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Two Steps Back

The Impact of Ontario's Rollback on Healthcare Access for Uninsured Residents

A Report by the Health Network for Uninsured Clients. Authors: Mauriene Tolentino, MPH, Cathy Schmidt, MSW, Sarah Marshall, MA, Diana Da Silva, MSW, Shezeen Suleman, RM, Josyl Singh, HBSc

August, 2024

The Health Network for Uninsured Clients would like to express our deepest gratitude to all the service providers who participated in this research. Their insights and expertise offered a comprehensive and nuanced understanding of how uninsured clients and those who support them have been impacted by the end of the PHSUP program.

Many thanks to all the people who provided thoughtful support, feedback and guidance for this report: Rebecca Cheff, Sarah Shahid, and Theresa Polyakov.

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Executive Summary

On March 31st, 2023, the Government of Ontario ended the Physician and Hospital Services for Uninsured Persons (PHSUP) funding. The Ministry of Health implemented the PHSUP policy in March 2020 as a response to the COVID-19 pandemic, expanding access to free hospital care and some physician services for people without provincial health insurance (OHIP). This program marked a positive step towards making healthcare accessible to all residents of Ontario.

To capture the impacts of the cuts to this important program, the Health Network for Uninsured Clients (HNUC) surveyed members working directly with uninsured people and interviewed key informants about their experiences providing care to their uninsured clients since the removal of the PHSUP policy. Between January and March 2024, a total of 66 service providers responded to the survey, and 15 providers participated in interviews. Participants represented different professions, including midwives, physicians, social workers, care navigators, nurses, and nurse practitioners, as well as health institutions, including hospitals, community health centres, midwifery clinics, non-profit organizations and specialty health clinics.

Health and social service workers reported concerning impacts on their clients' access to health services and general well-being, as well as an increase in their workload in supporting their clients, because of the end of the PHSUP program. A number of access and system barriers were noted, including poorer coordination between community-based care and hospitals, higher service fees, and increased discriminatory practices toward uninsured clients. Participants linked these barriers to worsened health outcomes among their clients who are uninsured. Emergency care, reproductive care and non-acute care for severe or chronic conditions were highlighted as areas that have been particularly impacted by the cuts. Practitioners also noted increased overall workload and moral distress due to the difficulties in providing equitable and medically appropriate care for uninsured clients within the context of these barriers. Overall, findings underscore grave implications for uninsured people as a result of the cuts due to barriers to accessing life-saving and health-promoting care, increased financial stress, and discriminatory experiences in the health system.

RECOMMENDATIONS

We envision a society where all Ontario residents can access the healthcare and social programs vital to their health and well-being. We call on the provincial and federal governments to ensure that all residents of Ontario and beyond have full and comprehensive access to the healthcare and services they need to live healthy and dignified lives.

Policy changes through the Ontario Ministry of Health:

1. **Establish OHIP for all.**
   A comprehensive OHIP for all policy would eliminate many of the administrative barriers that continue to create current and worsening inequities in access to healthcare.

2. **Immediately reinstate the PHSUP program.**
   In the reinstatement of a permanent PHSUP program, the Government of Ontario and the Ministry of Health should consider adequate coverage and proper roll-out of the program:

   a. **Expand billing codes used by primary care and establish clearer billing processes to improve access to healthcare for uninsured clients**. Billing codes should be expanded to cover more services and should be made permanent with clearer direction so that they can be better utilized.

   b. **Ensure the program is standardized within and across Ontario hospitals**. Standardizing the program across hospitals is necessary to ensure hospitals can fully implement the program and work effectively with other care providers in the community to provide comprehensive care for uninsured clients.

   c. **Educate healthcare professionals about healthcare options for uninsured people**. General education and awareness of uninsured care issues are vitally important for healthcare professionals so that they can better meet the healthcare needs of this population.

   d. **Ontario Health Teams should work with hospitals and health services in the community to ensure care is coordinated in compliance with the PHSUP program**. Ontario Health Teams (OHTs) are regional health organizations established throughout the province, tasked with the ground-level coordination of care between hospitals and communities for all people living in this province. OHTs will play a vital role in ensuring services are accessible to those who are uninsured.

3. **Ontario Health Teams should advocate and work towards OHIP for all.**
   OHTs are key players in calling for healthcare access for all residents in their regions, including those without OHIP. OHTs should use the levers they have at their disposal to ensure that all residents in the province, including those without OHIP, can justly access care in each region.

Recommendations to the Federal Government:

4. **Status for all.**
   We join the calls for a broad, inclusive regularization program for all residents without permanent status, including 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, and help to reduce other inequities currently experienced by non-permanent residents in Canada.

Introduction

On March 31st, 2023, the government of Ontario ended the Physician and Hospital Services for Uninsured Persons (PHSUP) funding[1]. The PHSUP policy provided funding for persons without public health insurance coverage through the Ontario Health Insurance Plan (OHIP) or other health insurance to access medically necessary hospital services and select primary care services. The implementation of the PHSUP policy in March 2020 expanded uninsured patients' access to timely and affordable healthcare when they needed it, and signified a positive step towards making healthcare accessible to all Ontario residents[2]. The revocation of this policy has meant that uninsured people are once again being denied healthcare, or experiencing delays in receiving healthcare, leading to a greater risk of severe illness or death among an already marginalized population.

Health care is a human right. The right to health is recognized in the 1948 Universal Declaration of Human Rights and Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR)[3]. Article 12 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and the responsibility of signatory states to take steps to protect this right, including "the creation of conditions which would assure to all medical service and medical attention in the event of sickness." Historically, Canada has consistently failed to meet this standard for uninsured residents. The PHSUP program temporarily bridged the gap in fulfilling health rights for marginalized uninsured populations, including racialized migrants, newcomers, and people experiencing homelessness[4 5]. This policy was a step towards addressing longstanding health inequities experienced by uninsured residents of Ontario and upholding the fundamental human right to healthcare for all. Taking this policy away was regressive, moving us further from Canada's obligations to protect the human right to health.

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[1] Ministry of Health. (2020, March 20). OHIP bulletin 230305. Government of Ontario. https://www.ontario.ca/document/ohip-infobulletins-2023/bulletin-230305-physician-and-hospital-services-uninsured-persons

[2] Schmidt, C., Suleman, S., Da Silva, D., Gagnon, M., Marshall, S., & Tolentino, M. (2023). A bridge to universal healthcare. Health Network for Uninsured Clients. https://www.hnuc.org/reports

[3] UN High Commissioner for Human Rights and World Health Organization. (2008.) The Right to Health. Fact Sheet No. 31.

[4] Tolentino, M., & Wadehra, R. (2023, September 29). Commentary on the impact of cutting temporary COVID-19 policies. Wellesley Institute. https://www.wellesleyinstitute.com/newcomer-health/commentary-on-the-impact-of-cutting-temporary-covid-19-policies/

[5] United Nations. (n.d.). Universal Declaration of Human Rights. https://www.un.org/en/about-us/universal-declaration-of-human-rights#:~:text=Everyone%20has%20the%20right%20to%20a%20standard%20of%20living%20adequate,age%20or%20other%20lack%20of

This report aims to understand the impact that the removal of the PHSUP policy has had on uninsured people's access to healthcare and overall health and wellbeing, as well as the impact it has had on the service providers caring for them. To capture these impacts, between January and March 2024, the Health Network for Uninsured Clients (HNUC) surveyed members working directly with uninsured people and interviewed key informants about their experiences providing care to their uninsured clients since the removal of the PHSUP policy.

The report's first section provides background information on the uninsured population in Ontario and the impacts of the PHSUP policy. The second section reports on survey and interview findings to describe service providers' perspectives on the impacts of removing the PHSUP policy. In the final section, we outline recommendations to ensure better access to care and overall improved health and well-being for uninsured people in Ontario.

Background

Although there are no accurate measures of the number of uninsured people, as of 2016, it was estimated that 500,000 uninsured people lived in Ontario.[6] Many uninsured people are ineligible for OHIP because of their immigration status, including some migrants on temporary work or study permits and people who are "undocumented" or without authorized immigration status. Current Canadian immigration policies limit access to provincial health and other social programs for many non-permanent residents, creating overlapping structural barriers to accessing health services. Some people are also uninsured for reasons unrelated to immigration status, including challenges maintaining a health card due to mental health challenges or the stresses of being unhoused.[7]

Unaffordable costs associated with accessing care, as well as fears and experiences of discrimination, are significant barriers to care. Before the introduction of the PHSUP program, 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.[8]

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[6] 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/.

[7] 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.

[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

Because of these barriers, research shows uninsured people are less likely to access timely and comprehensive care than people with insurance.[9] [10] Being unable to access healthcare can significantly impact 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.[11] [12]

THE PHSUP PROGRAM

The COVID-19 pandemic highlighted several gaps in the healthcare system and the importance of providing necessary care and protection for all people in Ontario, regardless of insurance. As a COVID-19 mitigation strategy, the Ontario Ministry of Health (MOH) introduced the PHSUP program in March 2020, which covered the cost for uninsured patients to receive medically necessary hospital-based services and select primary care services in the community.[13]

The implementation of the PHSUP program by the Ministry of Health and in hospitals had significant gaps.[14] HNUC and other grassroots groups made extensive efforts to improve the implementation of the program in hospitals so uninsured clients would have lower-barrier access to care.[15] These included significant efforts to advocate for uninsured clients' access to services at no cost and to educate hospitals and community clinics on the new PHSUP policy. Although the PHSUP program did not translate to eligibility for OHIP,[16] nor did it resolve all barriers to care facing uninsured populations in Ontario, the program significantly improved access to healthcare services in the short term between March 2020 and March 2023.[17]

HNUC's 2023 report highlights improved health outcomes and reduced financial hardship for uninsured clients, as well as overall benefits to the workload of service providers who typically spent significant time advocating for their clients.[18]

Similarly, Siu and colleagues also found that the PHSUP program enabled health providers in emergency departments to offer the best medical options for their uninsured clients' health.[19]

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[9] 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.

[10] 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.

[11] 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.

[12] Gagnon, M., Kansal, N., Goel, R., & Gastaldo, D. (2022). Immigration status as the foundational determinant of health for people without status in Canada: A scoping review. Journal of Immigrant and Minority Health, 1-16.

[13] Ontario Ministry of Health. (n.d.). OHIP bulletin 230305. https://www.ontario.ca/document/ohip-infobulletins-2023/bulletin-230305-physician-and-hospital-services-uninsured-persons.

[14] Schmidt, C., Suleman, S., Da Silva, D., Gagnon, M., Marshall, S., Tolentino, M. (2023). A Bridge to Universal Healthcare: The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents. Health Network for Uninsured Clients. https://www.hnuc.org/reports.

[15] Katz, A., Agahbanaei, N, Cheff, R., Harris, T., Hwang, S. W., & Schmidt, C. (2023). Hospital care for patients uninsured due to immigration status during the COVID-19 pandemic in Toronto: Lessons from front-line knowledge translation. Healthcare Quarterly, 26(2), 24-31

[16] Katz, A., Agahbanaei, N, Cheff, R., Harris, T., Hwang, S. W., & Schmidt, C. (2023). Hospital care for patients uninsured due to immigration status during the COVID-19 pandemic in Toronto: Lessons from front-line knowledge translation. Healthcare Quarterly, 26(2), 24-31.

[17] Tolentino, M., Wadehra, R. (2023, September 29). Commentary on the impact of cutting temporary COVID-19 policies. Wellesley Institute. https://www.wellesleyinstitute.com/newcomer-health/commentary-on-the-impact-of-cutting-temporary-covid-19-policies/

[18] Schmidt, C., Suleman, S., Da Silva, D., Gagnon, M., Marshall, S., Tolentino, M. (2023). A Bridge to Universal Healthcare: The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents. Health Network for Uninsured Clients. https://www.hnuc.org/reports.

[19] 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.

Media has also highlighted perspectives of healthcare providers and advocates indicating that care improved because the PHSUP program enabled their clients to access urgent services and life-saving treatments that they would otherwise have been denied or that they would have sought only when feeling "acutely unwell."[20]

On March 31, 2023, funding for the PHSUP program was terminated.[21] This has resulted in more profound health inequities and entrenched pre-existing barriers to accessing healthcare services.[22] [23] Based on an analysis done by the Ontario Medical Association (OMA), over 400,000 patients were served through the program by 7,000 physicians.[24] The cuts have had dire impacts on health equity as those who benefited most from the PHSUP program were people from marginalized populations.[25]

The OMA outlines that the PHSUP program improved autonomy over one's health for all individuals and improved access for people who do not have a health card, including people experiencing homelessness, newcomers, international students, and temporary foreign workers. Considerable advocacy from many other health and social service organizations and migrant-led organizations before and after the PHSUP cuts underscored the consensus around the need for this policy to ensure everyone can access health care services.[26]

[20] 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

[21] Ontario Ministry of Health. (2024, February 12). OHIP bulletin 240203. https://www.ontario.ca/document/ohip-infobulletins-2024/bulletin-240203-phsup-billing-deadline-march-31-2024

[22] Tolentino, M., Wadehra, R. (2023, September 29). Commentary on the impact of cutting temporary COVID-19 policies. Wellesley Institute. https://www.wellesleyinstitute.com/newcomer-health/commentary-on-the-impact-of-cutting-temporary-covid-19-policies/

[23] Alhmidi, M. (2023, March 25). Ontario doctors blast province for ending health care for uninsured residents. Global News. https://globalnews.ca/news/9578660/ontario-doctors-blast-province-ending-health-care-uninsured-residents/

[24] Cukier, A. (2023, July 19). Ontario doctors urge government to create permanent program for uninsured patients. Ontario Medical Review. https://www.oma.org/newsroom/ontario-medical-review/latest-issue/summer-2023/ontario-doctors-urge-government-to-create-permanent-program-for-uninsured-patients/

[25] Cukier, A. (2023, July 19). Ontario doctors urge government to create permanent program for uninsured patients. Ontario Medical Review. https://www.oma.org/newsroom/ontario-medical-review/latest-issue/summer-2023/ontario-doctors-urge-government-to-create-permanent-program-for-uninsured-patients/

[26] Katz, A., Agahbanaei, N, Cheff, R., Harris, T., Hwang, S. W., & Schmidt, C. (2023). Hospital care for patients uninsured due to immigration status during the COVID-19 pandemic in Toronto: Lessons from front-line knowledge translation. Healthcare Quarterly, 26(2), 24-31.

Methods: Survey and Interviews

An online survey and semi-structured interviews between January and March 2024 were used to collect the perspectives of health and service providers in Ontario, primarily in the Greater Toronto Area, about the impacts of the cuts to the PHSUP program. The survey and interviews were conducted online; the survey was administered through Google Forms, and the interviews took place on Zoom. Study participants were recruited through purposive and snowball sampling. Recruitment targeted health and social service workers working with uninsured clients in Ontario. The survey and interview requests were shared via various avenues, primarily through the Health Network for Uninsured Clients membership listserv. Individual HNUC members also shared the survey among their organizations and networks.

The survey included six Likert scale questions. The first three questions focused on the impacts of the cuts on uninsured clients, including access to health care, morbidity or severity of illness, and general well-being. The second set of questions focused on the impacts of the cuts on providers' work experiences concerning time spent on administrative work, time spent on advocacy work, and provider well-being.

The survey also allowed respondents to add further comments, in long-text format, on their experiences after the cuts. The semi-structured interviews focused on understanding the impacts of the PHSUP cuts on uninsured clients' access to care and their overall well-being, as well as the impacts on the participants' work with uninsured clients. Demographic data was collected for both survey and interview participants related to their professional role, the type of institution they work in, and how often they work with uninsured clients.

Interview transcripts and survey long-text format responses were coded and analyzed using a thematic approach to identify the impacts of the cuts on both uninsured clients and service providers. Likert scale responses were also synthesized for each question, and presented in pie charts as shown in the following sections. The HNUC research committee met and discussed their analyses to consolidate their findings. Overall, the report findings synthesize service provider perspectives on the impacts of the PHSUP cuts.

Report Findings

66 service providers responded to our survey. These included: midwives (n=24), physicians (18), social worker (7), care navigators (6), nurses (3), nurse practitioner (1), personal support worker (1), midwifery student (1), midwifery clinic administrator (1), chiropodist (1), medical lab assistant (1), lawyer (1), emergency department deputy chief (1). 15 service providers were interviewed, including administrator or care navigators (n=5), physicians (3), midwives (3), nurse (1), nurse practitioner (1), social worker (1). Different kinds of health institutions were represented, including hospitals, Community Health Centres (CHC), non-profit organizations, and specialty clinics for midwifery or reproductive care, palliative, and HIV/AIDS care.

OVERALL ACCESS AND SYSTEM BARRIERS

Across the different areas of care, health providers described system-level changes that have resulted in access being even poorer than it was prior to the PHSUP program due to higher hospital fees and an overall lack of coordination between hospitals, clinics, and Community Health Centres (CHCs) in supporting uninsured clients.

A significant challenge that all interview participants noted was the reinstatement of fees for hospital and specialist care. Since the Ministry of Health ended the PHSUP program, hospitals and physicians have begun charging uninsured clients out-of-pocket for all services. Some participants noted that hospital and physician fees seem to be much higher than they were before the PHSUP program. Some clients have also been charged for hospital and specialist services that were previously covered by CHCs prior to the PHSUP program or for hospital facility fees that were not in place before COVID-19

There is no provincial oversight or regulation of the fees that can be charged for non-insured patients; as a result, different hospitals have widely differing practices and fees across the GTA. Within this context, there was a perception among some providers that certain hospitals have been taking advantage of the cuts to the PHSUP to raise the fees they charge for services. In addition, providers described a lack of transparency at some hospitals about their fees, making it more difficult for providers to provide accurate information to their clients about costs.

Some providers also identified changes to how hospitals assess resident status. Hospitals commonly charge different rates for non-insured residents and non-insured visitors. Resident rates are typically set at the same fee level as OHIP fees, while visitor fees are much higher.

However, some providers noted that the hospitals they work with have changed their requirements for proving residency, making it much more difficult for uninsured clients to prove they qualify as residents. As a result, Ontario residents are being charged the higher visitor fees. Providers working in midwifery, CHCs and other community-based settings perceived there to be poorer system coordination with hospitals. Many felt that certain hospitals and hospital-based specialists are less open to collaborate to serve uninsured clients since the end of the PHSUP program

In 2012, there were efforts to address system coordination through agreements between certain CHCs and hospitals at the level of the Toronto Central Local Health Integration Network (LHIN), which enabled CHCs to better access hospital care for their uninsured clients. Hospitals would charge CHC uninsured clients OHIP-level rates, and CHCs would cover these costs with their funding.[27] As noted by a CHC primary care director, in the current post-PHSUP environment, and with the dissolution of the LHINs in 2019, these agreements seem to no longer be in place or have not been updated, contributing to the deterioration of system coordination. In the larger context, participants described that the lack of coordination between CHCs and hospitals reflects an overall lack of willingness to support those who are uninsured.

IMPACTS ON UNINSURED CLIENTS

Impacts on Client Care, Health and Well-being

Across interview and survey results, a large majority of participants described the cuts as having a dramatic negative impact on uninsured access to care, resulting in worse health outcomes and creating stress for clients. From the survey findings:

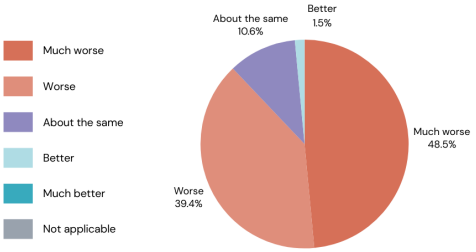
87% reported access to care was worse.

92% reported negative impacts on clients' general well-being.

76% observed worse health outcomes for their uninsured clients as a result of the cuts.

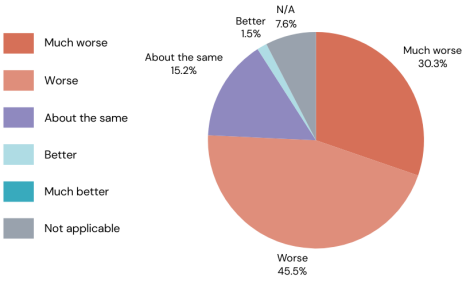
Impacts on uninsured clients' access to health care (e.g. delays in care; refusal of care)

66 RESPONSES



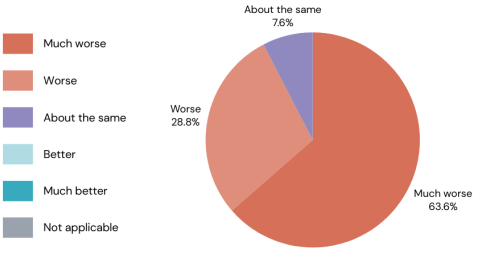
Impacts on uninsured clients' morbidity or severity of illness

66 RESPONSES



Impacts on uninsured clients' general well-being (e.g., psychological stress; financial stress)

66 RESPONSES



[27] Toronto Public Health. (2013, April 15). Medically Uninsured Residents in Toronto. https://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-57588.pdf

Delayed Care Resulting in More Severe Conditions

Clients have experienced substantial delays in care due to a lack of access to specialist consultations and clients forgoing treatment due to unaffordable fees. Within the context of high fees for care, many providers described concerns that their clients have limited agency to make decisions about their health since people are making decisions about accessing services based on what they can afford rather than what is medically recommended. For example, several participants described examples of their clients opting out of necessary treatment or delaying seeking recommended care because of the fees they would have to pay. As a hospital-based physician described in their survey response:

> **"Decision-making around tests and treatments is always more difficult when having to communicate potential cost to patient. Patients often leave without necessary treatment or investigations.**
>
> – Physician, hospital

Because of a lack of access to specialist consultations and clients avoiding unaffordable services, practitioners note that clients are more likely to access care at acute stages when a medical condition becomes so severe that they can no longer manage the symptoms themselves. Midwives and physicians in emergency departments described seeing significantly more uninsured clients accessing their care at later stages of a complicated pregnancy or an already developed cancer or AIDS. In many cases, these more advanced medical issues could have been preventable if clients had been able to access care earlier when they were experiencing less severe symptoms. For example, providers described clients who have experienced prolonged symptoms of stroke due to the lack of access to rehabilitation care. Providers also described preventable complications for pregnant people, including loss of pregnancies.

Discrimination and Mistreatment

In addition, participants described having witnessed a rise in discriminatory treatment and harassment towards uninsured clients within hospitals.

Some uninsured clients have been denied care because of their non-insured status or inability to pay upfront.

Many providers raised concerns related to finance departments persistently and aggressively calling clients to demand deposits and payments.

These calls cause tremendous stress for clients and create fear and anxiety around being able to access needed medical and emergency services.

A midwife described how calls from the hospital's finance department to pregnant clients led their clients to believe that they would not receive medical care if they arrived at a hospital in labour and had not paid the deposit required for registration.

An ED physician and midwife also described instances where hospital financial department staff have come to post-operation or post-partum rooms shortly after a birth or procedure, demanding payment upfront.

As the midwife explained:

> **The finance department will sometimes visit them [non-insured clients] while they are on the postpartum unit with their newborns, in a vulnerable state, and threaten them about payments, saying things like "this will follow you from generation to generation." This was said to my client, who is a victim of domestic violence living in a shelter.**
>
> – Midwife, clinic and hospital

Increased Stress

Together, these issues have led both to poorer health outcomes for uninsured clients and to greater anxiety and financial stress. A hospital social worker described how these factors converge to create stress for uninsured clients:

> **In general, we have seen an increase in the levels of stress that our uninsured patients experience. Typically, when they are accessing hospital services it's due to an emergency and/or medical situation that is inevitable or can no longer be prolonged any further. As a result, they are faced with large medical bills that are incredibly daunting - which cause emotional and mental distress. This was not a concern for most during the PHSUP program. Also, when we are seeing uninsured patients (with the exception of accident injuries/traumas), their medical conditions are typically exacerbated due to it being poorly managed from their inability to access preventative care. On our part, this requires additional time to address patient concerns, provide information about billing, and also give them community resources.**
>
> – Social worker, hospital



A nurse who works at a community-based clinic for people living with HIV described the immense stress her uninsured clients deal with because of the uncertainty about whether they will be able to access life-saving treatment:

> **I think it's a huge mental stress. Not knowing if you're gonna have access to lifesaving care and treatment that you need. Anyone, anywhere could put themselves in those shoes and think about how that would feel. To know that you need something to live and not be sure if you're gonna have access to it [...] That's what our patients are facing all the time.**
>
> – Nurse, community-based clinic

The impacts of the PHSUPs cut have particular implications for different areas of healthcare. In the following sections, we describe the impacts on three main areas of care: emergency care, reproductive care; and non-acute care for chronic conditions.

Emergency Care

Ten physicians working in hospital emergency departments (ERs) participated in the survey, and two participated in in-depth interviews. Physicians reported that since the removal of the PHSUP policy, they have seen more severe and life-threatening health complications for uninsured clients resulting from delays to care since healthcare decisions are often dictated by financial viability rather than medical urgency. The cases then require increasingly complex care for patients and more time-consuming approaches for service providers.

ER physicians are also seeing uninsured patients with chronic conditions who need urgent care because they have been unable to access regular treatments. For example, one physician described instances where uninsured patients were missing vital health appointments for dialysis, which then led to life-threatening complications. Such situations highlight the profound impact that inadequate health coverage has on uninsured patients, where the financial infeasibility of receiving care means that preventable emergencies occur.

As described by a physician:

> **A patient had a life-threatening illness because their potassium is too high. […] So they could have a malignant arrhythmia, or they're very short of breath, needing oxygen because they're in fluid overload. They need to have emergency dialysis when that could have been avoided should they have been able to more easily connect with their nephrology team… [to get] that care that you need. And so it just really complicates their care and instead of helping to streamline and get them the support they need in a timely manner, I think it really delays care for people and there are negative consequences to that for morbidity and mortality.**
>
> – Physician, ER department

Emergency physicians have also treated uninsured clients with severe cases such as chronic wounds or bleeding, only to later find out that they have cancer. In these cases, clients have described having ongoing symptoms for a significant time prior to seeking emergency care and have delayed seeking care due to their fears of costly hospital fees.

Providing patients with comprehensive and ongoing healthcare has, therefore, become much more difficult since the removal of the PHSUP policy, with patients once again avoiding care until it becomes an emergency and they can no longer put off seeking care. This contrasts with the streamlined and timely care that healthcare workers could provide when the PHSUP policy was in place.

Such delays to care have been shown to result in an increase of more severe cases and people dying upon arrival to the emergency room.[28] [29]

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[28] Garasia, S., Bishop, V., Clayton, S. et al. Health outcomes, health services utilization, and costs consequences of medicare uninsurance among migrants in Canada: a systematic review. BMC Health Serv Res 23, 427 (2023). https://doi.org/10.1186/s12913-023-09417-4

[29] 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

Reproductive Care

Perinatal Care

Twenty-four midwives responded to our survey, and three participated in in-depth interviews. Midwives described a crisis in perinatal care for uninsured patients due to high hospital fees, which vary significantly across hospitals. As described in detail below, these have resulted in a range of harms for pregnant people, including less access to routine prenatal consultations and tests, poorer access to OB/GYN specialist care for patients with high-risk pregnancies, pressures to give birth out of hospital to avoid the high cost of hospital care; increased emotional and financial stress; and worse maternal and fetal health outcomes.

Barriers to consultations, tests, and specialist care

Due to high fees, pregnant patients are being denied important prenatal consultations, tests, and specialist care necessary for maternal and fetal health. These include consultations for issues like gestational diabetes and anemia, as well as hospital ultrasounds and prenatal non-stress test assessments. Specialist consultations that midwives were accessing easily for their clients during the PHSUP program are now more difficult to access.

As a result of these barriers, uninsured clients are unable to access routine forms of care that are necessary for maternal and fetal health. One midwife shared an example of how high fees lead to heightened risks for clients and their fetuses:

> **"For example - a client comes into a routine prenatal appointment, and the fetal heart rate is abnormal. For every pregnant person in this situation, we send them to maternal triage at the hospital for the on-call midwife to do fetal monitoring. It has to be done there so we can escalate care if abnormal. But these clients will be charged $431 for just the bed fee. If that discourages them from coming in, that is dangerous care for the fetus and the person. I can't speak to other disciplines but I think for pregnant people not providing wraparound care is unconscionable.**
>
> – Midwife, clinic and hospital based

Midwives observed that the PHSUP cuts have led to an increase in clients who opt out of medically advised care because of the high fees of hospital procedures, causing risks for clients and stress for providers. Pregnant people are being put at risk for severe clinical issues such as preterm labour and preeclampsia, which can be life-threatening for both pregnant patients and infants.

The impacts of cuts have been especially difficult for pregnant people with high-risk pregnancies for whom midwifery care is not appropriate, such as those who have gestational

diabetes and hypertension or those living with chronic conditions who need OB/GYN care. Midwives described the difficulty of finding providers who will provide care for these clients. Some midwives described cases when they have not been able to ethically keep high-risk pregnant clients in their care, given the need for specialist care. However, some high-risk clients are reluctant to be referred out of midwifery care because they cannot afford the costs of specialist care.

One midwife shared a story of a client who had been diagnosed with gestational diabetes and was referred for a specialist consult at the hospital but declined to go because of the high cost of care:

> **"So this patient ended up declining when they called her to book, but she said "No, I'm going to manage it on my own". She has to be with a higher risk provider. We can't ethically keep her in our care with the complication she has. If you're not able to manage your gestational diabetes, on your own, you have higher risk for stillbirth, you have higher risk for your baby growing very big. And that puts you at more risk of complications during the birth such as shoulder dystocia. And it can cause a big blood sugar crash after baby's born. So hypoglycemia, because the baby is exposed to a high level of blood glucose through the umbilical cord. And then after birth, once the cord is cut, suddenly that sugar levels cut off. And [...] at the worst case, it can cause brain damage. And I really think that if it was covered, if there was no fee, she would do it. It's only the cost, that's the issue.**
>
> – Midwife, clinic

High hospital childbirth fees and denials of care

Some hospitals are now demanding large deposits (e.g. $6000 to $10 000) for pregnant people to register for their childbirth. As a result, some clients are choosing to opt out of hospital births even if this is not their preference because they cannot pay hospital fees, opting instead for home birth. In addition, two midwives described how some of their clients have chosen to give birth at alternate hospitals where they do not hold midwife privileges because the fees were lower; as a result, the midwives could not attend their clients' births. Childbirth fees cause great stress for pregnant clients, and this has been exacerbated by the practices of finance departments in some hospitals that aggressively seek payment from clients.

Midwives shared stories of clients being denied specific medical services if they cannot pay upfront. For example, one midwife reported that the urology department refused to remove a urinary catheter for a woman one week postpartum without being paid. Another midwife described how her client was denied anesthesia while birthing unless she paid upfront.

As a result, her partner had to leave the hospital to get the money:

> **So he had to drive around town to multiple different ATMs while his partner was alone, and without supportive care, for him to be able to get the funds to do this and then come back hours later. That's traumatic for the birthing person. To lose their support like that and feel so unsupported from the health care system.**
>
> – Midwife, clinic and hospital based

Health crises and their impacts on the well-being of uninsured pregnant people

As a result of these barriers to care, midwives described an increase in clients experiencing avoidable medical complications and worse health outcomes. For example, one midwife described how their hospital labour and delivery department has seen several cases of emergencies that would have been avoided if uninsured people had access to routine prenatal care. This included a recent case where both of a client's twins were born stillborn. Another client declined a cervical cerclage to prevent preterm labour because she was unable to pay the hospital fee and lost her baby unnecessarily at 23 weeks. The midwife described the distress that witnessing such preventable health crises creates for healthcare providers:

> **The emotional toll this takes on all of us on the labour and delivery floor is marked. We are being put in terrible, heartbreaking situations. It is disgusting to see this happening in a country as rich as ours.**
>
> – Midwife, community-based clinic and hospital

These situations are creating high levels of stress for pregnant patients who are unable to access the care that their health providers recommend or who must make difficult choices to take on healthcare fees they cannot afford. As one midwife described:

> **Clients are much more stressed throughout pregnancy wondering how they are going to pay hefty hospital bills. Their mental health is impacted negatively by the hospital calling them asking for large sums of money for deposits. They are stressed out wondering if they will be turned away. Clients who have complications and require hospital follow ups are being asked to pay money at each visit, and there is a lot of pressure because many don't have enough money to pay rent or buy healthy foods.**
>
> – Midwife, non-profit advocacy and service provider organization

One midwife also commented that since the cuts to the PHSUP, they've seen a "**drastic increase in the number of homeless pregnant clients as shelters, underfunded and over-crowded, are turning people away. I have had women in situations of intimate partner violence and the only thing I can offer them is the option of weighing violence over being pregnant and living on the street without health care."** This comment highlights how the cuts to the PHSUP came at a time of record forced migration and in the midst of a housing crisis in Toronto; these crises have converged to create multiple harms for uninsured pregnant people.

Abortion Care

The cuts to the PHSUP program have also drastically reduced the ability of uninsured people to access abortion care. System navigators with a national organization providing referral, advocacy and funding support for people to access abortion care across Canada described the changes they have seen since the PHSUP was cut. When the program was in place, they received fewer uninsured clients from Ontario, indicating that people were more able to access abortion care. When clients from Ontario contacted them, they could redirect uninsured clients to the PHSUP program, and their organization primarily offered advocacy support since most procedure costs were covered. However, since the program has been cut, they are receiving many more uninsured clients from Ontario. Options for referrals and services for uninsured people have been significantly reduced, and they are sometimes unsure where to send their clients.

System navigators described how, because of the many barriers to care and the lack of awareness about abortion options for uninsured people, by the time people are referred to their organization, many clients are later in pregnancy and are no longer eligible for medication abortions. For pregnancies before 10 weeks gestation, medication abortions can be accessed with the support of some midwives and physicians. When uninsured people cannot afford the fee and must delay seeking care beyond 10 weeks, they then need surgical abortions, which are more costly and harder to access, often requiring patients to travel in order to access facilities that can perform the procedures. There are very limited options for abortions in Canada beyond 24 weeks gestation. In some cases, this means that people are not able to access abortion at all. Service navigators who work with uninsured clients to access abortion care described how a client had been trying to save up money to pay the $500 required for medication abortions. However, by the time the client had saved up the money, they were much later in their pregnancy and were no longer eligible for medication abortion. At this point, the client was referred to their organization:

> **"They were much further along at that point, [I] believe closer to the 24 week mark which meant that actually there aren't any hospitals or facilities that could take this patient on. So not only was the availability of the service not there for them, but of course the cost was way more than what it would have been at the time when we first were seeking an abortion. And so we had gone through a different route to try to get them access to care and that route did not work out unfortunately. And so that was sort of the last option for this client and then they ended up having to go forward with the birth.**
>
> – Care navigator, non-profit organization

In addition, a midwife described how access to urgent hospital care is necessary to keep medication abortion safe. Providers counsel clients who have heavy bleeding, cramping, or other signs of complications to go directly to the nearest emergency department. The cuts to the PHSUP have, therefore, reduced the safety of medical abortions for uninsured clients. As the midwife explained:

> **With the cuts, we lost this easy access that created guardrails for this care. So now, if a client pages with heavy bleeding, I have to counsel them to go to the ED but I also have to tell them there will be a charge. And some may elect not to go, which could be catastrophic.**
>
> – Midwife, community health centre

Non-Acute Care for Chronic Conditions

Practitioners described several concerns for uninsured clients with severe or chronic conditions resulting from the end of the PHSUP program. These include a sudden loss of access to treatment and chronic care management, delays to care, clients seeking out or opting into treatment later in their symptom development, and overall increased financial stress from the cost of treatment. Altogether, practitioners note that the loss of access to care had significant negative impacts on their clients' physical health and overall well-being.

> **It helped our patients greatly that they didn't have to worry about paying for dialysis treatments. It's a stressful thought that patients will risk not attending their life-sustaining treatment because they cannot afford it**
>
> – Social worker, hospital

Participants described a sudden loss of access to care among uninsured clients. When the PHSUP program ended, access to referrals was reduced, and hospitals and specialized clinics immediately reverted back to issuing significant bills for necessary treatment and chronic care management. In some cases, hospitals have refused to accept referrals or care upon realizing that the client is uninsured. CHC practitioners, hospital physicians and social workers have all noted seeing clients lose access to life-sustaining treatment such as dialysis and cancer treatment because they are unable to pay for it. One CHC care provider described this as a "dire and stressful" situation for chronic care management.

Physicians and nurses also described seeing clients with delayed cancer diagnoses and delayed treatment due to substantial hospital fees, resulting in worse health outcomes. Healthcare providers shared examples of clients who could only afford and access certain parts of a care plan; as a result, clients cannot fully recover or get treated in a timely manner and incur more costs over time.

Several case examples included clients with HIV that have developed into AIDS and other AIDS-defining illnesses such as cancer and other serious infections.

> **I have seen clients have delayed diagnoses of cancer due to fear of having to pay, having delayed and denied care due to this as well. It's very emotionally and mentally taxing for these clients and very disconcerting to participate in a healthcare system that does not treat patients equitably.**
>
> – Physician, hospital

Clients are forced to make difficult decisions because of the high costs of care, and when they access medically necessary treatment, they are left with overwhelmingly high bills that they are unable to pay. A nurse who coordinates a primary care clinic for uninsured people shared the story of a client who has been working in Canada on a temporary work permit and now has an $80 000 hospital bill:

> **Unfortunately, he became very ill and his work permit expired. He wasn't able to renew it, and it was then determined that he was actually quite sick with cancer, like a CNS (central nervous system) lymphoma and needed treatment for that in the hospital […]**
>
> **So this patient is left with, you know I have a copy of the bill somewhere in my office, but it's a gigantic fee. It's like an $80,000 hospital bill. But basically, if this person declined this treatment, they were not going to live. The doctors were like, this is a life saving treatment. It might not even work. That's how sick you are. You need to accept it. So it was actually a really interesting conversation with the oncologist, you know, talking about first line versus second line treatment. Like, could you imagine if you had a cancer that might kill you and you're debating about that? Of course you want the first line treatment. Of course you want the best treatment available, the one that gives you the best chance of surviving. It was really hard to have that conversation, really heartbreaking for us as his providers, and also for the patient.**
>
> – Nurse, primary care clinic

Other than financial stressors, providers also expressed several health system barriers faced by uninsured clients, which have significantly worsened since the end of the PHSUP policy. Clients have repeatedly faced discrimination and harassment, and have experienced instances of overt racism from clinics or hospital administrators. Providers have noted that their clients have been dismissed or treated poorly by clinics they have referred them to. Some clients have been denied care for life-saving surgeries, rehabilitation, or cancer treatments. In one example, a CHC nurse was supporting a client who developed cancer and needed urgent surgery to remove it but was refused a timely surgery by several hospitals. When they did find one surgeon who was open to providing this care, it was under the condition that they

organize a payment plan, which further delayed the operation for weeks due to the amount of paperwork. This client was supported by her daughter, who has described several instances of harassment and challenges in her attempt to seek out care for her mother.

> **"Lots of things have happened with her, and every time she has an appointment or has to go to the hospital, I have to do a bunch of paperwork. The daughter's been fighting. They all refused her care. At one point, the surgeon, they refused to do the surgery at first until they had organized the payment plan to pay for it all [...] Because we [CHC], we'll pay for a lot of the cost, but we don't pay for the hospital fee, the specialist cost medications and all these other things. [...] But the hospital fee itself was something like $3000 and the daughter, you know, lives alone, works alone, single income, supporting the two of them. It was not feasible. And so [...] there's just a lot of back and forth again, a lot of emails, a lot of advocacy getting this woman seen. And ultimately the daughter ended up filing a complaint through the hospital with their ombudsman or human rights department.**
>
> – Nurse practitioner, community health centre

The gravity of the impacts resulting from the PHSUP cuts for uninsured clients with chronic conditions will likely become magnified over time due to the compounding health impacts of delays and denials of necessary treatment.[30] [31]

[30] Marwah, S. (2014). Refugee Health Care Cuts In Canada: System Level Costs, Risks and Responses. Wellesley Institute. https://accessalliance.ca/wp-content/uploads/2018/06/Refugee-Health-Care-Cuts-In-Canada-.pdf

[31] McKeary, M., & Newbold, B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. Journal of Refugee Studies, 23(4), 523-545

IMPACTS ON SERVICE PROVIDERS AND STANDARDS OF CARE

Service providers discussed how removing the PSHUP policy has impacted their ability to meet appropriate and ethical standards of care. They reported increased workload and moral distress. The combination of these issues has led to increased stress for many service providers.

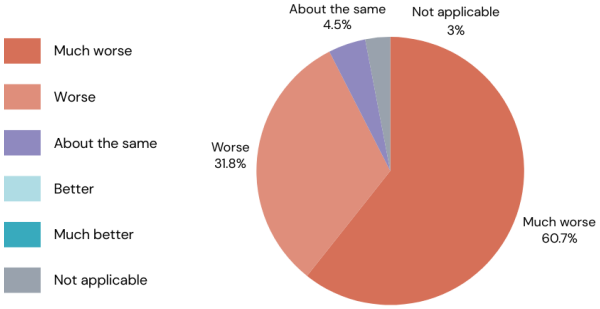
92% indicated their administrative workload was higher.

88% reported that their advocacy workload was higher.

89% reported that the cuts have had a negative impact on their well-being as a service provider.

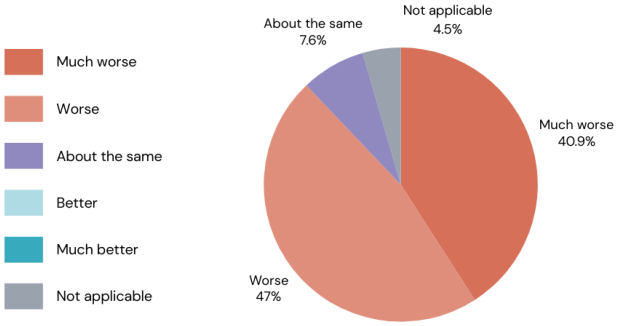
Impacts on your administrative work (e.g. time spent with care coordination, processing bills for services)

66 RESPONSES



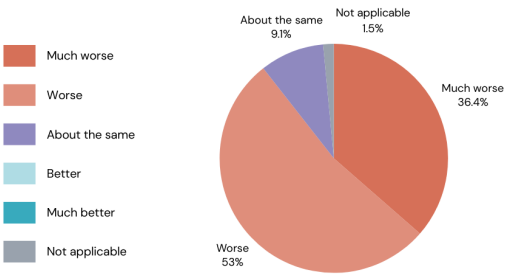
Impacts on your advocacy work (e.g. time spent supporting uninsured clients with accessing health services, liasing with other service providers, hospitals, CHCs, etc.)

66 RESPONSES



Your well-being as a service provider (e.g. your own mental health, feelings of burnout, etc.)

66 RESPONSES



Impacts on Advocacy and Administrative Workload

The removal of the PSHUP policy has significantly increased the administrative burden placed on healthcare providers and the time they spend on administrative and advocacy-related tasks. Participants reported spending more time helping their patients with appointments, finding referrals, navigating the health and social service system, and doing additional research to find care alternatives. Additional advocacy work included researching funds and other resources, developing payment plans, and negotiating terms with hospitals and specialist services. Many service providers have described this as a frustrating and depleting process for themselves and their clients, leading to increased provider stress.

> **We have to book longer appointments to be able to cover what their questions and priorities are as well as the things that I actually need to do as part of my job. So there is a bit of extra work and then of course there's secondary trauma from seeing someone so distraught over those kinds of fees and making choices that you know they wouldn't make had they had the coverage.**
>
> – Nurse, specialist community health centre

In particular, service providers expressed frustrations in working with hospital financial departments. Participants shared that negotiations with hospital billing departments required significant efforts to advocate for "appropriate" amounts.

> **[I faced] increased difficulty reaching financial departments of hospitals to determine the fixed amount uninsured clients are expected to pay. Increased phone calls going back and forth in the hopes that our uninsured clients will receive seamless care. I have been given multiple amounts for hospital fees at the same hospital regarding non-insured clients sometimes ranging from $2,000 to $6,000. Inter-professional colleagues seemingly annoyed with increased TPA letters [i.e. Transfer Payment Agency letters that authorize funding to flow from the Ministry of Health to pay for consultants, labs and diagnostics for care of uninsured midwifery patients] . Incredible increase in financial stress and mental health concerns for clients following the end of [the PHSUP policy].**
>
> – Midwife, midwifery clinic and hospital

Several participants shared that they have had to do this work "on the side of our desks" or outside of work hours since there has been a significant increase in cases that need urgent support. Since the removal of the PHSUP policy, service providers have also been doing case management work that falls outside the scope of their jobs, including educating themselves about affordable resources and services available to uninsured clients.

In the absence of a standardized policy enabling accessible, free or low-cost services to uninsured people, many health providers described additional research and case management as a necessary part of their roles to support uninsured clients. However, many saw this situation as unsustainable, increasing the burden, work-related stress, and moral distress among service providers. As one care navigator described:

> **"[The end of the PHSUP policy] created a situation where you're having to rely on these kind of band-aid situations and people to kind of go above and beyond and maybe outside what they perceive as the scope of their role in order to help patients who would otherwise fall between the cracks.**
>
> – Care navigator, non-profit organization

Compromising Standards of Care

Without the PHSUP program, participants express an overwhelming concern that the standards of care to which they are professionally committed simply cannot be met. While the policy was in place, participants noted having a sense of relief that they could support clients more thoroughly by focusing on what they medically need and not on what is affordable. With the policy revoked, providers report having to, yet again, weigh the financial costs of services rather than basing healthcare decisions on what would be most beneficial or recommended for patients. As stated by a participant:

> **"We're not making medical decisions, we're making financial decisions.**
>
> – Midwife, community health centre

Service providers report needing to laboriously search for or coordinate creative medical options that are free or low-cost. If they find such an option, they are often not ideal medical options and/or are also time-consuming. For instance, a midwife describes caring for a client without OHIP who had a high-risk preterm birth at 35 weeks gestation. Ordinarily, in the case of preterm birth at this gestational age, the birth parent and infant would stay at the hospital for a few days after delivery for observation of the infant in case more acute care is needed. In this case, the family was very worried about the bills they would need to pay for the postpartum observation. They opted to be discharged home, and the midwife caring for them provided home visits daily to assess the dyad, including carrying out blood work to assess bilirubin levels for the baby over the course of 3 days. This was a time-consuming process for the midwife, which would otherwise have been conducted while the infant was in hospital. As this midwife's experience illustrates, service providers have to use creative solutions that are time-consuming and not within the standard scope of care to ensure that clients are not receiving high bills they cannot pay.

Another participant working as an ED physician described seeing a client with multiple conditions. In trying to figure out how best to manage the conditions, the physician and the client had to prioritize which condition needed to be addressed the most. In another example, the physician had referred an uninsured client to outpatient care in order to minimize the cost for their client, even though they would have preferred to refer them to a specialist at their institution:

> **In a case where maybe I would consult another specialist at our site to come and see them, we've avoided doing that collectively because that was something the patient was fearful they couldn't afford. So then you have to get creative outpatient plans for patients who probably would do better if they could see someone on site and that if they could afford it, would have had that consult. So there's a direct impact on the gold standard of care, which they may not be getting anymore because they can't afford it. And it's not that we wouldn't provide it to them, but it's a choice that you end up having with patients.**
>
> – Physician, emergency department

Several participants expressed concern about the lack of available support for clients, as well as the unfair treatment clients receive when navigating the health system, stating that these conditions reflect the health sector's unethical disregard for the human rights of uninsured people. Providers spoke of their responsibility as healthcare workers to "do no harm." However, that responsibility becomes difficult and sometimes feels impossible when providing care to uninsured clients. Many practitioners are aware that when clients are unable to access optimal medical treatment, it leads to an overall increase in complications in the long term. As one participant states:

> **This feels wrong [...] it goes against a moral code to provide a high standard of care**
>
> – Physician, emergency department

Impacts on the Wellbeing of Service Providers

While the PHSUP policy was in place, service providers experienced a decrease in distress-related work challenges.[32] Health providers recounted having a sense of relief when they were able to rely on the PHSUP program to provide thorough care for their clients:

> **Over the three years or so that we had [the policy in place] there was a sense of relief from providers and patients. You don't need to worry about this and you can have that direct conversation with patients […] "It's OK, you're not gonna get a bill in the mail. You're not going to get screwed over months down the line that you have this huge, unexpected payment that's on your shoulders now." And it made it easier to facilitate follow up on physician referrals.**
>
> – Physician, emergency department

Now, the significant challenges of care for uninsured people have been taking a toll on service providers' mental health and wellbeing. Service providers reported feeling increasing pressure and feelings of distress; some described their experiences over the past year as "painful" and observed that they felt "helpless," "frustrated," and "upset" about being constrained in terms of the level of care that they can provide. These issues are contributing to burnout for some, as providers increasingly feel that they are limited in what they can do to support their clients.

> **When I can't even provide the most appropriate care because of financial limitations, that takes a toll on me emotionally and psychologically as a provider. It's very difficult to watch someone make a decision in favour of their finances instead of their health. Even though of course I understand why people make those decisions, it's incredibly painful to watch as a care provider with the level of responsibility that I carry as an on-call provider for care like labour and birth.**
>
> – Midwife, clinic and hospital

[32] Schmidt, C., Suleman, S., Da Silva, D., Gagnon, M., Marshall, S., Tolentino, M. (2023). A Bridge to Universal Healthcare: The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents. Health Network for Uninsured Clients. https://www.hnuc.org/reports

Some participants also expressed feeling distressed and frustrated with the consistent roadblocks they encounter while trying to access care for their clients within the larger health and social services system. One physician in a hospital stated it feels "very disconcerting to participate in a health care system that does not treat patients equitably." A midwife described unprecedented levels of exhaustion after decades of working with uninsured clients.

> **"As a provider in this area I have no adequate words to describe how awful access to pregnancy care has been for people. I have done this work for 25 years and have never felt so exhausted and despondent as a healthcare provider. I have heard from dozens of midwives experiencing the same burden and resulting burnout. Taking care of uninsured clients is 10 times harder with every system slamming its doors - especially hospitals.**
>
> – Midwife, clinic based in CHC and hospital

Service providers described increased feelings of moral distress due to the psychological toll of not being able to provide medically necessary care to uninsured clients who cannot afford to pay for it. Many providers referred to the moral difficulties they feel in their work as they cannot maintain the standards of practice they are committed to, and overall feel like they have failed to meaningfully support and care for their clients. Some providers described it as "moral injury."

> **"As you may know, there's like a burnout epidemic and or moral distress within healthcare. [...] When you feel like you can't help patients and optimize their care, that just straight up sucks. And that gets people down. And that continual nagging and chipping away on the human who is the physician takes its toll.**
>
> – Physician, emergency department

Recommendations





The recommendations are targeted to provincial and federal levels of government to ensure uninsured clients can access the care they need. 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. While some recommendations aim to be interim changes in the current context of a two-tiered health system where some residents are not covered by provincial health insurance, more permanent and fundamental changes are needed in both health coverage and immigration policies.

Recommendations to the Provincial Government

1 Establish 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 Ministry of Health should, therefore, extend OHIP coverage to all Ontario residents**. While the PHSUP program alleviated many barriers to healthcare services, even with the policy in place, there were still significant gaps that left many vulnerable people without holistic access to the full spectrum of support they needed. Although funding for Community Health Centres (CHCs) and midwives covers some services for those without OHIP, tremendous amounts of client advocacy, system navigation, and supplemental financial support are still required to provide decent care for people who are uninsured. A comprehensive OHIP for all policy would eliminate many of the administrative barriers that continue to create current and worsening inequities in access to healthcare.

2 Immediately reinstate the PHSUP program that enables access to healthcare for uninsured clients.

We call on the Ministry of Health and the provincial government to immediately reinstate the PHSUP program and make it permanent in order to ensure that all residents of Ontario can continue to access hospital care without fees. In the reinstatement of a permanent PHSUP program, the government and Ministry of Health should consider adequate coverage and proper roll-out of the program:

a. **Expand billing codes used by primary care and establish clearer billing processes to improve access to healthcare for uninsured clients**. As part of the PHSUP policy, the Ministry of Health created billing codes that primary care providers in the community can use to cover some services for uninsured people. HNUC's 2023 report on the impacts of the PHSUP policy found that, while these billing codes were a promising initiative, they were not effectively used throughout the primary care system. In the reinstatement of a program similar to the PHSUP policy, billing codes should be expanded to cover more services and should be made permanent with clearer direction so that they can be better utilized.

b. **Ensure the program is standardized within and across Ontario hospitals**. Despite the promise of the PHSUP policy, the program fell short in terms of the effective implementation and dissemination of information about the program across the health system. The current report also underscores gaps in coordination between hospitals, CHCs and other community clinics, which gravely impact uninsured clients' access to care and their health outcomes. Standardizing the program across hospitals is necessary to ensure hospitals can fully implement the program and work effectively with other care providers in the community to provide comprehensive care for uninsured clients.

c. **Educate healthcare professionals about healthcare options for uninsured people**. In addition to reinstating the program, general education and awareness of uninsured care issues are vitally important for healthcare professionals 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.

d. **OHTs should work with hospitals and health services in the community to ensure care is coordinated in compliance with the PHSUP program**. Ontario Health Teams (OHTs) are regional health organizations established throughout the province, tasked with the ground-level coordination of care between hospitals and communities for all people living in this province. OHTs will play a vital role in ensuring services are accessible to those who are uninsured. They can work to reduce the barriers to healthcare access that continued even while the initial PHSUP policy was in place, including harmful hospital-based discriminatory practices highlighted in this report, which, if not addressed, are likely to continue even with the reinstatement of the PHSUP program.[33] These practices include charging upfront fees to access hospital care, or simply denying care and services due to someone's insurance status – all of which have served to gatekeep and prevent access to health-promoting and life-saving services.

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[33] Schmidt, C., Suleman, S., Da Silva, D., Gagnon, M., Marshall, S., Tolentino, M. (2023). A Bridge to Universal Healthcare: The Benefits of Ontario's Program to Make Hospital Care Accessible to All Residents. Health Network for Uninsured Clients. https://www.hnuc.org/reports

3 OHTs should advocate and work towards OHIP for all.

OHTs are key players in calling for healthcare access for all residents in their regions, including those without OHIP. **OHTs should use the levers they have at their disposal to ensure that all residents in the province, including those without OHIP, can justly access care in each region**. This includes supporting the call for OHIP for all and the reinstatement of PHSUP

Recommendations to the Federal Government

4 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 announcement that migrant care workers who come to Canada will receive permanent residency upon arrival. However, this announcement does not apply to all migrant workers or other 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

The PHSUP program, otherwise known as the Ministry of Health's Directive on uninsured patients, was a significant step towards greater health equity in Ontario. As HNUC outlined in its 2023 report, while there were gaps in the PHSUP policy, the program improved access to care and health outcomes for uninsured clients while also giving care providers the assurance that they can provide care to their clients regardless of their ability to pay.[34] Extending the health coverage for uninsured clients effectively addressed long-standing gaps and health inequities and brought Canada closer to fulfilling its human rights commitments and establishing a truly universal healthcare system in the province of Ontario.[35] [36] [37]

This report underscores that the cuts to the PHSUP program have re-established significant barriers to accessing life-saving and health-promoting care for uninsured people living in Ontario. At the time of completing this report, in July 2024, the Government of Ontario had not announced any measures to address the gaps left by the elimination of the PHSUP program. If this issue continues to go unaddressed, in the context of the continued restructuring and privatization of Ontario's healthcare system,[38] uninsured clients' access to healthcare will only worsen over time. Healthcare providers and uninsured clients continue to lack the support that they need to provide and receive accessible, affordable, and comprehensive healthcare. Until all residents in Canada have comprehensive access to healthcare, Canada will not have a truly universal healthcare system, and cannot fulfill the country's commitment to uphold the right to health. The reimplementation of the PHSUP and the extension of OHIP coverage to all Ontario residents are critical steps to ensure that all residents can access the healthcare they need in order to live a healthy and dignified life.

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