • Uninsured populations face same health issues as rest of population but often present with more severity due to delayed care (i.e. avoidable) (according to nearly half of respondents) • Cost constraints acted as a barrier to receiving quality care • Discrepancies between CHCs in the delivery of care to the uninsured and undocumented population. • Barriers: Long wait lists at CHCs experienced, limited funding for CHCs to provide services to this population, limits to access due to catchment area (some individuals have no accessible CHC), limited knowledge about CHCs by the population, language and cultural barriers, fear of authority figures/trust issues around being reported or being able to afford care • Reliance on service providers to advocate and connect them to care, or they would seek other, potentially (alternative care) harmful methods of addressing their health- care needs • Some 'behind the scenes' relationships made it possible for clients to access care they otherwise would not be allowed to. The downside is that because these relationships were informal there was no consistency