

# BMJ Open Qualitative evaluation of a mandatory health insurance ‘wait period’ in a publicly funded health system: understanding health inequities for newcomer im/migrant women

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**To cite:** Hamel-Smith Grassby M, Wiedmeyer M, Lavergne MR, *et al*. Qualitative evaluation of a mandatory health insurance ‘wait period’ in a publicly funded health system: understanding health inequities for newcomer im/migrant women. *BMJ Open* 2021;**11**:e047597. doi:10.1136/bmjopen-2020-047597

► Prepublication history for this paper is available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2020-047597>).

Received 03 December 2020  
Accepted 19 July 2021



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## ABSTRACT

**Objectives** To evaluate impacts of a residency-based waiting period for health insurance coverage on lived experiences of health and settlement for im/migrant women in British Columbia, Canada.

**Design** The IRIS study is a mixed-methods, community-based, qualitative evaluation of recently arrived im/migrant women’s access to sexual and reproductive care. In-depth, semistructured interviews were conducted by trained multilingual and multicultural interviewers with lived migration experience in the participant’s preferred language.

**Setting** Metro Vancouver, British Columbia, Canada from July 2018 to January 2020.

**Participants** Data collected from community focus groups (four groups, n=29) of both service providers and im/migrant women was used. Following this, qualitative interviews with service providers (n=10) and im/migrant women (n=47) were conducted. Eligible participants self-identified as women; were aged 18–49 and had arrived in Canada from another country. Eligible providers were employed in the health, social or legal sectors working with im/migrant women.

**Results** The wait period resulted in mistrust and internalised stigma for racialised im/migrant women, for whom the policy resulted in feeling ‘undeserving’ of care. Resulting administrative burden produced delays and unmet need for care, particularly related to sexual and reproductive healthcare and children’s health. Unexpected costs meant difficult choices between survival and care. Negative health outcomes included the inability to family plan, difficulties during pregnancy, as well as hardships related not being able to seek help for sick children. Community-based organisations provided support in many areas but could not fill all gaps produced by this policy.

**Conclusions** Findings highlight severe, yet commonly overlooked, health inequities produced by a mandatory health coverage wait period within a purportedly ‘universal’ healthcare system. Health system policies such as mandatory ‘waiting periods’ produce discriminatory and inequitable outcomes for im/migrant women. Policy reforms towards full ‘healthcare for all’ are urgently

## Strengths and limitations of this study

- During COVID-19, many health insurance wait period policies in a variety of health systems were adjusted: either temporarily repealed or changed, making this analysis of the commonly overlooked implications of these policies both unique and timely.
- Our study used purposive sampling, ensuring diversity in voices, including those not well-represented in previous quantitative studies (eg, those with precarious or insecure status) and Canadian research.
- Data collection was by a community-based team, most of whom have experienced the same wait period. Analyses were reflexive, led by multiple coders from diverse backgrounds (eg, Euro-Canadian, racialised women with lived im/migration experience), and informed by ‘member-checking’ in follow-up interviews using multilingual videos highlighting key findings with participants, and ongoing meetings and engagement with community partners.
- Our findings are supported by research elsewhere, and they may be relevant to other contexts where similar ‘wait periods’ and gaps in health coverage exist.
- Recruitment in collaboration with community partners means that our results may not represent im/migrants who may be more disconnected from community supports.

needed to affirm the health and human rights of all im/migrants.

## INTRODUCTION

Eligibility for health insurance coverage is closely connected to im/migration status worldwide. We use the term ‘im/migrant’ to include the diversity of refugee, immigrant and migrant people born in other countries who entered Canada, including long-term and recent arrivals, asylum seekers, economic and undocumented



im/migrants.<sup>1</sup> Within a number of healthcare systems considered universal (eg, Canada, France, Portugal), health coverage policies include residency-based waiting periods that produce gaps or periods of precarious healthcare access for otherwise eligible im/migrants.<sup>2-4</sup> These gaps are especially relevant during the COVID-19 pandemic, with some jurisdictions waiving wait periods or granting temporary residency to improve equitable care access in recognition of the harms of delayed care during a pandemic.<sup>5</sup>

In many settings, im/migrants face stark gaps in health insurance coverage, particularly for those with insecure or temporary status.<sup>6</sup> When immigration status impacts health coverage and health systems cooperate with border services, the healthcare system becomes a site of im/migration control, producing stigma and fear that increase barriers to care.<sup>7 8</sup> While important work has documented severe inequities in healthcare access related to immigration status,<sup>2-4 6-8</sup> the impacts of *temporary* gaps posed by residency-based waiting periods remain poorly understood.

Health insurance waiting periods may result in delays in timely care access, which is a recognised determinant of health and shows no evidence of cost saving, only cost delay.<sup>9</sup> Wait periods may pose a number of negative health outcomes, including increased downstream costs from delay and worsening health issues.<sup>10</sup> With patients being turned away due to lack of insurance coverage, gaps and deficiencies are common and detrimental in primary and perinatal care,<sup>11 12</sup> and related to negative perinatal outcomes<sup>13-15</sup>

Although popular perceptions characterise Canada's health system as universal, research shows various groups are excluded from this definition. This includes Indigenous individuals who face a different structure of health coverage based on colonial history of violence and control, resulting in drastic health inequities as compared with the settler population.<sup>16</sup> Im/migrants are temporarily or entirely excluded from health coverage, which may perpetuate health inequities and impede adjusting to life in Canada.<sup>17 18</sup> Deep-rooted and intersecting structural forces that manifest as structural racism, the policing of immigration status, poverty and patriarchal structures mean that racialised im/migrant women often face more immediate or severe health and socioeconomic challenges in destination settings.<sup>19-21</sup> Canadian provinces determine health coverage independently, leading to a patchwork of waiting periods and coverage policies within the country. During the COVID-19 outbreak, the province of Ontario repealed their wait period policy, with access remaining variable and limited.<sup>22</sup> Less evidence exists in British Columbia (BC), where the wait period was repealed, then reinstated within 6 months.<sup>23</sup> While COVID-19 has highlighted health insurance coverage disparities, BC's mandatory wait period for health insurance policy has always produced serious concerns for public health. Given the necessity for evidence-informed policy, we evaluated the impact of this wait period on the

health and settlement experiences of im/migrant women in BC, Canada.

## METHODS

The Evaluating Inequities in Refugee Immigrants' Health Service Access (IRIS) study is a 5-year, mixed-methods study of im/migrant women's sexual and reproductive health (SRH) service access in BC. The IRIS study draws on principles of community-based research including: iterative community collaboration across all stages of question development, data collection and analysis; a commitment to community advocacy through cocreation of knowledge dissemination products and knowledge translation and exchange with participants, community partners and the broader im/migrant community.<sup>24</sup>

### Patient and public involvement statement

Preliminary consultations and focus groups helped shape research questions and priorities for IRIS, and included community partners and interested participants in various language (English, Farsi, Dari, Tigrinya and Spanish) and cultural communities. Community partners are listed in the acknowledgements and include community-based organisations (CBOs) offering support services for im/migrants and refugees and government-funded not-for-profit settlement agencies.

The focus for this analysis, evaluating the impacts of the 3-month wait period, arose from these consultations as well as advocacy work conducted by community partners, made urgent by the COVID-19 crisis. Community partners provided feedback that shaped the emphasis and focus of data analysis. For participants who requested a second interview, in-depth follow-up interviews inviting feedback on common themes and findings were conducted. Common themes and findings were also shared with participants in other ways (eg, via videos during COVID-19) and participants were invited to share feedback. These two processes allowed for member checking,<sup>25</sup> where participants could comment on and reflect on the overall findings as well as their experience during the initial interviews. Participants reported feeling comfortable and included throughout this process and supported recommendations to waive the 3-month wait period, hoping for policy change in the future.

### Data collection

This analysis drew on in-depth one-on-one interviews with recent im/migrant women (N=47) and service providers (N=10) across Metro Vancouver from December 2018 to July 2020.

Recruitment was led by research team members in collaboration with CBOs and networks. Participants for interviews and focus groups were purposively selected<sup>26</sup> to include diverse and under-represented perspectives, including women with insecure or recently acquired status and recent arrivals to Canada.

Eligibility criteria for im/migrant women: self-identifying as a woman (cis or trans); aged 15–49 years; moved to Canada from another country; and able to provide informed consent. *Eligibility criteria* for providers: employed in the health, social or legal sectors with im/migrant women and able to provide informed consent.

Interviews and focus groups were conducted by trained multilingual and multicultural interviewers with lived migration experience in Farsi, Dari, Spanish and English. Interviews included open-ended questions on im/migration history; experiences with health and social services in Canada; and recommendations for improving health service access. Interviewees provided written informed consent prior to participation and confidentiality protocols were followed. All sessions were conducted in each participant's preferred language, audiotaped, and lasted approximately 1.5 hours. All im/migrant women received an honorarium of \$C40 and were offered referral to relevant community-based social, health and legal supports as needed.

### Data analysis

Interviews were simultaneously transcribed and translated into English by a bilingual team member, followed by accuracy checking by another bilingual team member. All personal identifiers were removed. Data were inductively coded<sup>27</sup> and managed using NVivo V.12 (QSR, Australia). Content analysis was used to generate a set of initial codes to organise the data and describe key features. As interviews were conducted, the coding team iteratively adapted the coding scheme. Driven by community advocacy and the urgency of changing policy considerations in BC during the COVID-19 crisis, this analysis used data previously coded under policies and enforcement, healthcare experiences, immigration status, economic considerations and participant recommendations to explore specific experiences of the 3-month waiting period. Interpretation decisions were informed by community and participants through sharing of preliminary results, 'member checking', and regular meetings with community partners.

In the final stages of analysis, MH-SG reflexively considered their own experience with the wait period as a White Canadian citizen moving between provinces. Sharing some experience with the participants, but in a very different context meant this author consistently returned to participant voices to centre participant experiences and limit the impact of the author's own assumptions on the findings. While the policy impacts all new residents, elements of privilege like White citizenship produce less exposure to harm compared with the experiences of racialised, im/migrant women, especially those with precarious status. This descriptive analysis highlights these experiences commonly overlooked by dominant power structures. Narrative findings show how health needs specific to sex assigned at birth, gender-related responsibility for family and children's health, structural racism, language barriers, poverty maintained by costly health services and

**Table 1** Im/migrant women participant characteristics (N=47), 2018–2020

Variable	
Age, years*	31 (18–49)
Region of origin	
Latin America and Spain	34
Other: Afghanistan, Iran, Eritrea	13
Primary language	
Spanish	34
Other: Farsi, Dari, Tigrinya, English, Urdu, Hindi, Turkish	13
Im/migration status at time of interview	
Permanent resident/citizen	19
Refugee/applicant/asylum	7
Tourist visa	5
Work permit	3
No status/unknown	13
Time in BC, years*	1.75 (0.25–11)

Data are N (#) of women, unless otherwise indicated.  
\*Median (range).  
BC, British Columbia.

immigration processes, and access determined by im/migration status converge to produce disproportionate harm as a result of the 3-month wait policy.

## RESULTS

### Participant characteristics

The 47 women included in this analysis had a median age of 31 and lived in BC for a median of 1.75 years (table 1). The majority of women experienced racialisation in the predominantly white-European context of BC, identifying with a wide variety of ethnicities (eg, Latina, Afro/Latina, Black/Caribbean, Black/African, Middle Eastern) that are racialised in Canada.<sup>28</sup> The 10 providers all identified as women and held a variety of roles (eg, nurse practitioners, settlement and community outreach workers), originated from a variety of countries and spoke many languages (eg, Arabic, Spanish, Punjabi, Tigrinya, Urdu) (table 2). Staff from CBOs added important information for context and background information that informed the analysis and narrative findings.

### Narrative findings

Women's lived experiences highlighted the deleterious health and settlement implications of the 3-month wait period for im/migrant women and their families. The wait period resulted in high levels of mistrust and internalised stigma for im/migrant women participants, who felt 'undeserving' of care. Resulting navigational and cost barriers produced delays and unmet need for care, particularly related to sexual and reproductive healthcare and children's health. Im/migrants often face converging



**Table 2** Service provider participant characteristics (N=10), 2018–2019

Variable	
Age, years*	43 (33–57)
Gender	
Woman	10
Place of birth	
Canada	3
Other (eg, Asia, Europe, Africa)	6
Prefer not to say	1
Years working with im/migrant women, years*	7 (2–30)
Roles	
Community advocate/outreach worker	2
Nurse/nurse practitioners	4
Settlement worker	2
Other (eg, social worker)	2

Data are N (#) of women, unless otherwise indicated.

\*Median (range).

effects of exclusion as a result of racism, precarious immigration status and discordant language experience. Im/migrant women experience these overlapping effects, as well as gendered power dynamics and the responsibility for children's health. These outcomes are distinct from those with privileges associated with male gender, White racialisation, secure immigration and English language communication,<sup>20</sup> which are rooted in patriarchal, racist, xenophobic and colonial power structures.<sup>29</sup> Women's narratives highlighted the ways in which intersecting effects of gendered racism and exclusionary im/migration policy manifested in the health system to produce disproportionate harms for im/migrant women in this sample. Narratives of adaptability and community resilience emerged as survival strategies for navigating the multitude of healthcare and other barriers women and their families faced.

#### Stigmatising experiences: right to healthcare and mistrust in a system that withholds coverage

Perceptions of 'deservedness' and the right to healthcare were woven through interviews along with observations that the Canadian system instils mistrust in new im/migrants by making them wait arbitrarily for needed health coverage (box 1). Experiences under the policy gave participants the impression that im/migrants are seen as only taking from Canada, without recognising the contributions to and rights of im/migrants within destination settings.

Women reported facing racism when being asked targeted questions about their immigration status when trying to access healthcare. This was seen through loud and invasive questioning by medical receptionists who doubted their right to access care and portrayed suspicion when deciding who can 'access health care and who can

#### Box 1 Stigmatising experiences: right to healthcare and mistrust in a system that withholds coverage

##### Arbitrary nature of the policy

*Please, the medical insurance shouldn't have the three months period to be used. Many things can happen in 3 months, so I think that's unacceptable. Why three months? I don't see the logic behind that. I don't understand why they make you wait. It should be faster because you are talking about a person's health. (Latin American woman, 3.5 years in BC)*

##### Health access is a right

*It's access... if you don't have status or a precarious status, it's bad and if you just applied for a student visa or work permit you have to wait 3 months. And if during those 3 months you need medical attention, for example me being pregnant, you can't access it. And supposedly health is a right, it's a right that should be given to everyone. (Western Asian woman, 0.75 years in BC)*

##### Dehumanising impacts of being forced to wait

*1 month is a long time. In 1 day, anything can happen. In 1 day, a person can lose their life. 1 month is a very long time for someone to wait. That's why they should provide antibiotics or other medications to help them. It's ok that someone may not have a Care Card, but the doctors need to provide humane help. I understand the laws and that laws are important but humanity should come before law. A person should also be able to do a humane thing and help other as well. (Western Asian woman, 1.33 years in BC)*

die' (Latin American woman, 7.92 years in BC). Experiences like this, where race is created by structural hierarchies between residents and 'non' residents (re)enforced by the wait period's exclusionary approach, further attach race to citizenship.<sup>30</sup>

Other participants felt healthcare providers viewed the wait period as an opportunity for additional income, seeing patients without coverage as 'dollar signs' (Latin American woman, 1 year in BC). Participant narratives described denying access to a service, requiring large payments for care or providing differential access based on waiting periods as going against fundamental ideas that 'supposedly health is a right, it's a right that should be given to everyone' (Spanish focus group participant). This made them feel they did not deserve access to healthcare, as a mother who could not find treatment for her very sick child in the 3-month wait period described the 'dehumanising' nature of the policy.

#### Administrative burden: system navigation and high out-of-pocket costs

Participants described initial confusion related to being uninformed about the wait period prior to arriving in Canada, the variability of eligibility that constantly shifted, and burden of confusing paperwork,<sup>31</sup> with few places to turn for help. Participants and providers explained how illogical and stressful the policy is: it was unclear who must wait, for how long exactly, when applications could be submitted, and which administrative processes to follow (box 2). Women expressed exasperation at the

## Box 2 Administrative burden: system navigation and high out-of-pocket costs

### Confusion caused by lack of information

*I feel like it is difficult to access or to have access, even if you have status... because for me, it was difficult someone that helped me to activate or... to enrol with the MSP. I mean, I didn't have information, I practically did it on the website, but it was blindly, I didn't, didn't know, so, well, I did it alright and I got, I got the cards, but I didn't have a lot of information, so I believe that, that newcomers, well, face the same problems... (Latin American woman, 2.33 years in BC)*

### Lack of clarity in administrative processes

*Also the system, for example... the, what is the care card, is, eh... to apply for it is another process, and to fill in forms, to wait... so, eh... that doesn't exist in my country either... and, and it is very very hard to apply to that, the same, eh... when one has children, the vaccines, um... it is very very complicated. (Latin American woman, 2.08 years in BC)*

### Added stress to an already stressful time

*If I had an emergency, I wouldn't know where to go. Add all the stress of waiting for the refugee status to that. This has caused us many complications. [...] I don't have health coverage right now, and I don't know where to go. (Latin American woman, 2.08 years in BC)*

### Reliance on informal provider assistance

*The doctor told that you first need to go get your photo taken then apply. No one had told me this before. If they had told me, I would have gone early on. I told them that I have health issues, but you won't see me and after that is when they told me I need to go and apply. (Western Asian woman, 1.33 years in BC)*

### Urgent care means vulnerability to high out-of-pocket costs

*Well, yes, that they should provide us with service – in other words, if you are asking for a service it is because you are in need of it urgently, you shouldn't have to wait three months to have that service given to you—it's my experience, right? (Latin American woman, 1.5 years in BC)*

### Unmet health needs due to cost

*So I wait two months for my PR card, otherwise I had the confirmation of my PR. But I could not go to any medical center anything because I didn't have my health card and service card so I need to wait for that. [...] You're not into the insurance, you cannot get any medicine, you cannot go to visit a doctor or anything, I think these are the issues that the people are really facing to that. (Western Asian woman, 1.33 years in BC)*

### No coverage for children's health needs

*Only when they get sick, when they get sick...yes...but unfortunately [only one child] has MSP card...I can take her any place...but [the other child] no, she does not have, I need to look for a place because consultations are very expensive here... (Latin American woman, 1.17 years in BC)*

### Unavoidable costs due to administrative processes

*My work permit came with conditions, and to um carry out that condition [...] I had to take medical tests, that I remember back then they were like, I don't know, like 400 dollars, something like that. Blood tests, like x-rays, er an interview with the doctor. (Latin American woman, 3.75 years in BC)*

idea that their illnesses would wait 90 days to manifest or require care.

Administrative burden was further complicated when managing insurance from another province or a federal

programme, or differential access within a family. One family faced very high hospital bills after moving to Vancouver from another province. They were told they would be reimbursed by the other province, but never were. Having already undergone the wait period in the other province, they did not understand and were frustrated at having to wait again: 'we thought Canada is one Canada' (Western Asian woman, 7 years in BC). Sometimes well-meaning healthcare providers took it on themselves to help patients navigate the system, by helping patients understand and file paperwork or using informal networks to advocate for care. Participants identified this support as 'life-saving' and deeply appreciated these providers efforts, but information at the point of care was often too late, or providers themselves lacked knowledge of correct processes.

Women's narratives indicated the wait period imposed a period of extreme vulnerability to high out-of-pocket costs and unmet health needs. During the wait period, lack of coverage for urgent pregnancy and children's health needs resulted in serious economic stressors and impacts (box 2). The feminisation and racialisation of poverty that is both managed and enforced through policies like this that disproportionately impact racialised women cannot be ignored.<sup>30</sup> One family experiencing confusion around their coverage found themselves in a waiting period for their daughter's care and had to pay a large hospital bill.

In many cases, participants described devastating consequences of children being subjected to the wait period policy resulting in high costs for parents. Infants born in Canada are eligible to apply for coverage as Canadian citizens, however, in B.C. they are still subject to the 3-month wait if their parents are without coverage, a lengthy and important gap for a newborn. Application is typically linked to a parent, and if parents' status is insecure, enrolment application is shaped by fear of detention or removal following reporting to border services. Once (if) enrolled, the infant must still undergo the 3-month wait.

One family spent their last few hundred dollars on a doctor's visit and medication for their sick child, leaving them with nowhere to sleep and little money for food. One parent could not understand why they 'had to wait two to three months for the government to give me a document...What was I going to do with my sick son then?' (Latin American woman, 1.25 years in BC). When another family's status changed to having a work permit, they enrolled in the public insurance plan, and brought their ill, infant daughter to the hospital. Unfortunately, as coverage was not yet active due to the waiting period, they were charged unanticipated, high out-of-pocket costs for the visit.

In BC, there are no clear guidelines for healthcare providers on how much to charge uninsured patients, beyond being 'reasonable'<sup>32</sup>—and participants commonly felt they were paying for more than the service warranted. Participants discovered other out-of-pocket costs built into administrative processes throughout the journey to a more secure status. This included paying for medical

### Box 3 Negative health implications of the waiting period

#### Lack of ability to family plan with no contraceptive access

*We do not have a solution in those first three months and I think that is what happens to many women that arrive here and end up pregnant because they arrive thinking, like me, that here you can family plan in the same way as in your home country, and it turns out that no, that we are blocked, to family plan.* (Latin American woman, 1.25 years in BC)

#### Negative impacts of delays in care during pregnancy

*After one month or around 20 days of arriving, I got pregnant and after that, I had the issues. I needed to get checked, but they didn't check my bloodwork, they didn't give me ultrasounds, they didn't do anything for me. I still don't know why and what happened that I got a miscarriage. This really hurts me.* (Western Asian woman, 8.17 years in BC)

#### No power to escape or speed up the wait period

*We arrived here with work permits. You can receive medical attention here after 3 months. In my case, I was pregnant and diagnosed with a high-risk pregnancy. So, to wait three months to get medical attention for a pregnancy was very complicated. I knocked, and my husband too, knocked [on] many doors in associations, foundations, so that I could get medical attention or to speed up the process.* (Spanish focus group participant)

#### Efforts to treat children's illnesses at home

*All the challenges I faced because of the Care Card. At night I would stay up with my daughter because of her stomach-ache, I would give her medications, massage her [...] home remedies, I would massage her belly, would put the hot water bottle on her stomach for it to soothe the pain a little. My daughter would cry from pain. I would cry with her until the morning [...] the doctors were refusing to see her. What if something happens to my daughter? Coming to Canada had become a negative experience for me because I was worried about losing my daughter[...] I've faced so much hardships and continue to face hardships.* (Western Asian woman, 1.33 years in BC)

#### Children in pain not being able to get care

*After that, my little girl was unwell again, I took her to another clinic, there they told me that my little girl had to wait three months to be seen and indeed, she was unwell, and until three months later was when they started to see her.* (Latin American woman, 1.5 years in BC)

tests for work permit eligibility, and then once finally eligible, costs incurred while subject to the 3-month wait for coverage.

#### Negative health implications

Key negative impacts of the wait period discussed by participants included unmet need for contraception, unintended pregnancy, psychosocial impacts (eg, stress) and delayed or unmet prenatal and children's healthcare needs (box 3). Multiple experiences of unintended pregnancy due to the lack of contraception arose. Not only was medication coverage its own barrier, but one participant experienced an unintended pregnancy after the wait period prevented her from visiting a doctor for a prescription to continue her usual contraceptive method.

Negative impacts of the inescapable nature of the wait period were intensified during pregnancy. Participants made every effort to try and 'speed up the process' (Spanish-speaking focus group participant) of accessing

care. This time of urgent need is exacerbated by the fact that many private insurance companies view pregnancy as a pre-existing condition and will not grant coverage for prenatal care or labour and delivery.<sup>35</sup> This left pregnant people in the 3-month wait with no option but to pay unaffordable costs out-of-pocket.

Many participants described alarming experiences of being denied care during pregnancy, not being informed about options for care (eg, midwives), being denied access to their health information and experiencing anguish around delivery costs. Frequently, care was not accessible until the last weeks of pregnancy, putting individuals at known risk for negative perinatal and infant health outcomes. Fortunately, becoming connected to CBO im/migrant support organisations improved access to prenatal care for many.

Some women compared these experiences to their home countries as shocking in comparison, expecting Canada to have a much more inclusive health system. Efforts to navigate this system increased their stress levels during pregnancy, most often marked by worry—even while in labour—about how to pay for their delivery. Not knowing how they would afford it; participants sometimes left the hospital before they were ready, in an effort to cut costs.

Being unable to access medical attention for children subject to the wait period resulted in parents left trying to treat their children's illnesses at home. Experiences of being isolated with children who were in pain with no treatment available were painfully recounted. One participant reflected on her hopes for a better life when coming to Canada and how pointless it all would have been if she lost her daughter in the process.

Importantly, once the wait period had ended, participants described the positive implications of finally being eligible for coverage as highly impactful and suddenly making life much easier. Even if they did not need to access care right away, after the wait period ended, participants described no longer living in fear of a medical emergency that could effectively undermine their ability to survive in Canada.

#### Community support and connection: mitigating isolation and supporting access to care

Women described high isolation and having health needs arise during the wait period as highly stressful (box 4). They turned to informal networks within their own communities, and often through social media and word of mouth, would be connected to CBOs. CBOs provided interpersonal support and helped demystify paperwork, understand available services, and reduce delays in care. This community support was highly influential in shaping women's and families' ability to receive affordable and appropriate care, where possible.

Participants described a strong sense of unity and a shared sense of responsibility to help other im/migrants with health system navigation and the settlement process. Particularly through connections and programmes



## Box 4 Experiences of social support and community resilience

### Sharing coping strategies and information

*I have some friends who have brought the [birth control] pills from their countries for three months, until they find out here where to go to get them. (Latin American woman, 7.92 years in BC)*

### Informal support connection to and by community-based organisations

*Being with people who support you and who are in a similar situation to yours, and that can help you by providing you with different kinds of support. That is what helped me a lot, meeting people. For example, I am very, very, very grateful to the people who helped me during my pregnancy. (Latin American woman, 7.92 years in British Columbia)*

### Freedom associated with health insurance speak to need to remove wait period

*Well, really, we now have a little bit more knowledge... since receiving my health card, I like... can go to certain places, I can... search for a medication, it like, yes, it has changed a lot... well some time ago... two years ago... impossible, now we already have that ease of... not having that thought of how much we are going to have to pay for a consult... like, yes, you feel the change. (Latin American woman, 4.25 years in BC)*

### Resilience despite feeling an utter lack of support from formal structures

*It's not that I decided to go to a foreign country just because I wanted to, no, it's hard, it's hard, migrating is hard, and arriving here and at least to have a little bit of help or guidance would be nice, because you arrive here and until you get settled, until you are able to get a status, it's hard. Getting sick and not being able to go to a doctor is so hard[...] that is what I think should change. (Latin American woman, 2.25 years in BC)*

offered by CBOs, women described being connected to others with similar life experiences, struggles and successes, as promoting feelings of inclusion and resilience. Instances of newfound communities rallying together to find schools for children, clinics to access without fear, advice on accessing affordable healthcare, language-specific care and other examples of system navigation support were described as helpful in ameliorating some of the isolation and structural barriers faced during and beyond the wait period. However, it is clear that regardless of the support accessed, this wait period remains a very painful barrier for im/migrant women.

*I saw the light at the end of the tunnel, the sun came out...when MSP sent me the card, my midwife and I jumped from happiness. (Latin American woman, 7.92 years in BC)*

## DISCUSSION

Our findings suggest health system policies such as mandatory wait periods produce and exacerbate inequitable health and social outcomes for im/migrant women and their families. Resulting harms include delays and unmet care needs, negative pregnancy and children's health outcomes, internalised stigma and socioeconomic

stressors. This study adds to previous research describing health access inequities faced by im/migrants, including lack of sufficient health insurance coverage, which has been a subject of increasing attention during COVID-19.<sup>34</sup> An earlier scoping review of migrants in Canada identified delayed, denied and unaffordable care as key access barriers faced by im/migrants with insecure or precarious status.<sup>10</sup> Our findings show little change and highlight tension produced between immigration policy enforcement in the health sphere and healthcare providers' ethical and social responsibility to provide care.<sup>8</sup> This is no less obvious during the COVID-19 pandemic which has disproportionately impacted racialised im/migrants across diverse settings,<sup>35</sup> including those with insecure or temporary status, who are more likely to live and work in conditions where physical distancing and recommended hygiene measures are impossible because of poor living conditions, economic precarity and occupational conditions as essential workers.<sup>36</sup>

While not the first to question Canada's health-care system universality, our study adds analysis of this specific policy of residency-based waiting periods.<sup>37</sup> With mounting evidence during COVID-19 of the health disparities faced by (particularly racialised) im/migrants in destination countries like Canada, this analysis is timely and necessary.<sup>35</sup> Previous literature on health insurance has addressed various disparities,<sup>38</sup> but limited research has examined insurance coverage gaps like the 3-month wait *specifically* for im/migrant women. This information adds to previous literature on discrimination experienced by im/migrants under similar wait period policies elsewhere.<sup>39</sup> Our study used purposive sampling<sup>26</sup> to ensure diversity in voices, including those not well represented in previous quantitative studies, such as women with precarious or insecure status.<sup>40</sup> Community-based interview recruitment means results may not represent people who are not already linked to community support, however, connecting through community was important for ensuring trust. The 3-month wait policy is positioned within a larger system of immigration control and health system policy, meaning that necessary limitations exist within this analysis in that we cannot and should not attempt to separate the fact that many women impacted by the 3-month wait also experienced additional gaps in insurance and status delays.

### Recommendations: 'universal' systems are falling short

While the COVID-19 pandemic has exacerbated inequities and further entrenched precarious conditions for many migrants—including further restricted mobility due to border closures,<sup>41</sup> it also represents an important window for policy change. Current evidence-based recommendations in response to COVID-19 include the urgent rollout of universal and equitable access to *health systems for all* regardless of im/migration status, including the immediate suspension of laws and fees that limit access to healthcare services and other supports.<sup>42</sup> These changes within the Canadian context are affirmed by key global

policy bodies, including Amnesty International and the UN Human Rights Committee: Canada's denial of health coverage on the basis of immigration status represents a violation of human rights.<sup>43</sup>

Temporary protection measures offered during COVID-19 are scaling back—as is the case in BC, where temporary health coverage has already been withdrawn.<sup>44</sup> A long-standing colonial history rife with xenophobia and racism operates through the 3-month-wait policy to produce differential health experiences for racialised, im/migrant women in BC. The current policy within this system of structural racism pits BC residents against incoming (racialised) residents, through the lens of resource scarcity,<sup>44</sup> sustaining exclusion and making it clear that in Canada, health coverage is far from universal.

Permanent repeal of exclusionary health system policies such as mandatory wait periods is necessary to advance calls for *health for all*,<sup>45</sup> regardless of immigration status, as a strategy for promoting health equity, justice for im/migrant communities and basic human rights obligations.

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**Acknowledgements** We extend our gratitude to our study participants for their time, courage and valuable contributions to this research. We thank our community partners, including Watari, Sanctuary Health, MOSAIC, Pacific Immigrant Resources Society (PIRS). We also wish to thank all IRIS interviewers, trainees and staff, including: Ruth Carillo, Elmira Tayyar, Eloina Alberto, Selamawit Hagos, Stefanie Machado, Shaina Schafers, Zarmina Ali, Megan Bobetsis, Belen Febres-Cordero, Irene Santos, Germaine Tuyisenge and Refugio Reyes.

**Contributors** MH-SG performed the qualitative analysis of interview data and wrote the manuscript with support from M-LW, MRL and SMG. SMG oversaw conceptualisation, analysis and drafting of the manuscript. M-LW contributed to the study design and interpretation of the data. All authors provided critical revisions throughout the drafting process and reviewed and approved the final version of the manuscript.

**Funding** This research is funded by the Canadian Institutes of Health Research (CIHR) (PJT 165834), Vancouver Foundation (FOI19-2552) and the Michael Smith Foundation for Health Research, and received seed funding from Simon Fraser University (M003130). MRL is supported by the Michael Smith Foundation for Health Research. M-LW received support from a BC SUPPORT Unit (Fraser Centre) Graduate Student Fellowship and a Frederick Banting and Charles Best Canada Graduate Scholarship-Master's (CGS M). SMG is partially supported by a CIHR New Investigator Award and the U.S. National Institutes of Health.

**Competing interests** None declared.

**Patient and public involvement** Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**Patient consent for publication** Not required.

**Ethics approval** IRIS is approved through the Providence Health Care/University of British Columbia (UBC) and Simon Fraser University (SFU) harmonised ethics review boards (REB number H19-00820).

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** Data are available on reasonable request. Due to our ethical and legal requirements related to protecting participant privacy and current

ethical institutional approvals, deidentified data are only available on request pending ethical approval. Please submit all request to initiate the data access process to the corresponding author.

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#### REFERENCES

- 1 Key Migration Terms. International organization for migration, 2015. Available: <https://www.iom.int/key-migration-terms> [Accessed 5 Aug 2020].
- 2 Gray BH, van Ginneken E. Health care for undocumented migrants: European approaches. *Issue Brief* 2012;33:1–12.
- 3 Linhas R, Oliveira O, Meireles P, et al. Immigrants' access to health care: problems identified in a high-risk tuberculosis population. *Pulmonology* 2019;25:32–9.
- 4 Kaufman A, Derksen D, McKernan S, et al. Managed care for uninsured patients at an academic health center: a case study. *Acad Med* 2000;75:323–30.
- 5 UNAIDS commends Portugal's decision to grant temporary residency rights for immigrants and asylum seekers. Available: [https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/20200402\\_portugal](https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/20200402_portugal) [Accessed 21 Jul 2020].
- 6 Goldman DP, Smith JP, Sood N. Legal status and health insurance among immigrants. *Health Aff* 2005;24:1640–53.
- 7 Hacker K, Anies M, Folb BL, et al. Barriers to health care for undocumented immigrants: a literature review. *Risk Manag Healthc Policy* 2015;8:175–83.
- 8 Caulford P, Rahunathan S. Caring for refugees, new immigrants, and uninsured women: social responsibility and access to healthcare. In: d'Agincourt-Canning L, Ellis C, eds. *Ethical issues in women's healthcare: practice and policy*, 2019: 89–91.
- 9 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83:457–502.
- 10 Magalhaes L, Carrasco C, Gastaldo D. Undocumented migrants in Canada: a scope literature review on health, access to services, and working conditions. *J Immigr Minor Health* 2010;12:132–51.
- 11 Delvaux T, Buekens P, Godin I, et al. Barriers to prenatal care in Europe. *Am J Prev Med* 2001;21:52–9.
- 12 Caulford P, Vali Y. Providing health care to medically uninsured immigrants and refugees. *Can Med Assoc J* 2006;174:1253–4.
- 13 Bobadilla A, Orchard T, Magalhães L, et al. Ontario healthcare coverage eligibility among new permanent residents: a scoping review. *J Immigr Refug Stud* 2017;15:384–405.
- 14 Collins CH, Zimmerman C, Howard LM. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Arch Womens Ment Health* 2011;14:3–11.
- 15 Heaman MI, Martens PJ, Brownell MD, et al. The association of inadequate and intensive prenatal care with maternal, fetal, and infant outcomes: a population-based study in Manitoba, Canada. *J Obstet Gynaecol Can* 2019;41:947–59.
- 16 Martin D, Miller AP, Quesnel-Vallée A, et al. Canada's universal health-care system: achieving its potential. *The Lancet* 2018;391:1718–35.
- 17 Government of Canada - Immigration Refugees and Citizenship Canada. Infographic: immigration and economic growth, 2019. Available: <https://www.canada.ca/en/immigration-refugees-citizenship/news/infographics/immigration-economic-growth.html> [Accessed 28 Jun 2020].
- 18 Campbell RM, Klei AG, Hodges BD, et al. A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *J Immigr Minor Health* 2014;16:165–76.
- 19 Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. *Du Bois Rev* 2011;8:115.
- 20 Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev* 1991;43:1241.
- 21 Nwoke CN, Leung BM. Historical antecedents and challenges of Racialized immigrant women in access to healthcare services in



- Canada: an exploratory review of the literature. *J Racial Ethn Health Disparities* 2020;3:1–9.
- 22 Government of Ontario M of H and L-TC. *OHIP – Bulletins – Health Care Professionals – MOHLTC [Internet]*. Government of Ontario, Ministry of Health and Long-Term Care, 2021. <https://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4749.aspx>
  - 23 Ministry of Health. Medical Services Plan Response to COVID-19 - Province of British Columbia. Available: <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/msp-covid-19-response> [Accessed 28 Jun 2020].
  - 24 Israel BA, Schulz AJ, Parker EA, *et al*. Review of community-based research: assessing partnership approaches to improve public health. *Annu Rev Public Health* 1998;19:173–202.
  - 25 Creswell JW, Miller DL. Determining validity in qualitative inquiry. *Theory Pract* 2000;39:124–30.
  - 26 Corbin J, Strauss A. *Basics of qualitative research: techniques and procedures for developing Grounded theory*. Sage publications, 2014.
  - 27 Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval* 2006;27:237–46.
  - 28 Canadian Institute for Health Information. *Proposed standards for Race-Based and Indigenous identity data collection and health reporting in Canada*. Ottawa, ON: CIHI, 2020.
  - 29 Spitzer DL. Migration and health through an intersectional lens. In: *Handbook of migration and health*. Edward Elgar Publishing, 2016.
  - 30 Walia H. *Border and rule: global migration, capitalism, and the rise of Racist nationalism*. Haymarket Books, 2021.
  - 31 Ministry of Health. Coverage Wait Period - Province of British Columbia. Available: <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/eligibility-and-enrolment/how-to-enrol/coverage-wait-period> [Accessed 28 Jun 2020].
  - 32 CPSBC. College of Physicians and Surgeons of British Columbia: Practice Standard - Charging for Uninsured Services, 2019. Available: <https://www.cpsbc.ca/files/pdf/PSG-Charging-for-Uninsured-Services.pdf>
  - 33 Caulford P, Vali Y. Providing health care to medically uninsured immigrants and refugees. *CMAJ* 2006;174:1253–4.
  - 34 Woolhandler S, Himmelstein DU. Intersecting U.S. epidemics: COVID-19 and lack of health insurance. *Ann Intern Med* 2020;173:63–4.
  - 35 Kirby T. Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities. *Lancet Respir Med* 2020;8:547–8.
  - 36 Orcutt M, Patel P, Burns R, *et al*. Global call to action for inclusion of migrants and refugees in the COVID-19 response. *The Lancet* 2020;395:1482–3.
  - 37 Kuile S, Rousseau C, Munoz M, *et al*. The universality of the Canadian health care system in question: barriers to services for immigrants and refugees. *Int J Migr Health Soc Care* 2007;3:15–26.
  - 38 Goldman DP, Smith JP, Sood N. Legal status and health insurance among immigrants. *Health Aff* 2005;24:1640–53.
  - 39 Bäckström B. Migrants and health in Portugal. *Health Culture Society* 2014;7:80–93.
  - 40 Khan M, Kobayashi K, Lee S. Research Brief No. 24 - (IN)Visible Minorities in Canadian Health Data and Research. Population Change and Lifecourse Strategic Knowledge Cluster Research/Policy Brief [Internet], 2016. Available: [https://ir.lib.uwo.ca/plc\\_rpb/vol1/iss6/12](https://ir.lib.uwo.ca/plc_rpb/vol1/iss6/12)
  - 41 Immigration Refugees and Citizenship Canada. Coronavirus disease (COVID-19): Who can travel to Canada – Citizens, persons registered under Canada’s Indian Act, permanent residents, foreign nationals and refugees [Internet]. aem, 2020. Available: <https://www.canada.ca/en/immigration-refugees-citizenship/services/coronavirus-covid19/travel-restrictions-exemptions.html>
  - 42 Orcutt M, Patel P, Burns R, *et al*. Global call to action for inclusion of migrants and refugees in the COVID-19 response. *Lancet* 2020;395:1482–3.
  - 43 Amnesty International Canada. Canada: people with irregular status have the right to access essential health care, 2018. Available: <https://www.amnesty.ca/news/canada-people-irregular-status-have-right-access-essential-health-care> [Accessed 23 Jul 2020].
  - 44 Kines L. Return of medical services plan 90-day wait comes under fire. Times Colonist. Available: <https://www.timescolonist.com/news/local/return-of-medical-services-plan-90-day-wait-comes-under-fire-1.24179312> [Accessed 4 Aug 2020].
  - 45 WHO. Priorities: Health for all [Internet]. Available: <http://www.who.int/dg/priorities/health-for-all/en/>