

Free to Some

Examining the Landscape of Health Services for
Uninsured Residents in Toronto





Canadian Centre for Victims of Torture

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EXECUTIVE SUMMARY

In 2014, the Health and Mental Health Working Group of the Toronto South Local Immigration Partnership identified the need for further research on the difficulties faced by uninsured residents in Toronto attempting to access health services, in order to identify ways to improve service to this population. A report was commissioned through the use of both an environmental scan and interviews with frontline workers. This report provides the findings of the research and recommendations for service delivery improvements.

The following are some summary points of the main project findings:

Barriers to Accessing Services:

- Financial barriers of accessing private health insurance and of hospital bills;
- Knowledge and information gaps, causing confusion and limited services;
- Administrative delays resulting in a lack of health coverage, especially for refugees;
- A lack of linguistically and culturally appropriate care; and
- Fear of discrimination and, specifically for non-status residents, fear of being reported to the Canadian Border Services Agency.

Key Health Issues for the Uninsured:

- The two most common health issues for uninsured clients are reproductive and mental health issues; and
- A common theme emerging from the research has been issues of delayed access to care as a result of the complicated service landscape.

Available Services and Service Challenges:

- Uninsured residents can access health services at some walk-in clinics and doctors' offices, however this care is inconsistent and clients are faced with expensive bills;
- Community Health Centres and dedicated uninsured clinics are shouldering the burden of providing care to the uninsured, however these services suffer from long waitlists and funding shortfalls;
- Midwives are playing an important role for uninsured pregnant women, however there is an insufficient supply of midwives to meet the demand;
- Due to the lack of ongoing care, uninsured clients are relying on hospitals for medical needs, which has significant costs not only for the client but for the healthcare system as a whole;
- Frontline staff face significant challenges in connecting clients to available health services, which can have adverse effects on the staff; and
- A key theme emerging from the research is that the current service landscape is offered on an ad hoc basis, providing inconsistent care through volunteer run and underfunded agencies which is unsustainable in the long term

Project Recommendations:

1. Support the elimination of the three-month wait period for OHIP;
2. Support the re-instatement of the Interim Federal Health Plan benefits prior to the 2012 cuts;
3. Lobby for increased funding for Community Health Centres, dedicated uninsured

- clinics, and midwives;
4. Facilitate discussions between hospitals and frontline agencies to establish consistent hospital and administrative fees;
 5. Establish a knowledge-sharing network on available services for the uninsured;
 6. Increase training of staff and volunteers to reduce administrative confusion;
 7. Increase public education efforts; and
 8. Enhance collaboration between the settlement and legal sectors.

The purpose of this report was to add to the research on the landscape of health services for uninsured residents in Toronto in order to inform efforts to improve access for this population. It is the hope that this report will act as a starting reference point for discussions and collaboration between agencies of the Toronto South Local Immigration Partnership to act as leaders in pursuing the policy recommendations as set out in the report.

PROJECT DESIGN AND METHODOLOGY

The Toronto South Local Immigration Partnership consists of a number of working groups and committees that discuss emerging issues newcomers in Toronto face. The Health and Mental Health working group recently set a priority to learn more about the difficulties faced by uninsured newcomers, especially in light of the 2012 changes to the Interim Federal Health Program for Canada's refugee population. The goal of this research project was to explore the current health services landscape in relation to uninsured newcomers with the goal of identifying ways to improve service to this population.

Research was conducted through a combination of an environmental scan and informal interviews with frontline staff that have direct experience with uninsured clients.

Existing research, including published reports, interviews, and newspaper and journal articles were utilized during a comprehensive literature review. A total of eight informal interviews were conducted with a total of eleven frontline staff members from various organizations. Interviews were not conducted with uninsured clients directly due to the timeline of the project and its impacts on ethics review and recruitment of participants. All interview participants were provided with an informed consent form, outlining that all information gathered would remain confidential but would be used to help inform the report.

The majority of interview participants were from member organizations of the Toronto South LIP, interviews were conducted with frontline staff working at organizations in other areas of Toronto in order to gather as much evidence as possible on the experiences of uninsured residents in Toronto as a whole.



DEFINING THE ISSUE, DEFINING THE POPULATION

Policy Landscape

Prior to examining the current landscape of health services available to uninsured residents in Toronto, it is crucial to examine the policy context within which the necessity for this research is embedded. Over the past few decades, and increasingly so in the past few years, there has been a shift towards non-permanent migration to Canada; moreover,

federal immigration policy has increasingly favoured temporary and circular migration over permanent residency, as seen through an increased focus on temporary foreign worker programs and international students, and through restrictions to refugee claimants and family class applicants (City of Toronto, 2013; Social Planning Toronto, 2013; Solidarity City, 2013). This shift in immigration policy has resulted in an increase in the number of uninsured residents in Canada.

All new permanent residents of Ontario face an arbitrary three-month wait period before receiving provincial OHIP health benefits. Newcomers are disproportionately affected by this wait period since those who have moved from other Canadian provinces or territories maintain access to their original health benefits until OHIP takes effect, whereas newcomers are left to provide for their own care. It is important to note that new immigrants start paying taxes immediately upon arrival in Canada, yet they must still undergo a wait period to access health care services supported through tax income (Goel & Beder, 2012). Ontario, Quebec and British Columbia are the only provinces that have a three-month wait period for health insurance. As it will be noted in the project findings, the three-month wait period is a major barrier to accessing health services.

Between 2000 and 2009, over 60,000 refugees arrived in the City of Toronto (City of Toronto, 2012) yet, refugee access to healthcare services was significantly reduced following the 2012 cuts to the government's Interim Federal Health Plan (IFHP). The IFHP was created by the government to offer health services for refugees as recognition of the trauma and conditions claimants were fleeing from, and as recognition that refugees often lacked health services in their own countries and were thus more vulnerable to serious health risks.

The IFHP included basic healthcare services, coverage for medications, dental care, vision care, ambulatory services, and coverage for

mobility assistance devices (City of Toronto, 2012). However in June 2012 a series of cuts were made to the program, which instituted different levels of coverage for different categories of refugee claimants. For example, refugee claimants from countries designated as safe by the government, known as Designated Countries of Origin (DCOs), were only eligible for health care coverage if their condition poses a threat to public safety. The cuts were justified by the federal government as a "cost-saving" measure.

As a response to the cuts to the Interim Federal Health Plan, the Ontario Interim Federal Health Plan, the Ontario government in January of 2014 implemented the Ontario Temporary Health Program (OTHP) for refugee claimants in order to address the gaps caused by the cuts to the federal health program. The program is designed to provide short-term and essential health care services, laboratory and diagnostic services, and to provide some coverage for medications. Toronto is also a unique location within Canada to study health access for uninsured residents, given the city's recent commitments to become a Sanctuary City for non-status and undocumented residents. By becoming a Sanctuary City, the City of Toronto has voted to uphold the principles of Access without Fear policies, allowing non-status residents to access city services without having to provide proof of status. However it must be noted that this has limited impacts on health service access given that the majority of health services are provincially or federally funded.

It is important to note that in July 2014, the Federal Court of Canada asked the Government to either present new guidelines or revert back to the pre-2012 cuts model by November 2014. The federal government had filed an appeal and wanted to wait for that decision before making any changes, but that request for extension was refused. While the matter is being appealed, the Government has implemented temporary health-

care measures as of November 5, 2014, consistent with the Federal Court's ruling. Please see link for more information: <http://www.cic.gc.ca/english/department/media/notices/2014-11-04.asp>

Defining Uninsured

It is important to define what is meant by uninsured residents. The medically uninsured can include those who have lost their identification, which is most often associated with the homeless; those in the three-month OHIP wait period; temporary visa holders such as international students and visitors, with the exception of some temporary foreign workers; refugees affected by the cuts to the Interim Federal Health Plan; and undocumented or non-status residents (City of Toronto, 2013; Steele Gray et. al., 2010). An accurate number of uninsured residents in Toronto is unknown, but estimates for the number of non-status residents, for example, range around 200,000 for the City of Toronto, and 500,000 for Canada as a whole (City of Toronto, 2013; Solidarity City, 2013; Toronto Public Health, 2011). A focus on the health needs of uninsured residents is important, as this group is one of the most vulnerable in our society. These residents pay taxes and contribute to Toronto's diverse community, yet they lack access to health services which adversely affects their settlement and reinforces marginalization (Solidarity City, 2013).

Refugees specifically are already in a vulnerable position when they enter Canada and research shows that a lack of health care reinforces vulnerability and threatens health status (Barnes, 2014). Of the uninsured residents, non-status or undocumented residents are especially vulnerable since they are not eligible for social support, and are not even eligible to purchase private health insurance, given that they lack official identification (City of Toronto, 2013). A lack of access to health services, and services which address the social determinants of health such as food banks and shelters, puts the health

of the city at risk, not just the health of the individual (Solidarity City, 2013).

PROJECT FINDINGS

The project findings have been grouped into different categories, including (1) barriers to access, (2) key health issues, (3) available services and services challenges, as well as (4) emerging collaborative efforts. Each of these themes will be discussed below:

1) Barriers to Accessing Health Services

Uninsured residents are faced with many barriers in attempts to access health care services. The first significant barrier is that of a **financial barrier**, due to the high costs associated with accessing healthcare services. While the uninsured in theory can purchase private health insurance, which the federal government recommends, in reality private health insurance is too costly for these residents to afford.

A 2008 report written for Parliament noted that research has shown private health insurance to be prohibitive, often covering only emergency care, not preventative care, and that the need to pay for health services upfront (to be reimbursed by the insurance company at a later date) is a major barrier (Elgersma, 2008). Newcomers to Canada have often spent a significant majority of their personal savings through the process of migrating to Canada, and medical bills can have a significant impact on remaining financial savings (Goel & Beder, 2012). In addition, the concept of private health insurance may be a new concept to some, which can cause confusion.

Another financial barrier to accessing care is the cost associated with seeking services at hospitals. Many uninsured residents will delay seeking care until it is absolutely necessary, and thus utilize hospital emergency room services with complicated health issues, which results in

large hospital bills. Uninsured residents are vulnerable to begin with, given that they are typically low income, and thus large hospital bills can burden individuals and families with excessive levels of debt. There is no standardization of rates for services between hospitals or even within hospitals and while some hospitals will work out payment plans, not all will. There have been cases where hospitals have kept patients in the hospital until they are able to demonstrate that they will pay the fees, there have been reports that show hospitals charge rates higher than what OHIP charges would be, and there is documentation of patients being charged fees insured patients are not charged, such as hospital facility fees (City of Toronto, 2013; Steele Gray et al., 2010).

A recent City of Toronto report highlighted the story of a mother and daughter who were new to Canada, and in the three-month OHIP wait period; the daughter fell ill with chicken pox and had complications, which led to the daughter having a stroke. The family had not yet been able to purchase private health insurance before their daughter fell ill, and thus faced a nearly \$100,000 hospital bill from the daughter's two-month stay. The mother was able to work out a payment plan with the hospital but due to her low-income status, could only afford to pay back \$20 a month, and would thus be in debt to the hospital for 375 years (City of Toronto, 2013). The fear of high hospital bills deters uninsured residents from accessing health services, which has adverse effects on their well-being due to a lack of ongoing and preventative care.

Another barrier faced by uninsured residents is a **knowledge gap** on available services. Often, staff of healthcare services are unaware of services offered to uninsured clients and are faced with challenges when trying to determine if a patient is eligible for care or not. Uninsured clients face bureaucratic hurdles dealing with staff members as a result (Toronto Public Health, 2011). The confusion of healthcare providers has

increased significantly since the 2012 cuts to the Interim Federal Health Program which saw the introduction of a multi-tiered system of refugee health benefits, with certain groups qualifying for different levels of coverage.

There is a significant level of confusion among healthcare providers as to which clients qualify for what, and research is showing an increasing unwillingness to deal with the complicated nature of the benefits program, with many physicians now turning away refugees as clients even if they qualify for IFHP benefits (City of Toronto, 2013; Evans, Caudarella, Ratnapalan & Chan, 2014; Marwah, 2014; Steele Gray et al., 2010).

Others are requiring refugees to pay up front for health service, or sign waivers prior to receiving care, even if these claimants qualify for health benefits (Evans et al., 2014). The introduction of the Ontario Temporary Health Program for refugee claimants has also increased confusion levels since there is a lack of understanding of how the program works. In order to be reimbursed by the Ontario Temporary Health Program, physicians must first apply for reimbursement from the Interim Federal Health Plan, wait for the rejection letter, and then submit the rejection letter to the Ontario Temporary Health Program, which can be time consuming, often taking a few months for the reimbursement process. Interview participants highlighted that there needs to be increased education for physicians and frontline staff on how the program works in order to streamline the process.



Uninsured residents are also faced with **administrative delays** which impact their access to health care services. A theme which was highlighted in numerous interviews conducted with frontline staff. A significant delay affecting access to services was the wait time many uninsured residents are faced with; for example, a 2013 Social Planning Toronto report looking at access to city services overall for non-status residents found that extended wait times for health services could range from a few months to nearly two years (Social Planning Toronto, 2013). Data from the Scarborough Volunteer Clinic shows that many uninsured clients faced an average of a 2.1 year wait period to gain access to OHIP benefits, significantly longer than the stated three month wait period (Caulford & Vani, 2006).

Refugee claimants appear to experience significant administrative delays which affect their access to health care. Every year for a variety of reasons, refugee claims are abandoned due to the long wait period from the backlog of refugee claims and these claimants thus lose access to the IFHP program (Caulford & Vani, 2006). A 2008 Parliamentary report noted that refugee claimants are particularly vulnerable to delays in accessing health care, noting that claimants often have to wait months or years to gain access to health insurance due to administrative delays (Elgersma, 2008). Interviews with frontline staff highlighted challenges with the administration of the Interim Federal Health Program, specifically challenges with a delayed renewal process.

In one case shared during interviews, a client performed their due diligence and submitted their renewal application for their IFHP benefits months before it was to expire but due to administrative delays they did not receive renewed coverage before the expiry date; this client has fallen ill and needs surgery that would cost thousands of dollars without the IFHP coverage. The frontline worker is attempting to advocate on behalf of the client with the federal

government to speed up the renewal process, however the only method of communication available with the IFHP is through direct mail, which adds to the delays. In other cases, clients have received IFHP benefit cards that have expiry dates days after they have been received or even ones that are missing an expiry date altogether.

Another barrier is the **lack of culturally competent care** available, which is a burden for all newcomers, not just uninsured residents. Interpretative services are not always available when uninsured residents access the health care system, which impacts their ability to describe their condition and subsequently impacts the quality of care they receive. (City of Toronto, 2013). In addition, patients may not feel comfortable with having a physician of the opposite gender which may result in longer wait times to find an appropriate physician. Due to language barriers, uninsured clients may also find the healthcare system confusing; as noted by one interview participant, if physicians and hospitals are confused by the current service landscape, then the confusion among newcomers must be two-fold. For clients who have access to resource workers the situation may not be as bad, but for those without access to assistance the situation can be more challenging. Frontline staff highlighted challenges connecting clients to medical services offered in French, one of Canada's official languages, let alone other languages.

Research shows that uninsured residents can internalize their perceived criminality as they experience harassment, discrimination and racism (City of Toronto, 2013). Fear can act as a barrier to accessing services, as uninsured residents may be concerned about the cost of services or concerned about potential embarrassment and harassment from health care providers (Steele Gray et al., 2010). Non-status residents are particularly impacted through the fear of accessing services, due to concerns over

deportation if reported by medical staff.

Moreover, often non-status residents will delay seeking care or will seek informal care at home due to fears of being reported, detained, or deported if the hospital or healthcare facility reports them to the Canadian Border Services Agency (City of Toronto, 2013; Toronto Public Health, 2011).

2) Key Health Issues for the Uninsured

There are a number of health issues that uninsured residents experience and are vulnerable to, ranging from cancer, communicable diseases, sexual health issues, chronic diseases, occupational health issues, and dental issues, among others (Steele Gray et al., 2010). The lack of dental services was highlighted by research participants, as it is difficult to find free or affordable services that offer comprehensive dental care. The two most common health issues for uninsured residents, however, have been identified as reproductive health issues and mental health issues (Steele Gray et al., 2010; Women's College Hospital, 2010). A common theme emerging from the environmental scan and interview process highlights delays in accessing care as one of the most significant health challenges.

Reproductive health has been identified as the most frequent health need for uninsured clients by Women's College Hospital. Uninsured women are more likely to start prenatal care later in pregnancy, have home births instead of hospital births, and are more likely to have complications during pregnancy (City of Toronto, 2013). Uninsured pregnant women often do not access health care services until six or seven months into their pregnancy (Toronto Public Health, 2011). Delayed care during pregnancy means that women may miss important medical tests and run the risk of having complicated home births (Women's College Hospital, 2010). As an example, a 2006 report by the Scarborough

Volunteer Clinic demonstrated that 60 percent of pregnant women who attended the clinic had serious health complications as a result of a lack of prenatal care (Caulford & Vani, 2006).

Uninsured pregnant women are one of the most vulnerable groups facing barriers to health services. Since the cuts to the health program, pregnant women coming from Designated Countries of Origin (DCOs) and rejected refugee claimants no longer have access to pre- or post-natal care or delivery coverage, a situation which puts the health of the mother and child at risk (City of Toronto, 2012). As previously noted in the barriers section, due to growing confusion over which refugee claimants qualify for what services, there is evidence that physicians are refusing to take on pregnant patients as clients. Furthermore, patients are required to sign waivers that they are responsible for all costs prior to offering services, and even stopping services mid-way through pregnancy due to fears of not being reimbursed for health costs or an unwillingness to deal with the paperwork associated with refugee clients (Marwah, 2014). This lack of access to health care, combined with a high risk of complications during pregnancy, will impact the lives not only of the mother, but of her child as well. This lack of care is counterproductive as it will lead to additional costs on the healthcare system down the road.

The Women's College Hospital has identified **mental health issues** as the second most important health issue for uninsured residents. Immigration to Canada can be a stressful and socially isolating process, which is compounded when taking into account challenges in accessing care and long-term stress and insecurity, all of which can perpetuate and amplify mental health issues (City of Toronto, 2013; Women's College Hospital, 2010). Participants noted that the wait period for health care benefits is an added trauma, since it can often take longer than six months to connect clients to mental health services. Mental health services have always

been a challenge to connect uninsured clients to, and this has become increasingly more difficult following the IFHP cuts. With the changing refugee guidelines being implemented, which emphasize quicker claim hearings, there is the risk of added trauma since claimants have the pressure of preparing for their hearings within tight deadlines, adding to both financial and emotional stresses. There are very few mental health services available to the uninsured. One area identified by frontline staff has been the significant lack of counselling services available for youth.



The most common theme emerging from an analysis of the key health issues impacting uninsured clients is the **impacts of delayed access to care**. Uninsured residents will often delay seeking medical attention until the situation is urgent and requires admission to the hospital, which is costly for both the patient and for the healthcare system itself (City of Toronto, 2013; Women's College Hospital, 2010). Many uninsured residents face more severe health issues due to the delaying of care, a situation which could be avoided especially in relation to unmanaged chronic diseases, occupational workplace injuries, and communicable diseases (City of Toronto, 2013; Steele Gray et al., 2010).

For example, uninsured residents are twice as likely as insured residents to require resuscitation due to unmanaged health conditions, and diseases such as tuberculosis and

HIV are likely to be diagnosed at later stages when they are more difficult to treat (City of Toronto, 2013). Clients will often delay care until they are eligible for insurance or until they can no longer wait. This results in more complicated conditions that require more extensive and expensive care; this impacts on the client, their families, and the Canadian healthcare system. (Caulford & D'Andrade, 2012).

A final barrier, closely connected to a lack of culturally competent care, is the **fear of discrimination and the fear of accessing services** that uninsured residents face. Over the past years, there has been an increasing criminalization of refugee claimants and non-status residents and a growing debate on whether these groups "deserve" care or not; negative discourse frames this population as taking advantage of our generous health care system and draining resources (Steele Gray et al., 2010).

When the government announced the cuts to the Interim Federal Health Plan in 2012, frontline workers spoke out with their concerns that the impending cuts were expected to increase the numbers of refugees accessing emergency department services at hospitals with more complicated conditions, due to the limitations placed on preventative and ongoing care (Raza et al., 2012). It appears as though these concerns are being actualized today as rates of refugees admitted into hospitals have increased. SickKids hospital in Toronto has been tracking the number of child refugee claimants admitted to the hospital six months prior to the IFHP cuts and six months after, and they have found that since the cuts to the health benefits, the admission rate of refugee children has increased from 6.4 percent to 12.0 percent. This means that admission rates for refugee children have doubled since the IFHP cuts (Evans, Caudarella, Ratnapalan & Chan, 2014). Presumably this can be connected to the lack of ongoing and preventative care.

Delayed care is perpetuated by a lack of access to medication for uninsured residents, since there is no coverage for medications available; while refugee claimants had access to coverage for necessary medications, this coverage was cut in 2012. For refugees and claimants with chronic diseases that require ongoing medication such as diabetes and angina, there is no coverage for medications such as insulin. Lack of proper treatment exacerbates their conditions and increases the risk of health complications (City of Toronto, 2012; Raza et al. 2012). While clinics can occasionally offer sample doses of medications to clients, this is not a replacement for care, such as insulin for diabetes.



3) Available Health Services and Service Challenges

As the goal of this research project was to examine the current service landscape of health services available for uninsured residents, the following section will highlight the different avenues for care this population has access to, and the challenges for each service avenue. As it will be shown, care for uninsured residents is provided in an ad hoc nature, with this group lacking access to consistent, preventative care.

Uninsured residents can access certain **walk-in clinics and doctors' offices**. While services will be charged, some physicians and clinics are willing to see patients without insurance. However, not all clinics and not all physicians are willing to see uninsured patients,

meaning the access is inconsistent and challenging for uninsured residents to navigate. Similar to the situation with hospitals, clinics and doctors' offices often charge inconsistent fees, which is another challenge for patients. There are a few clinics within Toronto which offer services where proof of insurance is not required, such as the Women College Hospital's Bay Centre for Birth Control, but these services are limited due to a lack of funding (City of Toronto, 2013). A challenge highlighted during the interviews is the lack of access to long-term, family doctors for uninsured residents.

Community Health Centres (CHCs) are the only organizations that are provided funding from the Ministry of Health and Long-Term Care to serve uninsured clients. CHCs are often able to cover the medical costs of a certain number of clients per month or per year. An added benefit of CHCs is that they are able to provide comprehensive services to clients, such as housing and settlement support. Yet, although CHCs are funded to provide care to uninsured clients, there are significant challenges associated with these organizations such as capacity limitations and long wait lists. The Scarborough Volunteer Clinic, for example, was started in 1999 as a response to the fact that Scarborough's only CHC at the time had a wait list of over 3000 uninsured newcomers (Caulford & D'Andrade, 2012). Another challenge with CHCs is that they are only able to serve clients that reside within their catchment areas; clients can be turned away if they do not meet eligibility requirements or possess documents proving that they reside in a certain area (Caulford & Vani, 2006).

A number of **dedicated uninsured clinics** have been created as a response to the current situation. There are a limited number of these clinics in Toronto; examples include FCJ Refugee Centre Clinic, the Scarborough Community Volunteer Clinic, the Women's College Hospital Crossroads Clinic, and the Access Alliance West-

End Non-Insured Clinic, and others.

Following the 2012 cuts to the Interim Federal Health Plan, many of these uninsured clinics scaled up their services to meet the increased demand from refugees and refugee claimants (Barnes, 2014). While these clinics are playing a crucial role in providing health services to the uninsured, they are mostly volunteer run, and thus are faced with limited resources and capacity. As a result, these clinics are only accessible during specific hours once or twice a week, and only on a walk-in basis. For example, some clinics are only offered twice a week or twice a month, with limited hours. As a result of the limited hours, uninsured clinics are often only able to see on average five to ten patients on a given day.

Midwives and birth centres are increasingly playing an important role for the reproductive health of uninsured clients, however Midwives are becoming overburdened by uninsured clients as there are insufficient midwives for the level of demand (City of Toronto, 2013; Marwah, 2014). Midwives are funded through the Ministry of Health and Long Term Care to provide care regardless of OHIP status, and thus are able to take on uninsured clients. It is estimated that uninsured clients make up 15 to 20 percent of the total client population of midwifery clinics in Toronto (City of Toronto, 2013). However, while midwives are funded through the Ontario government, diagnostic tests that pregnant women are to receive before and after pregnancy are not covered (Ontario Medical Association, 2011). In addition, if a client requires a hospital birth, they are responsible for all charges associated with the hospital.

Since many uninsured clients are late to care, it can be challenging for midwives to catch up on the prenatal care required for a healthy pregnancy. A research participant for this report highlighted that midwives that take on uninsured

clients often end up volunteering significant amounts of their time in order to assist these clients, as it is time consuming to connect them to additional services needed. While many midwives spend additional time with uninsured clients due to the desire to help those in a vulnerable position, there is a risk that midwives may eventually reduce the number of uninsured clients accepted since they often present with complicated cases, which is a disincentive for midwives who may already be overworked.

Due to the limited services available to uninsured residents, there is an increasing **reliance on emergency rooms** and hospital services by this population group. Uninsured clients often rely on emergency room services for conditions more suited to walk-in clinics or primary care doctors, since they are unable to access care elsewhere; uninsured clients often utilize the emergency room for reasons such as minor infections or getting prescriptions filled (Ontario Medical Association, 2011). Emergency rooms are also seeing many uninsured clients with complicated health issues stemming from delayed access to care, such as unmanaged chronic diseases, which is costly for the client and the hospital.

As noted by the Ontario Medical Association, "not only are people misusing this part of the health-care system, which is not well-suited to their complaint, but they may get sporadic and inconsistent care for conditions that require regular and ongoing physical attention" (2011, 14-15). As previously noted, accessing care in emergency departments often results in high medical bills, which can leave uninsured patients in long-term or permanent debt.

Research conducted by the City of Toronto has highlighted **challenges for healthcare providers** in serving uninsured clients, such as a high demand but limited resources, long wait lists of clients, complicated health issues which are more time consuming and costly to treat, time

spent attempting to locate additional services for clients, and limitations in being able to provide the same level of care to the uninsured (City of Toronto, 2013).

Physicians are faced with an ethical dilemma with uninsured clients, since although they have signed an oath to provide the best care possible to all patients, they are often unable to do so. A report by the Ontario Medical Association highlighted an interview conducted with a physician noting that having to ask patients how they will pay for their services "was well outside the fundamental principle of medicine, which is to care for the sick" (Ontario Medical Association, 2011, 14).

Frontline staff are also burdened by the time consuming process of attempting to both connect clients to available services, and advocating on behalf of their clients. Many uninsured clients rely heavily on their service providers to be connected to services, due to knowledge gaps (Steele Gray et al., 2010). Interview participants noted that the process of attempting to connect their clients to health services can be frustrating given the lack of resources and lack of knowledge of available services. Frontline staff often have to refer their clients to services located across the City of Toronto, and if clients are turned away from the services due to wait lists, it can be frustrating for both the clients and the frontline staff. Staff highlighted that different people have different perspectives and knowledge on the issues and thus communicating with hospitals and clinics can be frustrating since they must explain the situation each time they call and often receive different and opposing responses.

An area highlighted during interviews as an important area of focus moving forward is the impacts on frontline staff attempting to navigate the complicated health care system for uninsured clients. As more and more uninsured clients are presenting themselves to agencies, it

can increase workloads for frontline staff and cause stress-related issues. Frontline staff are burdened by the fact that their hands are often tied and they are unable to provide assistance to their clients, but they must watch these clients struggle and suffer. Often, before they are able to connect their clients to services, the clients disappear. There needs to be an increased emphasis on self-care for frontline staff, to avoid mental health issues and to avoid burnout of staff, yet many agencies do not have room in their budgets to offer services to staff.

Another impact on health care institutions, specifically related to the health care of refugees and refugee claimants, is that there has been a **downloading of costs of health care provision from the federal to provincial level**. The federal government has suggested that they will save \$20 million annually by 2017 from the Interim Federal Health Plan cuts however evidence is showing that since the cuts have taken effect, the burden of the costs has been placed onto the provincial government due to increased costs associated with more complicated health cases presented in hospitals (Marwah, 2014).

A research study conducted of refugee claimant children admitted into Sick Kids hospital found that after the cuts to the IFHP, over 90 percent of the hospital bills were not reimbursed, meaning that the costs of providing healthcare were shouldered by the hospital itself; this is contrary to the federal government position that the cuts would lead to cost savings (Evans, Caudarella, Ratnapalan & Chan, 2014). Interview respondents consistently noted that providing preventative care services would result in cost-savings in the long-term for the healthcare system.

Overall, a key theme that has emerged during both the environmental scan and interviews with frontline staff has been the **unsustainable, ad hoc nature** of health services

for uninsured residents in Toronto.

Many of the services available to uninsured clients are either volunteer-run, or are faced with significantly limited resources. Among other things, clinics and services available are limited by hours of operation, staff availability, funding limitations, and limited catchment areas, which limits the capacity of these health services to provide care for the uninsured.

Due to the ad hoc and inconsistent nature of service provision, it is difficult for health care providers and frontline workers to refer clients or offer long-term care, resulting in inconsistent health care for the uninsured (Elgersma, 2008). While efforts of service are able to assist the uninsured to a certain degree, these services, which are often volunteer-run, “lack the sustainability and generalizability to match the magnitude of the problem (Caulford & D'Andrade, 2012, 726). Ongoing health service access for the uninsured is a significant issue.

4) Collaborative Efforts

One area this report has hoped to highlight is that of collaborative efforts between different agencies and organizations that are working to improve access to health care for the uninsured. The research has highlighted that collaborations are crucial to improving access to services, since individual agencies are facing resource challenges that limit their capacity to increase services on their own. Frontline staff emphasized the importance of being involved in networks within the health community.

A theme that was consistently found in existing research and in the interviews conducted with frontline staff is the importance of partnerships between agencies, be they formal/informal partnerships; partnerships have been formed between CHCs, hospitals, private physicians, Toronto Public Health, and others, which are designed to enhance access to health services for the uninsured (Steele Gray et al., 2010).

For example, uninsured clients are often able to access to midwifery services, legal support, and general settlement services through collaborations between CHCs and other clinics and community agencies (Marwah, 2014; Steele Gray et al., 2010).

Examples of collaborative efforts that have been developed include a partnership between the Women's College Hospital and the Toronto Central Local Health Integration Network which has developed a voluntary agreement for hospitals and CHCs to establish consistent billing procedures (City of Toronto, 2013) and the Women's College Hospital Network on Uninsured Clients, which was established in 2007 to develop ways to improve access to services and raise awareness of the issues (Barnes, 2014). The West-End Uninsured Clinic has had significant success through partnerships, as they are able to refer complicated patients to established CHCs, referring 38 of 378 patients seen between June 2013 and June 2014. There is a significant level of collaboration occurring between midwifery clinics, CHCs, and in some cases, hospitals.



One midwifery association consulted noted that they have been able to establish a partnership with a CHC that covers the costs associated with two vulnerable patients per month, and also has a partnership with a hospital in Toronto that allows their clients to have a home birth at the hospital for a flat rate of \$500 (excluding additional complications that require other

services). Especially given that midwifery services discharge patients six weeks after birth, it is important to have partnerships in place to ensure that clients do not fall through the cracks after discharge. A significant level of collaboration has emerged as a result of the 2012 IFHP benefit cuts. To deal with the increased clientele following the cuts, many health care providers and different agencies have been forced to implement innovative practices to enhance their ability to provide services; an example of such collaboration is the Refugee Hamilton Centre which has developed a partnership with the School of Nursing at McMaster University to bring third-year nursing students in for placements to provide care for the clients (Marwah, 2014).

Another emergence in response to the cuts is the FCJ Refugee Centre's Primary Care Clinic which runs every Saturday at 208 Oakwood Avenue from 10am to 2pm. The clinic is open to anyone regardless of immigration status. The clinic is fully equipped with a primary care team made up of two primary physicians, three internationally-trained volunteer doctors, and a registered nurse. Moreover, as of April 2014, the clinic was supported by the Inner-City Health Associates, which permits them to offer better care and subsidize certain medically-associated costs (prescription, bloodwork, some examinations, etc.,)

Different organizations have also started collaborative efforts to track health cases of refugees and refugee claimants since the cuts to the Interim Federal Health Plan. For example, the organization Canadian Doctors for Refugee Care has developed an online data submission portal to track health consequences of refugee patients, and another project involved 40 different health care organizations in Toronto and Montreal is tracking the costs of health care cases for 3.5 years after the funding cuts (Marwah, 2014).

SYSTEM OPPORTUNITIES AND POLICY RECOMMENDATIONS

The research presented has demonstrated the different barriers to accessing health services, key health issues, and available

services and service challenges in providing care to uninsured residents. It is crucial that these challenges be addressed, as research shows that "the health of uninsured individuals is adversely impacted by a lack of or limited access to healthcare, even for a temporary period" (City of Toronto, 2013, 4). Canadians take pride in core values such as access to a universal healthcare system, yet at the moment hundreds of thousands of uninsured residents are not included within that system (Caulford & Vani, 2006; Goel & Beder, 2012). It is crucial that action is taken to provide healthcare to Canada's uninsured residents for the benefit of not only their health, but for the health of Canada as a whole. Uninsured residents are an active part of Canadian society, and many will become permanent residents and Canadian citizens in the future, yet the settlement trajectories of this group are at risk due to a lack of health care services.



In order to facilitate the productive investments of this group of residents, it is crucial that their access to health services is improved (City of Toronto, 2012; Raza et al., 2012).

Below is a list of policy and action recommendations set forth by this report that organizations can adopt in order to improve access to health services for the uninsured:

- **Support the elimination of the three-month wait period for OHIP.** While adopted by the Ontario government as a cost-savings measure, there is no evidence to show that this wait period results in

- savings. In fact, evidence shows that this wait period results in additional costs to the province as uninsured residents delay seeking care until conditions are worsened and become more complicated to treat, and visits to health care services increase substantially during the fourth month (Ontario Medical Association, 2011).
- **Support the re-instatement of the funding model for the Interim Federal Health Plan prior to the 2012 cuts.** Evidence has shown that the funding cuts have negatively affected all refugees and refugee claimants, due to the confusion surrounding the multi-tiered benefit system. The funding cuts have resulted in delays to seeking care, which is having significant effects on the health of refugees, which disproportionately affects pregnant women.
- **Lobby for the increased funding of CHCs, dedicated uninsured clinics, and midwifery clinics in order to improve service access for the uninsured.** Increasing funding will increase the capacity of these organizations to serve the uninsured and alleviate issues of long wait lists. Being able to provide preventative and ongoing care for the uninsured will reduce costs within the health sector in the long-run.
- **Facilitate a discussion between hospitals and frontline agencies to work towards the establishment of consistent hospital fees and administrative processes.**
- **Enhance collaboration between agencies through the establishment of a knowledge-sharing network on available services for the uninsured.** The Community of Practice that has recently been established by the Toronto South LIP could be a starting point for such efforts.
- **Increase training of staff and volunteers to reduce administrative confusion associated with health service accessibility for the uninsured and for refugees.**
- **Increase outreach and public education efforts to increase public awareness of the health challenges faced by uninsured residents and to reduce levels of discrimination and harassment.**
- **Enhance collaboration between the settlement and legal sectors, in order to enhance frontline knowledge of the legal immigration issues that affect the availability of health services.**

THE WORK CONTINUES!

The purpose of this report was to add to the research on the landscape of health services for uninsured residents in Toronto in order to inform efforts to improve access for this population. It is the hope that this report will act as a starting point for discussions and collaboration between agencies of the Toronto South Local Immigration Partnership to act as leaders in pursuing the policy recommendations set forth.

We encourage all members to share this report with interested parties in order to disseminate the information outside the boundaries of the Toronto South LIP. For additional information and questions about the report, please contact the Toronto South LIP at info@torontolip.com.

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