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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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 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.
Health outcomes, including increased downstream costs, primary and perinatal care, and related to negative gaps and deficiencies are common and detrimental in being turned away due to lack of insurance coverage, exists in British Columbia (BC), where the wait period of immigration status,2–4 6–8 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.9 Wait periods may pose a number of negative health outcomes, including increased downstream costs from delay and worsening health issues.10 With patients being turned away due to lack of insurance coverage, gaps and deficiencies are common and detrimental in primary and perinatal care,11 12 and related to negative perinatal outcomes.13–15

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.16 Im/migrants are temporarily or entirely excluded from health coverage, which may perpetuate health inequities and impede adjusting to life in Canada.17 18 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.19–21 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.22 Less evidence exists in British Columbia (BC), where the wait period was repealed, then reinstated within 6 months.23 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.24

**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,25 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 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 coded27 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 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.29 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

| Variable | N (%) | Median (Range) |
|----------|-------|----------------|
| 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.

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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, which are rooted in patriarchal, racist, xenophobic and colonial power structures. Women’s narratives highlighted the ways in which intersecting effects of gendered racism and exclusionary immigration 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 instills mistrust in new immigrants 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 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.

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, 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, or 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.30 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’32—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, 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. 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)

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. 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. 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. This is no less obvious during the COVID-19 pandemic which has disproportionately impacted racialised im/migrants across diverse settings, 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.

While not the first to question Canada’s healthcare system universality, our study adds analysis of this specific policy of residency-based waiting periods. 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. Previous literature on health insurance has addressed various disparities, 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. Our study used purposive sampling to ensure diversity in voices, including those not well represented in previous quantitative studies, such as women with precarious or insecure status. 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, 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. These changes within the Canadian context are affirmed by key global 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.

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.
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.33

Temporary protection measures offered during COVID-19 are scaling back—as is the case in BC, where temporary health coverage has already been withdrawn.44 A long-standing colonial history rife with xenophobia and racism operates through the 3-month-wait period 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, 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,45 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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