

A Bridge to Universal Healthcare

The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents of the Province



A Report by the Health Network for Uninsured Clients

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Executive Summary

Since March 2020, healthcare access for Ontario's population of residents without health insurance has vastly improved due to the Ontario Ministry of Health decision to extend hospital care to uninsured clients early in the pandemic. In March 2020, the Ministry of Health (MOH) issued a memo indicating that it would reimburse hospitals and physicians for all medically necessary services for uninsured patients. This marked an unprecedented change in health-care access for uninsured residents, who previously encountered a range of barriers in accessing hospital-based care.

The Health Network for Uninsured Clients (HNUC) is a network of over 70 health and community service organizations that have been working together for 16 years to improve access to health.

KEY FINDINGS

Survey respondents unanimously agreed that the directive has improved health outcomes and reduced financial hardship for uninsured clients who need hospital-based services.

The directive has allowed for a more timely access to care, without the need for lengthy negotiations with hospitals or advocacy work to find sources of funding to pay for care. Clients who are aware of the directive are also less likely to wait until their medical issues become severe or life threatening before seeking care. This is a major improvement from pre-directive, when uninsured people often faced worsening health outcomes to the point of critical severity, and at times death, due

to unnecessary delays to accessing care. Earlier access to care contributes to better outcomes for serious conditions like cancer and HIV.

Findings also highlight improved access and care experiences for those who need emergency, mental health, end-of-life, and maternal/perinatal care.

Healthcare providers consistently noted that the directive has led to reduced stress and improved well-being for their clients who need to access hospital care, including less financial stress. Before the directive, uninsured clients often accrued significant debt due to the costs of medical treatment, at times impacting people's ability to pay for basic necessities such as housing and food.

Providers also emphasized the directive's overall benefits to the health system. Providers experienced decreased administrative burden in their workload, without having to use their time to advocate for their clients or seek out funding for services. In addition, enabling access to earlier treatment for serious

medical conditions is beneficial for the health system as it reduces the need for more complex and costly acute care when conditions worsen.

Despite the many benefits of the directive, providers observed that the implementation of the program has had critical gaps. It has been unevenly implemented across hospitals which has often resulted in confusion and lack of knowledge among staff. At times, this has led to uninsured people either being asked to pay for necessary medical care or being turned away due to the lack of funds.

RECOMMENDATIONS

The MOH directive has been an important step forward to ensure everyone in the province has the basic human right to health. It has led to improvements in access to necessary care and to health outcomes among uninsured people in Ontario. However, the directive remains a precariously temporary measure, and more significant action is needed to fully realize commitments to ensuring health for all.

Immediate policy and program changes through the Ontario Ministry of Health:

- **Make the directive permanent.**
The creation of the permanent program should include measures to address implementation issues, including standardizing the program across hospitals, establishing clearer processes for billing, and increasing awareness of the program.
- **Improve access to primary healthcare for uninsured people.**
This can be achieved through more funding for community health centres and uninsured health clinics. In addition, the billing codes created to cover primary care services for uninsured people should be made permanent and expanded to cover more services.
- **Educate healthcare professionals about healthcare options for uninsured clients.** Education can occur through professional development and training opportunities within healthcare organizations.

Long-term policy changes through provincial and federal governments:

- **OHIP for all in Ontario.**
The simplest and most effective approach to ensure all residents can access needed healthcare is by expanding OHIP coverage and having one system for everyone.
- **Status for all residents in Canada.**
To remove the many structural barriers affecting people with precarious immigration status, the federal government must implement a broad and inclusive regularization program that provides real access to permanent residence for all residents, including those on study and work permits and those without status. Beyond access to healthcare, this would improve social determinants of health for many uninsured immigrants and support overall well-being.

Introduction

Since March 2020, healthcare access for Ontario's residents without health insurance has vastly improved due to the Ontario Ministry of Health decision to extend hospital care to uninsured clients early in the pandemic. In March 2020, the Ministry of Health (MOH) issued a memo indicating that the MOH would reimburse hospitals and physicians for all medically necessary services for uninsured patients.¹ This marked an unprecedented change in healthcare access for uninsured residents, who previously encountered a range of barriers in accessing hospital-based care.

The Health Network for Uninsured Clients (HNUC) is a network of over 70 health and community service organizations that have been working together for 16 years to improve access to healthcare for people living in the Greater Toronto Area without Ontario public health insurance (OHIP). HNUC believes access to healthcare is a basic human right, and promotes social inclusion in order to support better health and social outcomes for all. HNUC serves as a support and advice network and a clearinghouse for healthcare providers, frontline workers, researchers and policy specialists working on uninsured issues. Based on issues identified by the membership and by people who seek support from HNUC externally, we research and create resource materials and educational opportunities to build community capacity and create pathways to care that are meaningful, dignified and respectful to uninsured communities. The right to health is an internationally recognized human right. The 1948 Universal Declaration of Human Rights states that everyone should have the right to a standard of living adequate to maintaining

health and well-being, including medical care and necessary social services. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right of everyone to "the highest attainable standard of physical and mental health."² This right is based on one's status as a human rather than one's insurance status, or one's status as a citizen or resident of a given jurisdiction. Although Canada is a state party to the ICESCR, and is legally bound to realize the right to health, the health rights of people without provincial health insurance have often gone unrealized.

The extension of health coverage to uninsured people living in Ontario has been an important step forward within the province to meet these human rights commitments. In this report, and in our daily workings as a network, we refer to this MOH program as the "directive." In addition to extending access to hospital-based services, the directive also introduced temporary fee codes for the provision of medically necessary physician services provided in the community.

¹ Ontario Ministry of Health (March 25, 2020). OHIP bulletin 4749. <http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4749.aspx>

² UN General Assembly, International Covenant on Economic, Social and Cultural Rights, December 16, 1966, United Nations, Treaty Series, vol. 993, p. 3.

However, the focus of this report will be on hospital-based care, the area of where our members observed the largest impact. Over the past three years, HNUC members have observed and discussed the positive impact that the directive has had for their uninsured clients. We have noted significant improvements in uninsured people's access to healthcare and their health outcomes. However, we are concerned about the temporary nature of the directive.

The goal of this report is to document the impact of the directive on uninsured people's health and access to care, based on interviews and survey responses from HNUC members. The first section of the report provides background on the uninsured population in Ontario and their access to healthcare prior to the directive. Next, the report outlines the survey and interview methods used to collect the observations of HNUC health and service providers. The main body of the report summarizes provider observations of the impacts of the directive on the health and well-being of their uninsured clients. The report concludes with HNUC's recommendations for building on the current program to improve access to healthcare for all residents of Ontario.

Background: Access to Healthcare for Uninsured Ontarians

There are a number of reasons why people become uninsured and are therefore without access to health insurance coverage in Ontario, and many of the reasons are connected to immigration status. People who are uninsured include those on temporary work or study permits and people who are “undocumented” or without authorized immigration status.

Current Canadian immigration policies make it difficult for many migrants to attain permanent residence.³ These policies have created a range of “less-than-full” temporary immigration statuses – often called “precarious immigration status” – that limit access to provincial health insurance and other social programs.⁴ These immigration policies also contribute to growing numbers of people losing their legal status and becoming undocumented in Canada.⁵ People on temporary permits who have private health insurance may be underinsured if their insurance does not cover the same health services insured by OHIP, and does not meet their health needs. In addition, prior to changes made during the COVID-19 pandemic, new permanent residents were required to wait three months before they had access to OHIP. People can also be uninsured for reasons unrelated to immigration status, for example, people who are precariously housed or dealing with mental health challenges may have difficulty getting and maintaining a health card.⁶



³ Rajkumar et al. (2012). At the temporary-permanent divide: how Canada produces temporariness and makes citizens through its security, work and settlement policies. *Citizenship Studies*, 16(3-4), 483-510.

⁴ Goldring, L., Berinstein, C., & Bernhard, J.K. (2009). Institutionalizing precarious migratory status in Canada. *Citizenship Studies*, 3(3), 239-265.

⁵ Chen, Y.Y. B. (2017). The future of precarious status migrants' right to healthcare in Canada. *Alberta Law Rev.* 54(3):649-664.

⁶ Hynie, M. (2012). Seeking solutions symposium. Access to healthcare for the uninsured in Canada. Women's College Hospital <https://www.womenscollegehospital.ca/wp-content/uploads/2022/08/SEEKING-SOLUTIONS-REPORT-3.pdf>

The exact number of people who are uninsured in Ontario is unknown. As of 2016, there were an estimated 500,000 uninsured people living in the province.⁷ Uninsured residents are often invisible in mainstream discussions yet contribute to communities across Ontario in a myriad of ways, through paid and unpaid work and community involvement. As the director of an uninsured clinic described it, people without insurance often work in essential roles: “It’s people that are working. I always say it’s people that are putting food on your table, people that clean your houses, clean your buildings, clean your garbage, people that clean our streets when it’s snowing, people that are just out there serving your food in a restaurant, cleaning your dishes, doing everything.”

STRUCTURAL BARRIERS TO HEALTH FOR UNINSURED PEOPLE IN ONTARIO PRIOR TO THE DIRECTIVE

Uninsured people in Ontario face significant challenges when seeking healthcare due to overlapping structural barriers. Before the directive, uninsured people had to pay unaffordable out-of-pocket fees when seeking care, and research shows they were less likely to access timely and comprehensive care than people with insurance.^{8,9} In addition to these financial barriers, uninsured people also face discrimination when seeking healthcare that may arise from the health provider’s or health system’s biases against racialized groups, low-income people, and immigrants and newcomers in general.¹⁰

Costs associated with accessing care as well as fears of discrimination caused many uninsured persons to avoid seeking important healthcare services altogether. Undocumented immigrants may also face fears of

deportation and having their information passed along to Canada Border Services Agency agents.¹¹ Prior to the directive, these barriers resulted in uninsured people experiencing delays in treatment or being left untreated, leading to worse health outcomes and, in some cases, to people dying.¹²

Barriers to accessing healthcare can have significant impacts on a person’s overall health and well-being. These negative impacts are compounded by the social and economic marginalization faced by many uninsured people in Canada. Uninsured people, especially those who are from undocumented, low-income, and/or racialized migrant communities often face inter-connected barriers related to poverty, precarious employment, inadequate employment protections, lack of affordable child care, and other structural issues.^{13,14}

⁷ Barnes, S. (2016). Healthcare access for the uninsured in Ontario. Wellesley Institute. <https://www.wellesleyinstitute.com/publications/health-care-access-for-the-uninsured-in-ontario-symposium-report/>

⁸ Hynie, M., Ardern, C.I., & Robertson, A. (2016). Emergency room visits by uninsured child and adult residents in Ontario, Canada: what diagnoses, severity and visit disposition reveal about the impact of being uninsured. *Journal of Immigrant and Minority Health*, 18(5), 948-956.

⁹ Vanthuyne, K., Meloni, F., Ruiz-Casares, M., Rousseau, C., & Ricard-Guay, A. (2013). Health workers’ perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege? *Social Science & Medicine*, 93, 78-85.

¹⁰ Siddiqi, A., Zuberi, D., & Nguyen, Q.C. (2009). The role of health insurance in explaining immigrant versus non-immigrant disparities in access to healthcare: comparing the United States to Canada. *Social Science & Medicine*, 69(10), 1452-1459.

¹¹ Gagnon, M., Kansal, N., Goel, R., & Gastaldo, D. (2021). Immigration status as the foundational determinant of health for people without status in Canada: a scoping review. *Journal of Immigrant and Minority Health*, 24(4), 1029-1044.

¹² Hynie, M., Ardern, C. I., & Robertson, A. (2016). Emergency room visits by uninsured child and adult residents in Ontario, Canada: what diagnoses, severity and visit disposition reveal about the impact of being uninsured. *Journal of Immigrant and Minority Health*, 18(5), 948-956.

¹³ Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, 16(1), 165-176.

¹⁴ Gagnon, M. et al. (2021). Immigration status as the foundational determinant of health: a scoping review.

COMMUNITY HEALTH CENTRES

For many years, uninsured people in Ontario have had some access to primary healthcare at no personal cost through Community Health Centres (CHCs). These centres are located across the province and have a mandate to provide healthcare to those who otherwise have barriers to accessing care. Some CHCs, predominantly in Ontario's urban centres, have determined that uninsured residents are a priority population and receive funds from the MOH to cover non-CHC services for these clients (for example, lab tests and specialist visits). Not every CHC in the province has identified uninsured residents as a priority, and not every CHC receives funding to provide comprehensive care to these clients. As such, access to primary care depends in large part on geography, as well as on whether an individual is aware of CHC services.

Most CHCs serve only people that reside within their geographical catchment area. Uninsured people who live outside of a CHC catchment area can face difficulty accessing care due to narrow eligibility criteria.¹⁵ CHCs are also limited by a lack of funding, resources and capacity, which in turn shape the level and quality of care afforded to uninsured people.¹⁶ CHCs can have long waitlists, due to a higher demand for services than CHC capacity. Being placed on a waitlist and not having access to any other general or emergency care creates unnecessary delays to accessing care. Therefore, while CHCs play an important role in providing uninsured people access to healthcare, they are an incomplete and imperfect solution.

HEALTHCARE ACCESS IN THE TIME OF THE DIRECTIVE

Although the directive to temporarily expand coverage has not resolved all barriers to care facing uninsured populations in Ontario, it has significantly improved access to medically necessary services in hospitals.

As recently reported in the media, healthcare providers and advocates agree that care has improved since the directive was announced, with many patients accessing urgent services and life-saving treatments that they would otherwise have been denied, or that they would have sought only when feeling “acutely unwell.”¹⁷ Although little research about healthcare access under the directive has been published, Siu and colleagues interviewed staff in emergency departments, and found that the directive has enabled healthcare providers to offer the best medical options for their uninsured clients' health.¹⁸

This report aims to contribute to public understanding of the benefits which the current program has had for the health and well-being of uninsured residents of Ontario.

¹⁵ Magalhaes, L., Carrasco, C., & Gastaldo, D. (2010). Undocumented migrants in Canada: a scope literature review on health, access to services, and working conditions. *Journal of Immigrant and Minority Health*, 12(1), 132-151.

¹⁶ Barnes, S. (2016). Health care access for the uninsured in Ontario. Wellesley Institute. <https://www.wellesleyinstitute.com/publications/health-care-access-for-the-uninsured-in-ontario-symposium-report/>

¹⁷ Keung, N. (2022, July 28). Are thousands of uninsured people about to lose health coverage in Ontario? Fears grow about end to COVID-era OHIP rules. *Toronto Star*. <https://www.thestar.com/news/canada/2022/07/28/health-care-providers-urge-ontario-to-keep-providing-free-care-to-the-uninsured.html>

¹⁸ Siu, C., Rao, S., Hayman, K., Hulme, J., & Gajaria, A. (2022). Exploring the perspectives of health care providers that care for non-insured individuals utilizing emergency departments in Toronto. *Canadian Journal of Emergency Medicine*, 24(3), 283-287.

Methods: Survey and Interviews



To collect the perspectives, stories and insights of HNUC members, we asked members who work directly with uninsured clients to complete a survey about their observations of the impacts of the directive. Eighteen healthcare professionals who work directly with uninsured clients responded to our survey, including midwives (3), hospital and CHC social workers (5), primary care directors (3), and care coordinators and client advocates (6). The majority of respondents had more than five years of experience working with uninsured clients.

The survey included 5 Likert scale questions about the extent to which providers agreed that the directive has had the following impacts for their uninsured clients: 1) a positive impact on health outcomes; 2) reduced barriers to accessing hospital care; 3) reduced delays to accessing hospital care; 4) reduced financial hardship for clients needing hospital care; and 5) reduced stress for clients needing hospital care.

We also interviewed six key informants who have worked as frontline healthcare providers with uninsured clients for several years, and have extensive knowledge about how the directive has changed hospital access and client health outcomes. Key informants included a midwife, two client care coordinators at CHCs, a coordinator of a clinic for uninsured patients, a hospital-based physician, and a nurse who works with people with chronic conditions who are uninsured.

Findings: Impacts of the MOH Directive

SECTION 1: SURVEY RESULTS

Respondents unanimously agreed that the directive has improved health outcomes, and reduced financial hardship for uninsured clients who need hospital care (100% Strongly Agree). Respondents all agreed that the directive has reduced delays to accessing care (94% Strongly Agree; 6% Agree), and has reduced stress for uninsured clients needing hospital care (83% Strongly Agree; 17% Agree). Most respondents agreed that the directive has reduced barriers to hospital care for their clients (83% Strongly Agree; 11% Agree), while one strongly disagreed.

In addition to the scaling questions, survey respondents also had the option of sharing written observations about the directive, and stories about their clients' experiences.

The following three sections about the impacts of the directive are based on both the key informant interviews and the written survey responses. The term "providers" is used to refer to the health and service providers who participated in either the interviews or the survey.

SECTION 2: IMPACTS OF THE DIRECTIVE ON ACCESS TO HEALTHCARE AND HEALTH OUTCOMES

Providers described several significant changes in access to healthcare which have improved health outcomes for uninsured people

2.1 Reduced Delays in Accessing Care

The directive has enabled more timely access to healthcare for people without health insurance. Before the directive was in place, many uninsured people experienced delays in accessing healthcare which contributed to negative health outcomes. Providers

shared stories about uninsured clients who, before the directive existed, had experienced severe but preventable health problems due to unnecessary delays in accessing care.

A client care coordinator shared the following story about a client who was unable to access heart surgery:

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"I had a client who before, if he had been insured, would have received treatment probably within a week. **He needed to have surgery on his heart, but because there was such a delay because the hospitals were arguing back and forth about who was going to take him, he ended up losing the use of his right leg and the right side of his body became paralyzed.** He was in construction, so he could no longer work, so as a result he lost his housing, ended up in the shelter system, was heavily using substances at that point and his health really deteriorated. Whereas that now would not happen, because that delay in care would not exist."

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A midwife recounted the experience of a high risk pregnant client who was turned away from hospitals three times when seeking surgery to deal with a missed miscarriage. She was unable to access a hospital abortion clinic and as a result of the delay in accessing surgery, she had a life-threatening hemorrhage on a public transit bus and was found on the side of the road in critical condition. She almost died, needed multiple blood transfusions, and required a long stay in hospital in order to recover.

A nurse shared the tragic outcome of an international student who had HIV that went untreated for many years and, as a result, had developed into AIDS. He was admitted to a downtown Toronto hospital but was discharged without an affordable, accessible, reasonable care plan, and without access to immediate treatment. After years without being able to access care in Ontario, he made the difficult decision to return to his home country, and died a few months later.

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“I know that he didn’t access care in a timely way when he was sick, because he was sick for quite a while, because he assumed that he would get a really big bill at the end of it. He assumed that he couldn’t afford to get the care. He knew he was HIV positive but he didn’t know where to go. He was an international student, as well, so was without adequate coverage through his plan, which the government mandates that you purchase, but it doesn’t cover chronic disease such as HIV....**This was before the policy and the directive, and I can’t help but wonder if that had happened within this policy timeframe, if he would still be alive today.**”

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Such instances of preventable delays in care are rare now as the directive has significantly reduced barriers to accessing hospital care, resulting in less frequent and shorter delays for uninsured clients in receiving care.

Two important factors have contributed to reducing delays. First, with the directive in place, access to care is more seamless. There is no longer the need for lengthy advocacy or negotiation to take place with hospitals in order to gain access to care for clients, and no need for

patients or care coordinators to seek sources of funding before being able to access care. As a result, the time from when a client presents with an issue to when they begin treatment is much shorter. Uninsured clients can now receive care on an equivalent timeline to those who are insured, often resulting in better clinical outcomes than before the directive.

Secondly, since the directive has been in place, clients are less likely to wait until it is too late to seek care because they do not face the fear of debt that previously impacted many people’s decisions about whether or not to seek necessary medical care. Providers we interviewed observed that before the directive, they saw many people wait until their medical issues became truly life threatening before seeking care, because they were unable to pay and afraid of the financial debt that could result from seeking healthcare.

The reduction in delays has resulted in more positive outcomes and less mortality. Providers have seen better health outcomes for uninsured clients with cancer, HIV and other serious conditions, with earlier detection and reduced delays in receiving care leading to a greater likelihood of successful treatment. Reduced delays mean that medical conditions do not progress into more severe

issues which cannot be easily treated and can have devastating impacts for clients. As a nurse working in an uninsured clinic described:

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“People are accessing care earlier, before disease, injuries or infections are chronic and severe. People are going to the ER when they need to, instead of waiting until things get worse. So I think it [the directive] is avoiding hospitalizations generally for people who are precariously insured.”

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Survey respondents shared similar observations about the reduction in delays:

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“People were able to be seen to get concerns dealt with early and quickly, versus having to access more in-depth and ongoing care later on due to the concern being left untreated.”

— Social Worker

Being able to seek care saved my client’s foot. They had an infection and had they not been able to access hospital care prior to it becoming an emergency, they would have lost their foot completely to infection.

— Care Coordinator

Clients are now not afraid to seek help or agree to go to the hospital when required.

— Senior Director, Primary Healthcare

2.2 Better Access to Emergency Care

Providers observed that uninsured clients now have better and more equitable access to emergency department care at hospitals. Before the directive, uninsured clients faced multiple barriers to accessing emergency care. At some hospitals, people were asked to pay for care upfront or were turned away from care.

Other clients were seen but received less thorough care than OHIP-insured patients. In some cases, negative experiences at emergency departments led clients to be wary of seeking necessary care. Prior to the directive, the fear of hospital bills and past negative experiences at hospitals prevented many people from accessing care.

Since the directive has been in place, these issues have improved significantly. Although there have been some instances where clients have been asked for payment or denied care, these have been much less frequent and are more easily addressed and rectified through advocacy efforts to remind hospital staff about the directive.

Uninsured people are now less hesitant to access needed care once they are informed of the directive. As one provider described:

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“Some of my patients have injuries from work and now they go and get care. And they weren’t going before, so they were managing chronic serious injuries at home with no access to prescriptions or surgical interventions.”

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In addition, as a hospital-based physician described, uninsured patients in the emergency department now receive more equitable treatment. They can be treated in the same way as insured patients, and medical staff no longer have to make difficult decisions about whether to undergo time-sensitive tests and treatments based on how much these will cost.

“Before, I would get a lot more questions about patients being billed – how they would be billed, where they would have to pay, how much would each service or test or hospital bed cost. I remember a case where an older man came with his family. While he was at work, he developed a sudden, severe headache and nearly collapsed. It was the worst headache of his life. His blood pressure was very high. In these cases, the standard care is to get a CT scan of the brain to see if there is a hemorrhagic stroke or bleeding in the brain, which is extremely dangerous and can easily become fatal or disabling if not treated quickly.

“The family was told that because they didn’t have insurance, they would have to pay for the visit and tests. They asked how much the scan would cost. Instead of focusing on the patient, we had to search for cost lists and payment forms. We had to repeatedly explain how dangerous the situation was, because the family was trying to weigh how much money they had with the risks that the patient faced. It’s really an impossible situation to know that the essential and necessary care you need is available, right there in front of you, but if you go for it, your family might not recover from the financial burden. We would all be horrified if someone in our family experienced this.

“Now, people come to the ER and it’s a simple process. They register, they get triaged, they get the care they need. **For the most part, we no longer have to take valuable time away from patients who have already been waiting for a long time and clinicians who are understaffed and burned out to sort out ability to pay.**”

2.3 Improved Access to Treatment for Chronic Conditions

The directive has had a tremendously positive impact

for people with serious health conditions requiring multiple hospital-based treatments that could worsen if not diagnosed or managed early on. Before the directive, uninsured patients who needed multiple treatments would often end up with significant debt or would have to choose between treatment and paying for other basic needs. In some cases, this meant that people were unable to access the treatment that they needed.

A CHC care coordinator described how, prior to the directive, the CHC could help to arrange payment for a diagnosis, but in many cases, did not have the funding available to help patients access necessary treatment:

“In the CHCs, you can pay to get a diagnosis, because you could assist your clients to get the diagnosis. But once the diagnosis is there and they require, let’s say, some sort of cancer care, or access to treatment, that’s where it becomes problematic. And I’ve seen people die as a result of it because they couldn’t afford it and the CHC can’t afford to pay for it, or the facility fees are too high.”

In other cases, providers saw clients go into significant debt due to their needed treatment. A provider shared the story

of a client who needed regular dialysis treatments. Because they had to pay the hospital facility fee for each treatment, they quickly accrued massive debt which they were unable to repay, creating severe, ongoing stress. With the directive in place, patients with similar needs have much more seamless experiences of care and can focus on their health rather than worrying about the mounting fees

For individuals with serious conditions, access to hospital care also means that they are able to access support services provided within the hospital that were previously inaccessible to them and to their families. A provider described the impact of the directive for her patients with cancer:

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“Getting access to cancer care also means that people’s families are supported. Now they have access to mental health counselling for their families, childcare respite care, access to wigs – you know, all kinds of different things that exist in the hospital in terms of supports that people wouldn’t normally have access to.”

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2.4 Improved Access to Mental Healthcare

The directive has also had positive impacts for people who require mental healthcare. Prior to the directive, there were fewer options available to uninsured people experiencing severe mental health challenges. With the directive in place, people have been able to access treatment at the Centre for Addiction and Mental Health (CAMH) and other hospitals. One provider noted the importance of early intervention for her clients dealing with substance use issues and psychosis, who are more likely to have positive outcomes if they are able to access early treatment and support. As she described:

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“If you think about the intersections of who precariously

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insured people are and all the risk factors for mental health, like being isolated, being in a new place, having trauma sometimes coming from their countries of origins, they’re at a high risk for mental health challenges. I’ve noticed that people are actually going and getting care when they need it, which is seriously significant.... I’ve seen people in psychosis go to CAMH rather than not going and possibly having a serious outcome from not seeking care.”

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In addition, those who access hospital mental healthcare can now be treated based on their health needs, without the pressure of either accruing a huge hospital bill or having to leave the hospital early, before they are ready to return home. As a CHC care coordinator recounted:

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“Before, if a client was formed on Form 1¹⁹ for any suicidal ideation and they were in the hospital, in my experience, I noticed that people were being discharged before they were ready or before they had the appropriate community supports. Whereas now there’s no urgency to get rid of that person, there’s no pressure from the hospital’s higher ups

¹⁹ Form 1 is an application by a physician for a person to be assessed by a psychiatrist to determine if they need to be admitted to a hospital for voluntary or involuntary psychiatric care.

to make room for people who are insured, which often happened before.... Before it was like, we need to get this person out, finance would be calling. This person's suicidal and you're getting a call from finance every five minutes saying you owe us \$30 000 for being here for two weeks, and the person is obviously in a very vulnerable state. **So that is no longer what's happening which obviously improves overall well-being and they can just focus on their treatment versus focus on the amount of money they owe the hospital."**

2.5 Improved Outcomes and Experiences for Prenatal, Obstetrics and Postnatal Care

For those who are uninsured during pregnancy, the directive has had positive impacts both for access to prenatal and postnatal care, as well as for enabling access to childbirth in hospital when desired by the birthing parent or when medically necessary.

Uninsured pregnant people in Ontario are often referred to midwifery care because midwives provide free perinatal care for uninsured clients. However, as one provider described, many uninsured people are not aware of this and, prior to the directive, they often delayed accessing prenatal care until late in their pregnancies. Moreover, while midwives are able to oversee prenatal care and childbirth for healthy, uncomplicated pregnancies, certain conditions require consultation and/or prenatal care from obstetricians (OB) or maternal-fetal-medicine (MFM) specialists. A midwife described how, before the directive, midwives often had difficulty referring clients with medical needs requiring OB/MFM care due to the high costs of care associated with the hospital facility fees. For example, one of her clients had a high risk twin pregnancy best cared for at a complex pregnancy care clinic. However, the tertiary care centre would only take her on if she could pay a daily \$3,000 fee for inpatient care. As a result, the midwife had no choice but to keep the patient under her care for longer than clinically ideal because she could not find affordable care. This situation no

longer occurs with the directive in place because of the ease of clinically necessary referrals. The same midwife shared the story of a client who recently developed pancreatitis during pregnancy; in contrast to the client described above, she was able to access care early on and manage the illness effectively.

Another positive change is the ease with which clients can now be sent to hospital for assessment when medical emergencies arise suddenly in pregnancy. If a client presents with hypertension, which during pregnancy can be a sign of life-threatening problems, midwives can send them immediately to the hospital for assessment without concerns that the client may be turned away or end up with an unaffordable bill, and with no fear of unnecessary delays in assessment or receiving care. In the past, many clients would have delayed seeking care due to financial pressure. As a midwife responded in the survey: "I have numerous clients who would have delayed or not accessed care and whose lives would have been compromised by preterm labour, placental abruption, or severe fetal compromise."²⁰

²⁰ Preterm labour is when someone goes into labour before 37 weeks pregnant. Preterm labor can result in premature birth. The earlier premature birth happens, the greater the health risks for the baby. Placental abruption is an obstetric emergency and occurs when the placenta partly or completely separates from the inner wall of the uterus before delivery. This can decrease or block the baby's supply of oxygen and nutrients, and cause heavy bleeding in the birth parent

People also now receive better follow-up care from hospitals. Prior to the directive, when clients were assessed in hospital, they often would not receive follow-up care. The midwife would have to establish a follow-up plan for their client for a condition that is outside the midwife's care. With the directive in place, clients now receive follow-up care with the appropriate provider.

The directive has had a profound impact in reducing the financial and emotional stresses which uninsured people face related to childbirth. Before the directive, when preparing for childbirth, clients had to prepare a payment plan to cover a potential \$6,000 fee for a two-night hospital stay. Many clients felt pressured to choose an out of hospital birth for financial reasons, even if they would have preferred a hospital birth. Clients would be fearful of complications that would necessitate a hospital birth, because of the costs this would incur. For many clients who did need a hospital birth, the financial burden of their hospital bill led to stress and hardship, sometimes leaving lasting debt and creating additional challenges in meeting their new baby's basic needs. With the directive in place, pregnant people can choose to give birth in hospital if medically required or if this is what is most comfortable for them, without having to worry about the financial burden.

2.6 End of Life Care

End of life care has become more accessible under the directive for those who are uninsured. A provider explained that because home care is not accessible to uninsured patients, the ability to die in hospital can mean the difference between dying with dignity with good pain management, or dying without access to pain management and without care support. When people have to die at home without care, people may not have anyone to rotate them to prevent bedsores or to change their diapers, and may rely on family or household members who are not equipped to provide proper care.

As a care coordinator described:

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"When clients were diagnosed with cancer, often late stage cancer, before, it was basically, "Here's the diagnosis, here's what it would cost to get treatment.

You can't afford that, ok, well go back to your primary healthcare provider and they'll help you." And they would be left to die with no access to palliative care or dying with dignity. **Whereas now I've actually had a client in a similar situation with stage four bladder cancer, where they actually got access to pain management, they were in the hospital, they weren't forced to leave, they got palliative care, they were able to die with dignity, versus my other client who [before the directive] had to die at home with no supports, no nursing.** Pain medication was very limited because they couldn't afford it that well."

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Because of the directive, providers have been able to advocate for clients who need palliative care to remain in hospital for their deaths, rather than being sent home to die under unsafe conditions.



SECTION 3: IMPACTS ON THE OVERALL WELL-BEING OF UNINSURED PEOPLE

In addition to the positive impacts on access to healthcare and health outcomes, providers described the significant impacts of the directive in lessening the stress experienced by uninsured patients, and improving overall well-being and other social determinants of health for uninsured people needing hospital care.

3.1 Reduced Financial Stress

Before the directive, providers observed great financial stress experienced by their uninsured clients. In some cases, people were left in the desperate situation of having to choose between their basic needs of food and housing and necessary healthcare. Clients have lost their housing due to having to pay for medical care. Uninsured people who needed hospital care often accrued large bills and debt that created long term financial stress, with impacts for individuals as well as their family members. This financial stress exacerbated the stress that people experienced when dealing with serious illness or injury.

In contrast, under the directive, these sources of financial stress are no longer an added burden for uninsured people, who now are able to focus on their health issues, without the additional worry about how they will be able to pay for care. The reduced financial stress has a positive impact on other determinants of health as well, reducing people's risk of homelessness, food insecurity and being unable to meet their basic needs.

As a social worker noted:

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“Taking the cost out of someone accessing healthcare means people are not having to choose between rent and groceries versus getting necessary healthcare.”

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3.1 Reduced Psychological Stress

The elimination of the financial burden of medical care has reduced the emotional stress experienced

by uninsured clients. Several providers spoke about the fear that they observe in their clients as a result of their immigration status, which prior to the directive were exacerbated by further fears of becoming ill and being unable to afford care. A midwife noted:

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“If you’re uninsured, you live in fear constantly. You’re afraid to trip on the street, you’re afraid your child might fall.”

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A coordinator of an uninsured clinic described how fear of becoming ill and being unable to pay for care can contribute to the many fears that people with precarious immigration status already experience:

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“People are already afraid of being deported. People are already afraid of not having a response from the IRCC [Ministry of Immigration, Refugees and Citizenship Canada]. People are afraid already because of all the trauma they have been living and of all the situations that brought them to Canada. To have them be in fear of being sick, that’s something I cannot understand. Like there’s people that say: ‘Ok I don’t want to be sick, I don’t want to say that I’m sick or that I’m not feeling well, because I do not

have access to healthcare.’ They don’t want to be sick.”

Difficulties paying for healthcare can also lead to feelings of guilt for those who are financially dependent on their partners or family members. This stress is gendered, since women are more likely to be sponsored for immigration, and/or to be financially dependent on their partners due to caregiving responsibilities. One provider described a woman with diabetes deciding not to get treatment because they did not want their partner to have to deal with the financial burden of care.

In contrast, under the directive, providers have observed the positive impacts which free and accessible healthcare provides for emotional health. The midwife remarked on the difference she sees in the postpartum period under the directive. New parents are less stressed about the financial consequences of needing hospital care and also live with much less fear overall that they may need healthcare. Providers described the palpable emotional relief when they inform clients that they can access healthcare without cost, for themselves or their family members. A provider who works at an uninsured health clinic described a recent experience at an immunization clinic. A mother of a young baby was very worried about what she should do if her baby developed a fever because of the Tylenol/Advil shortage. When told she could go to a children’s hospital without having to pay if her baby needed medical care, the mother expressed a huge sense of relief.

The directive has not reduced all barriers to accessing care and, as discussed further in Section 5, improvements are still needed to ensure that people who are uninsured are treated with dignity and equity. However, providers agreed that the directive has greatly reduced the stress of seeking care. As one provider noted:

“There’s still stress walking into healthcare facilities, especially if you’ve had negative experiences or you have other intersecting identities, like you’re racialized and you’ve had negative experiences before. But I think the stress about the bill at the end, the stress about

how many thousands of dollars it is going to cost me – that’s decreased.”



SECTION 4: SYSTEM-LEVEL BENEFITS OF THE DIRECTIVE

In addition to the significant positive impacts on the health outcomes and overall well-being of uninsured patients, providers identified benefits to the health system as a whole.

4.1 Less Administrative, Navigation and Advocacy Work

A few providers described the changes to their workload and the reduction in the administrative burden of having to advocate for client access to needed healthcare. As a result, they are more able to focus on client health needs. As one client care provider described:

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“Personally, the amount of time I have to spend navigating and advocating has been substantially reduced, allowing me to pick up more clients and provide support in other meaningful ways. **I have also heard from hospital personnel how helpful this directive has been for them as they no longer need to allocate resources to collecting payments from uninsured clients, and clinical providers are able to offer care without worrying about payment.**”

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4.2 Earlier Treatment Avoids Costly Acute Care

Several providers noted that reduced delays in care provides important benefits to the healthcare system generally. Providing timely access to treatment is often cheaper and less complex than providing treatment for severe and/or chronic medical issues in later stages of illness. Unnecessary delays in care also increase the burden on healthcare staff and administrators.

4.3 More Awareness of Uninsured Care Needs Within the Hospital System

Finally providers noted the benefit of the directive in making uninsured people more visible within the healthcare system. Many doctors and specialists were previously unaware of how many people are uninsured, and of the complex issues facing many uninsured clients, because they did not see them regularly in their practices. One provider who works at an uninsured

primary care clinic observed that they now get calls from hospitals, both in Toronto and beyond the GTA, that are discharging uninsured patients and trying to ensure that they have follow-up care. She sees this as sign that hospital staff are making an effort to learn about the resources that are available for uninsured patients in the community:

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“Those hospitals that really want to do the holistic approach and really want to learn more, they started contacting us: ‘Hey, I have a client right now, we’re going to dismiss this person, but he’s non-insured. Is there any way that I can put this person on your waiting list, so he can get a family doctor or at least he can get a place where he can go for further assessments... It’s not that he’s doing badly, it’s just that we want to make sure that he’s going to have any kind of support in terms of access to healthcare.’ So that was really good because for me, it was like, oh, they’re going beyond, they’re not just providing the care that they need, no they are going beyond and they are trying to learn what kinds of places are available for that.”

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SECTION 5: IMPLEMENTATION PROBLEMS

Although all the providers interviewed agreed that the directive has had remarkable positive benefits for uninsured health outcomes, providers also described pervasive implementation problems that have reduced the efficacy of the program. The directive has been unevenly implemented across hospitals, and even within the same hospitals, which has resulted in staff confusion about its existence and duration. These implementation problems have also been regularly observed and discussed by HNUC. The HNUC Rapid Response Team (RRT) initially formed early in the pandemic in order to provide support to service providers and uninsured people who were being turned away from hospitals, or being asked for payment, despite the directive being in place. From March 2020 to the time of the writing of this report, the RRT has continued to be contacted about cases where uninsured people have been asked for payment before treatment, or have received bills after hospital care.

Providers commented directly on the problems they have seen in the directive's implementation. One nurse commented:

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"The directive has absolutely had positive impacts, decreased barriers and wait times, and financial impacts of accessing care. Lack of knowledge of the directive at the hospital level has continued to cause clients undue stress and barriers."

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Another nurse shared that she felt unable to refer clients to hospitals with confidence because of the frequency with which her clients experienced issues due to hospital staff being unaware of the directive.

A hospital-based physician described the problems they've seen in emergency departments:

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"The much-needed directive has had uneven spread and scale. And this is an issue with policy innovations and healthcare programs sometimes, where they are

immensely successful, should be everywhere, but don't get taken up because there are misunderstandings or uncertainty.

In this case, some of the barriers I've heard are that because it was announced as temporary, staff feel uncertain about whether it's still there, and they might revert to old practices like telling patients that they'll be charged for their care. It puts hospitals in a really tough position, because they don't know whether the Ministry of Health will reimburse them for their true costs of caring for the communities they serve. This isn't fair for hospitals that need to make ends meet as well when they're under increasing pressure.

It also creates confusion for patients, because they're getting mixed messages or no messages at all. Over two years after the directive came into effect, many clinicians and patients still are not aware of it."

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Recommendations

Based on the observations of our network members, as well as the knowledge and experience of the HNUC Executive Committee and Rapid Response Team, who are co-authors of the report, we recommend the following actions.

Immediate Recommendations for the MOH

1 Make the Directive Permanent

1.1 We call on the MOH and the provincial government to make the current program permanent, in order to ensure that all residents of Ontario can continue to access hospital care without fees. The permanency of the program is essential for ensuring that the benefits described above continue, and that the inequities of the old system do not again become the norm.

Moreover, the establishment of a permanent program would help to address the implementation problems that have been observed over the past three years. Making access permanent would remove unnecessary confusion among staff about the existence of the program, and would allow for more even implementation. A healthcare system that allows everyone to have equal access to healthcare, based on need rather than immigration status or ability to pay, would become the new normal.

Hospital systems could then make the necessary changes to fully implement this new approach. As a hospital-based physician described it:

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“When hospitals know that it’s permanent, they can be relieved of all the institutional things that are there under the old system, which are the signs saying how much patients will have to pay, the forms that tell registration and finance staff how to bill patients, the whole collections infrastructure about how to get money from patients.”

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To further address concerns about implementation, we recommend the following measures to support the success of a permanent program:

1.2 Ensure that the program is standardized within and across hospitals through the provision of adequate staff training, consistent channels of communication, and the establishment of internal accountability processes to ensure that uninsured clients are being treated with equity and dignity.

1.3 Establish clearer processes for billing, including a more defined timeline for payment so that healthcare providers know when they will receive compensation.

1.4 Raise awareness of the program within the community so that people are aware that they can access the healthcare that they need. As part of this awareness campaign, make it clear that hospitals are required to maintain client confidentiality and will not share information with immigration officials.

2 Improve Access to Primary Healthcare in Community for Uninsured People

Many uninsured people are unable to access the primary healthcare they need, which can lead people to seek hospital care unnecessarily. **In order to address these gaps and take the pressure off the hospital system, we recommend improving access to primary care by providing more funding for uninsured walk-in clinics, and more funding for CHCs to provide care to uninsured clients both in the GTA and across the entire province.**

In response to the COVID-19 pandemic, the MOH created billing codes that primary care providers in the community can use to cover some services for uninsured people. While these billing codes have not been effectively used throughout the primary care system, they are a promising initiative. The billing codes should be expanded to cover more services and should be made permanent with clearer direction so that they can be better utilized.

3 Educate Healthcare Professionals about Healthcare Options for Uninsured

It is vital that healthcare professionals have more awareness of uninsured care issues so that they can better meet the healthcare needs of this population. Education can occur through professional development within healthcare organizations, and through the inclusion of a unit on uninsured health – including the right to health – in training programs for physicians, nurses and allied health students.

Long-Term Recommendations

While the above changes are needed immediately, they will not change the fundamental two-tiered structure of the current healthcare system where some residents are not covered by provincial health insurance. Such a two-tiered system creates layers of unnecessary administrative work and will always result in administrative barriers to healthcare access. Ultimately, we envision moving towards a society where all residents of Ontario can access the healthcare and social programs that are vital to their health and well-being. This requires fundamental changes in both health coverage and immigration policy. The following long-term changes are therefore recommended:

Provincial Government of Ontario

OHIP for all

The simplest and most effective way to ensure that all Ontario residents can access needed healthcare is by having one system for everyone. **The MOH should therefore extend OHIP coverage to all Ontario residents.** This would eliminate the administrative barriers that continue to create inequities in access to healthcare, even with the current directive in place.

Federal Government

Status for all

Current approaches to immigration policy have created a system wherein hundreds of thousands of people live and work in our province without having equitable access to healthcare and social programs, including workplace protections, childcare and family income support programs, affordable housing programs and pensions. The inequities that this system creates go far beyond the issue of access to healthcare and shape the social determinants of health for many non-status immigrants. We are encouraged by the federal government's current indication that they are working on a regularization program for undocumented residents. We join the calls for a broad, inclusive regularization program for all residents without permanent status, including real and easier access to permanent residence for all residents on temporary work and study permits. This would eliminate the confusing and discriminatory eligibility criteria for healthcare access.

Conclusion



Ensuring that all Ontario residents are able to access the healthcare they need is the just thing to do and is essential for the public health of communities across the province. Each of the providers we interviewed highlighted the injustice in having a two-tier health system, within which some community members are denied the human right to health.

The MOH directive has marked an important step towards greater health equity in Ontario that can serve as a model for other provinces in recognizing the right to health for all residents. Our report highlights the many benefits that the extension of health coverage has created, as well as the many harms and human rights violations that routinely occurred under the former system of health exclusion.

If this vital program is rescinded, we risk moving back to a time where only some residents of the province received the healthcare they needed in a timely way, while many others were denied their right to health. Over the past three years, our healthcare system, through the existence of the directive, has course-corrected to address the inequity that has been built into our system. By creating access to care for all residents, the directive has moved the province closer to fulfilling the human rights commitments Canada has made internationally, and closer to a truly universal healthcare system.

“These are people we are issuing work permits to, inviting to be part of our society, and we’re not caring for them. There’s a really big disconnect. Or inviting them to study, as an international student in our educational institutions, but then not caring for them. So it doesn’t make any sense”

— Nurse at Uninsured Clinic



“We have to realize what a health equity issue this is. We are talking in large part about racialized and impoverished people. And if we are going to talk about health equity, we have to realize that there are lots of people that talk about immigration status as a social determinant of health. If we are going to talk about health equity, we have to find ways of taking care of this population well.”

— Midwife



“More fundamentally, our medicare system, our duties as healthcare workers and our values as a society go against providing healthcare to patients based on their ability to pay. It’s intuitively wrong. It feels wrong. From my end, it’s great that we no longer have that moral burden on top of the real healthcare work we need to do.”

— Hospital-Based Physician

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