



# Exploring the perspectives of non-insured individuals utilizing emergency departments in Toronto: a qualitative study

Colin Siu<sup>1</sup> · Sampreeth Rao<sup>2</sup> · Kate Hayman<sup>2,3</sup> · Jennifer Hulme<sup>3,7</sup> · Akm Alamgir<sup>4</sup> · Amy Gajaria<sup>5,6</sup>

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## Abstract

**Objective** Non-insured individuals face unique challenges when accessing emergency department (ED) care in Canada. This qualitative study explores the firsthand experiences of non-insured patients within the ED to understand how we can improve the system of care.

**Methods** This community-based research was conducted in collaboration with a community health center which has multiple service locations in Toronto, Ontario. 24 non-insured participants were recruited using a maximal variation sampling technique for semi-structured individual interviews. Participants must have received care as a patient in an ED in the last 3 years. We analyzed the data using Braun and Clarke's thematic analysis framework.

**Results** Interview participants felt unwanted and powerless, and faced health system navigation and access challenges. Subthemes include the anxiety of uncertainty regarding how to pay for ED care as well as concerns regarding insurance eligibility, healthcare access points, and language. Non-insured participants experienced stigma and discrimination; delayed care due to a lack of healthcare coverage; and difficulties with the ED registration and triage processes. The study also identified multiple instances where participants had positive experiences with clinicians and devised creative solutions to tackle challenges by engaging informal community networks and self-advocacy.

**Conclusion** Ways to improve the ED care of non-insured patients include providing ED care for all regardless of their healthcare coverage status, ameliorating clerical training, outlining clearer policies regarding payments, improving health system navigation, and fostering connections to community organizations. Many of the challenges that non-insured patients face may be applicable to other equity-deserving patient groups. By listening to and learning from the experiences of non-insured patients, a more equitable ED system can be built for this marginalized population.

**Keywords** Non-insured patients · Health equity · Emergency medicine · Qualitative research · Community-based research

## Résumé

**Objectif** Les personnes non assurées font face à des défis uniques lorsqu'elles ont accès aux soins des services d'urgence (DE) au Canada. Cette étude qualitative explore les expériences vécues par des patients non assurés dans le cadre de l'ES afin de comprendre comment nous pouvons améliorer le système de soins.

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✉ Colin Siu  
colinsiu@alumni.harvard.edu

<sup>1</sup> Department of Family Practice, University of British Columbia, Vancouver, BC, Canada

<sup>2</sup> Department of Medicine, Division of Emergency Medicine, University of Toronto, Toronto, ON, Canada

<sup>3</sup> Division of Emergency Medicine, University Health Network, Toronto, ON, Canada

<sup>4</sup> Department of Research and Evaluation, Access Alliance Multicultural Health and Community Services, Toronto, ON, Canada

<sup>5</sup> Centre for Addiction and Mental Health, University of Toronto, Toronto, ON, Canada

<sup>6</sup> Department of Psychiatry, University of Toronto, Toronto, ON, Canada

<sup>7</sup> Department of Family and Community Medicine, Division of Emergency Medicine, University of Toronto, ON, Toronto, Canada



**Méthodes** Cette recherche communautaire a été menée en collaboration avec un centre de santé communautaire qui compte plusieurs centres de services à Toronto, en Ontario. 24 participants non assurés ont été recrutés en utilisant une technique d'échantillonnage à variation maximale pour des entretiens individuels semi-structurés. Les participants doivent avoir reçu des soins en tant que patient dans une DE au cours des trois dernières années. Nous avons analysé les données en utilisant le cadre d'analyse thématique de Braun et Clarke.

**Résultats** Les participants à l'entrevue se sentaient indésirables et impuissants, et ont dû faire face aux défis de la navigation et de l'accès du système de santé. Les sous-thèmes comprennent l'anxiété liée à l'incertitude quant à la façon de payer pour les soins de DE ainsi que des préoccupations concernant l'admissibilité à l'assurance, les points d'accès aux soins de santé et la langue. Les participants non assurés ont été victimes de stigmatisation et de discrimination; des retards dans les soins en raison du manque de couverture médicale; et des difficultés avec l'inscription aux DE et le processus de triage. L'étude a également identifié de nombreux cas où les participants ont eu des expériences positives avec des cliniciens et ont conçu des solutions créatives pour relever les défis en faisant appel à des réseaux communautaires informels et en s'autodéfendant.

**Conclusion** Les moyens d'améliorer les soins de DE des patients non assurés comprennent la prestation de soins de ED pour tous, quel que soit leur statut de couverture médicale, l'amélioration de la formation des employés de bureau, la définition de politiques plus claires concernant les paiements, l'amélioration de la navigation dans le système de santé, et favoriser les liens avec les organismes communautaires. Bon nombre des défis auxquels sont confrontés les patients non assurés peuvent s'appliquer à d'autres groupes de patients méritant l'équité. En écoutant les patients non assurés et en tirant des leçons de leur expérience, on peut bâtir un système plus équitable de DE pour cette population marginalisée.

**Mots clés** Patients non assurés · Équité en santé · Médecine d'urgence · Recherche qualitative · Recherche communautaire

### Clinician's Capsule

#### *What is known about the topic?*

Non-insured individuals face unique challenges when accessing emergency department (ED) care in Canada.

#### *What did this study ask?*

What are the firsthand experiences of non-insured patients in accessing ED care and how can we improve their ED experience?

#### *What did this study find?*

Non-insured patients felt unwanted and powerless and faced health system navigation and access challenges when accessing ED care.

#### *Why does this study matter to clinicians?*

Improving ED care for non-insured populations can use strategies that improve care generally, thus improving care for other equity-deserving populations.

hard-to-reach, hard-to-sample population [1].” Non-insured individuals represent a heterogeneous population including new immigrants, refugees, temporary foreign workers, tourists, international students, and those who have lost or not been able to renew their healthcare coverage. One study in Montreal on non-insured individuals describe a mean period of 2.3 years and a range of up to 27 years without healthcare coverage [3].

Non-insured patients are defined within this study as patients who do not have healthcare access coverage under the Ontario Health Insurance Program, Interim Federal Health (IFH) Program, or Ontario Temporary Health Program. This includes, but is not limited to temporary foreign workers, undocumented residents, and refugee claimants with denied claims. Temporary foreign workers and undocumented residents are not able to access healthcare coverage in Canada. Refugee claimants can access the IFH program but subsequently lose access if their claims are denied.

The most recent study looking at the proportion of non-insured visits in emergency departments (ED) was from 2010 and reported a doubling of Ontario ED visits by non-insured patients from 2002 to 2011, representing 0.44% of ED visits [4]. Furthermore, compared to insured patients, non-insured patients are more likely to be triaged into the highest severity categories, leave without treatment, and die on ED arrival [4].

The objective of this study is to understand the emergency care system in Toronto from the perspective of non-insured individuals themselves. This study aimed to investigate the firsthand experiences of non-insured patients to gain insights into their experiences accessing emergency care, evaluate

## Introduction

Estimates of non-insured individuals residing in Canada range between 20,000 and 500,000, with nearly 50% residing in Toronto [1, 2]. The number of non-insured individuals in Canada is challenging to estimate as they “are considered to be a hidden population given that they are a

the effectiveness of current ED care delivery, and inform potential improvements in the system. This is the first qualitative study in Canada on the experiences of non-insured patients in EDs which draws on their own insights.

## Methods

### Study design and time period

This study is a community needs assessment using an appreciative inquiry approach which was conducted in collaboration with the Community-Based Research Department of Access Alliance from February to May 2022. The appreciative inquiry approach creates a supportive environment where every participant's perspective is equitable, and participants feel trusted [5]. The study was informed by a critical realist framework wherein we examined the experiences of non-insured patients in relation to our team's own experiences and to the existing literature [6]. Critical realism postulates that reality is experienced through one's sensory, cognitive, emotional, language, and cultural processes and encourages the comparison and triangulation of different patient perspectives [7]. This research paradigm informed the development of a semi-structured interview guide. The study protocol was approved by the University of Toronto Research Ethics Board [Protocol #33384].

### Study setting

This study was conducted at a time when the Ontario Ministry of Health introduced temporary payment mechanisms to facilitate free access to healthcare services for non-insured patients from March 2020 to 2023 [8]. This policy implementation presented a unique opportunity to examine ED care for non-insured populations as non-insured patients were previously required to pay for any health services received. This study was designed as a partnership between an academic center, the University of Toronto, and a community health center that is trusted by non-insured individuals, Access Alliance Multicultural Health and Community Services (Access Alliance).

Access Alliance's non-insured walk-in clinic (NIWIC) saw 6,177 non-insured patients between April 2018 and March 2023 [9]. The NIWIC, established 14 years ago, is a collaboration between 6 local community health centers to improve non-insured patients' access to primary care. Access Alliance runs the only clinic within the Greater Toronto Area that specifically serves the needs of non-insured clients.

Recruitment of participants included patients of Access Alliance as well as family, friends, and community members

in the Greater Toronto Area using a snowball recruitment approach.

### Population and sample size

To ensure representative sampling, we adopted a maximum variation purposive sampling technique with an intentional selection of participants that represent a diversity of perspectives [10, 11]. Purposive sampling is "the deliberate choice of a participant due to the qualities the participant possesses and a non-random technique that does not need underlying theories or a set number of participants [11]." Based on an environmental scan, we considered participants' region of origin, gender, spoken languages, age, and sexual orientation during recruitment.

Data collection was halted after data saturation was reached, defined as the degree to which sequentially collected data resembles previous data [12].

The eligibility criteria for inclusion in the study include non-insured patients in Access Alliance's Non-Insured Walk-in Clinic or under Access Alliance's longitudinal care or their contacts, those over 18 years of age, and those who received care as a patient in an ED in the Greater Toronto Area in the 3 years before the date of the interview. The exclusion criteria for the study include inability to give informed consent because of cognitive impairment or active medical treatment, and those who were too physically weak to speak in an interview.

We collected data from 24 participants recruited through staff advertisement of the study in Access Alliance's Non-Insured Walk-in Clinic and their families or friends with purposive communication to the select populations noted above. Though purposive sampling was employed in promotion of the study, no participants who expressed interest in the study were excluded due to their demographics. Potential participants were informed that their choice to participate or not in the study was voluntary and informed consent was provided. The sample size was considered to be appropriate by the research team as a smaller sample size is needed when the study's focus is on high information power, dense specificity, and strong dialogue [13]. Qualitative researchers are also encouraged to evaluate "saturation parameters found in prior methodological studies and sample size community norms [14]." As such, our sample size is consistent with other studies looking at the number of interviews required to reach data saturation [15–17].

During recruitment, an immigration research fellow with Access Alliance conducted a one-on-one interview at the Non-Insured Walk-in Clinic. The fellow was an internationally trained medical doctor with a graduate degree in public health and trained in trauma-informed interviewing. Interviews were conducted from February to May 2022 and each interview lasted up to 60 min. We provided live professional

interpretation if needed. Interviews were de-identified before coding by the research team.

## Data collection

We collected qualitative data through individual semi-structured interviews. Individual interviews were selected as we believed that one-on-one interactions between the interviewer and the participant would yield stronger dialogue [18]. Semi-structured interviews allow the participant to dictate the flow of the interview and to choose which topics to explore further [19]. To facilitate discussion and to ensure consistency over interviews, interview prompts were developed based on existing literature and themes that arose from the team's previous study of providers who provide care for non-insured patients (see Appendix A) [20]. The opening question for the interview was: "Tell us about the experiences you have had going to the emergency department." Data were transcribed using an intelligent verbatim approach. An intelligent verbatim approach "allows the transcriber to omit occasions when, for instance, an individual mis-speaks and corrects themselves, thereby allowing the transcriber to record closer to what was intended and how the interviewee might have portrayed themselves in a written form. [21]" Participants were also given the opportunity to review their interview transcripts for accuracy.

## Data analysis

Data analysis occurred after the completion of all interviews and between September 2022 and March 2023. Three individuals (AG, SR, and CS) separately coded the transcribed data using NVivo version 12 software. These individuals all have expertise in qualitative methodologies as demonstrated through publication of other qualitative studies [20]. Triangulation was then carried out with interrater variability adjustments. NVivo software was used to highlight coded passages for development of themes. The broader team then critically discussed the themes in a collaborative framework for validation, definition, and incorporation of research findings using Braun and Clarke's framework [22]. Braun and Clarke's framework is a well-known thematic analysis framework that emphasizes researcher reflexivity, theoretical flexibility, and the use of the research question as a guiding framework [23]. The study team interpreting the data consisted of providers in emergency medicine, family medicine, and psychiatry, as well as health systems researchers; all individuals have experience working with non-insured patients. Reflexivity was considered during the data interpretation process by discussing and challenging assumptions that arose. We sought to ensure rigor and credibility through triangulation of data sources and researchers. To highlight the voices

of our non-insured participants, we have included some anonymized participant quotes within the "Results" section of this manuscript with supplemental quotations available in Appendix B.

## Results

Demographic information regarding study participants can be found in Table 1. Approximately, 67% of participants were female which reflects the percentage of female non-insured individuals in Canada [24]. Though participants did not have formal primary care attachment, they were connected to Access Alliance's Non-Insured Walk-In Clinic which provided episodic primary care. Only one participant was excluded as during the interview process, the participant subsequently disclosed that they were not uninsured.

Key themes that were developed based on the participant interviews include feeling unwanted and powerless; encountering health system challenges; and coping with these challenges through resiliency and advocacy. Sub-themes were generated under each of these major themes and are summarized in Table 2.

### Feeling unwanted and powerless

#### The anxiety of uncertainty

A salient theme was the emotional and cognitive burden placed on non-insured individuals when navigating the health system, caused by the constant uncertainty involved in balancing healthcare access, payment, and other non-health-related priorities. Participants shared strong feelings of anger and fear trying to balance navigating payment for care while also experiencing pain, actively bleeding, or suffering from acute medical conditions. In some cases, this led to persisting negative feelings, including powerlessness, about the system and seeking care.

*"The moment they want to know if you have OHIP and you say no, there's this huge sense of insecurity because you're so scared to what the answer will be next and what other associated costs would come with that. It's a huge feeling of insecurity even to walk into a hospital or anywhere... it becomes such a huge stress along with the worry that you might have to face such a huge financial burden. It's a big stress factor not having OHIP and that whole question being asked." [Participant 014]*

**Table 1** Participant demographic Information

| Participant self-reported demographic information              | Number of interview participants (%)<br><i>n</i> = 24 participants |
|--|--|
| Gender   |  |
| Woman  | 16 (66.7%)   |
| Man  | 5 (20.8%)  |
| Transgender  | 2 (8.3%)   |
| Non-binary   | 1 (4.2%)   |
| Ethnicity  |  |
| South Asian  | 7 (29.2%)  |
| Latin American   | 5 (20.8%)  |
| Black-African  | 4 (16.7%)  |
| White-European   | 3 (12.5%)  |
| White-North American   | 2 (8.3%)   |
| Middle Eastern   | 1 (4.2%)   |
| Black-North American   | 1 (4.2%)   |
| Of mixed ethnicity   | 1 (4.2%)   |
| Country of birth   |  |
| Outside of Canada  | 21 (87.5%)   |
| Inside of Canada   | 3 (12.5%)  |
| Duration of stay in Canada at the time of interview            |  |
| Less than 1 year   | 6 (25%)  |
| Between 1 and 2 years  | 18 (75%)   |
| Sexual orientation   |  |
| Heterosexual   | 19 (79.2%)   |
| Bisexual   | 2 (8.3%)   |
| Gay  | 1 (4.2%)   |
| Lesbian  | 1 (4.2%)   |
| Preferred not to answer  | 1 (4.2%)   |
| Preferred language for communicating with healthcare providers |  |
| English  | 19 (79.2%)   |
| Spanish  | 3 (12.5%)  |
| Somali   | 1 (4.2%)   |
| Tamil  | 1 (4.2%)   |
| Presence of comorbid medical conditions <sup>1</sup>           |  |
| No comorbid medical conditions                                 | 16 (61.5%)   |
| Diagnosed comorbid mental health conditions                    | 5 (19.2%)  |
| Diagnosed comorbid physical conditions                         | 4 (15.4%)  |
| Preferred not to answer  | 1 (3.8%)   |
| Total household annual income                                  |  |
| \$0–\$14,999   | 8 (33.3%)  |
| \$15,000–\$19,999  | 1 (4.2%)   |
| \$20,000–\$24,999  | 6 (25%)  |
| \$25,000–\$29,999  | 1 (4.2%)   |
| \$30,000–\$34,999  | 1 (4.2%)   |
| \$35,000–\$39,999  | 1 (4.2%)   |
| \$40,000–\$59,999  | 1 (4.2%)   |
| \$60,000 or more   | 1 (4.2%)   |
| Preferred not to answer  | 4 (16.7%)  |
| Size of family household                                       |  |
| 1 individual   | 1 (4.2%)   |

Table 1 (continued)

| Participant self-reported demographic information        | Number of interview participants (%)<br><i>n</i> = 24 participants |
|--|--|
| 2 individuals  | 12 (50%)   |
| 3 individuals  | 2 (8.3%)   |
| 4 individuals  | 7 (29.2%)  |
| Preferred not to answer                                  | 2 (8.3%)   |
| Reasons for presenting to the ED                         |  |
| Musculoskeletal concerns                                 | 4 (16.7%)  |
| External bleeding  | 3 (12.5%)  |
| Infectious diseases concerns                             | 3 (12.5%)  |
| Renal colic  | 2 (8.3%)   |
| Pregnancy concerns                                       | 2 (8.3%)   |
| Dermatological concerns                                  | 2 (8.3%)   |
| Chest pain   | 1 (4.2%)   |
| Headache   | 1 (4.2%)   |
| Stroke   | 1 (4.2%)   |
| Syncope and head injury                                  | 1 (4.2%)   |
| Dental concerns  | 1 (4.2%)   |
| Gastrointestinal concerns                                | 1 (4.2%)   |
| Preferred not to answer                                  | 2 (8.3%)   |
| Reasons why participants were non-insured <sup>2</sup>   |  |
| Participant was in 3-month period awaiting OHIP coverage | 3 (12.5%)  |
| OHIP coverage expired                                    | 2 (8.3%)   |
| Participant involvement in refugee claimant process      | 2 (8.3%)   |
| University insurance expired                             | 1 (4.2%)   |
| Preferred not to answer                                  | 16 (66.7%)   |

<sup>1</sup>Some participants had both physical and mental health conditions resulting in a total of 26 interview responses. Percentages were calculated based on an interview response number of *n* = 26

<sup>2</sup>Participant non-responses to this question were likely higher than other questions due to privacy, safety and legal concerns related to answering this question

\*The demographic data of the single excluded patient were not obtained and hence not included within this table

## Challenges of navigating healthcare in Canada

Many non-insured participants were newcomers to Canada and were trying to navigate a new health system. They described confusion around insurance eligibility, healthcare access points, and language while seeking more accessible information and assistance with health system navigation.

*“Yeah. When they took me in the ambulance the paramedics – at that time I don’t know English too, no English. They asked me about OHIP, but I said I will apply for it this week. I felt bad when they asked me, because I thought why didn’t I get it right away? At that time my English is not good, I was asking people from my country to help me for things like - I want to go there, I want to apply to that, things like that.”*  
[Participant 018]

## Stigma and discrimination

Participants also felt discriminated against for being a person without health coverage, feeling that their treatment, particularly when registering and at triage, was impacted by this status. This contributed to feelings of being unwanted within the ED.

*“Income for sure. I was thinking, if I make enough money, this lady would not be asking these questions. Asking too many questions made me feel, oh my gosh I don’t have any money. And also repeating those questions because of (my) accent made me feel very different from others. Also, I felt I am not like Canadian. I felt I’m not welcomed and felt very tiny. Sometimes non-verbal cues or the people around*

**Table 2** Themes developed from participant interviews

| Themes   | Description  |
|--|--|
| Feeling unwanted and powerless                 |  |
| The anxiety of uncertainty                     | Participants reported anxiety associated with constant uncertainty involved in balancing health-care access, payment, and other non-health-related priorities  |
| Challenges of navigating healthcare in Canada  | Participants described confusion around insurance eligibility, healthcare access points, and language  |
| Stigma and discrimination                      | Participants also felt discriminated against for being a person without health coverage  |
| Health system concerns                         |  |
| Delayed care                                   | Participants noted experiencing a delay in their ability to access care due to their lack of health coverage   |
| Registration/triage issues and physical design | Participants expressed embarrassment at being asked about their ability to pay at registration, and frustrated at not knowing how much their care would cost. Participants described providers seemed confused about the nature of their health coverage. Other issues include difficulties navigating the physical space of the emergency department and concerns about a lack of privacy |
| Positive experiences with healthcare           | Participants differentiated between the challenges with health system design and navigation they experienced, and the positive care they received from clinicians in emergency departments   |
| Coping, resiliency, and advocacy               |  |
| Coping, resiliency, and advocacy               | Participants found ways to get around systems issues by leveraging informal community networks and non-health system care providers such as shelter staff. Participants also engaged in self-advocacy to health institutions   |

*her in the emergency department made me feel like I don't belong here." [Participant 002]*

## Health system concerns

### Delayed care

Participants frequently described experiencing a delay in receiving appropriate medical treatment due to an inability to access care because of their lack of health coverage. Many participants described trying to access services in lower acuity care settings but eventually coming to the ED when they could not get care elsewhere.

*"When we arrived, we stayed in a hotel for one week. My daughter was 10 months old that time and she got chickenpox during those seven days. I had symptoms of chickenpox on my face, hands and fever but I was not sure what they were. That time we did not have our OHIP card. At first, we went to a public clinic that was nearby. They told us we do not accept people who do not have OHIP card. We had a small baby and hearing those things were not a good experience." [Participant 016]*

### Registration/triage issues and physical design

The place where participants most often reported difficulties was during the registration and triage process. Most

participants reported embarrassment at being asked about their ability to pay at the registration desk and a lack of privacy and confidentiality when this occurred. Others described feeling frustrated at not knowing how much their care would cost and reported that they would prefer to hear this information earlier.

*"I went to the front desk or registration and she asked me my name and asked if I had the OHIP card. I said 'no'. She asked 'do you have any other insurance?' ... She asked me several times and questions about the insurance. I didn't like it. ... I had bleeding from my forehead, continuous dizziness, and was answering those questions. Of course, I was doing alright, but I was telling myself, 'they should give me some treatment, and then talk about money.'" [Participant 002]*

Participants also noted that providers often seemed confused about the nature of their health coverage and what services non-insured patients were eligible to receive without payment. They described difficulties navigating the physical space of the emergency department, concerns about having sensitive discussions without appropriate privacy, and suggested better training for staff as well as improved signage.

### Positive experiences with healthcare

Participants largely noted positive experiences when they interacted with clinicians. They reported feeling cared for and treated appropriately. They differentiated clearly



between the challenges with system design and navigation, and the individual care they received from clinicians.

*“In terms of doctor, she was really nice and said ‘oh it might have been hard for you, sorry you had to wait and sorry about your partner having to wait. It is like this because of covid and time.’ I told her it was frustrating and she was the only one that heard me out. She asked ‘do you want your partner to come and take you or are you okay leaving yourself?’ I said I was fine leaving myself. The only acknowledgement I got was from the doctor.” [Participant 005]*

### Coping, resiliency, and advocacy

Non-insured individuals described finding ways around systems issues by engaging informal community networks. They also were supported by non-health system care providers such as shelter staff who provided standardized letters around payment that non-insured patients could bring to the ED. At times, participants described taking back some control and power by advocating directly to the institution.

*“So, I did. Long story short, the end result to it was I wrote letters and I was actually able to get them to work with me and they have written the bill off. It is not anything I have to pay. Which I was very fortunate.” [Participant 013]*

## Discussion

### Interpretation of findings

This study represents a novel collaborative research partnership between the University of Toronto and Access Alliance; such collaboration was paramount to engaging an equity-deserving patient population in research. Key themes identified by non-insured participants include (1) feeling unwanted and powerless, (2) health system access and navigation concerns, and (3) coping, resiliency, and advocacy. Powerlessness is related to concerns about not having the financial means to pay and navigating an unfamiliar health system. This was compounded by stigma and discrimination that made participants feel that their non-insured status was leading to subpar care. Organizational challenges included a lack of clarity for ED staff regarding the scope of healthcare coverage for non-insured patients and concerns about patient privacy at triage and registration. It was notable that despite these challenges, participants took time to highlight positive experiences with individual clinicians, suggesting an appreciation of the difference between systemic factors and the efforts of individual clinicians.

### Comparison to previous studies

Our study highlights the multitude of systemic barriers that non-insured patients face when accessing ED care. Many of the themes from this study highlighting challenges with ED system navigation and experiences corroborate the perspectives of healthcare providers who provide care for non-insured patients [25]. Both care providers and non-insured patients highlight stigma and discrimination, lack of privacy, and unclear care pathways as specific systemic concerns, while providers additionally comment on challenges related to post-ED care, increased illness complexity, and language barriers [20].

Experiences of non-insured patients accessing ED care echo the experiences of other underserved populations navigating the health system. The ED in Canada is seen as point of healthcare access for all-comers and a safety net to serve the most equity deserving; this also means that it can be a place where Canada’s health system’s problems are made most apparent. Despite individuals from underserved communities reporting dissatisfaction with ED care, including experiences of stigma and discrimination [26, 27], the ED is also seen as one of the few healthcare settings that accept all patients regardless of healthcare status [28]. This duality locates health systems and providers in a perfect storm where effective and safe care becomes increasingly hard to provide. Themes from our study of non-insured patients around feeling disempowered, experiencing stigma and discrimination, and having challenges with navigating the healthcare system mirror the experiences of other equity-deserving groups [29, 30].

### Strengths and limitations of the study

Our study is the first qualitative study within Canada that explores the experiences of non-insured individuals accessing ED care through the lens of non-insured individuals themselves. These unique perspectives were obtained only through the foundational trust that exists between the non-insured individuals and Access Alliance, our community partner. Regarding limitations, our study explores the experiences of non-insured individuals within one province and one healthcare setting though this limitation is somewhat balanced with our use of maximum variation purposive sampling technique. More so, participants’ ED experiences may have been different during the COVID-19 pandemic compared to before and after the pandemic, though this also serves as a unique study context. In addition, other groups of non-insured individuals, such as those whose health care coverage have expired, may have differing experiences. Non-insured patients were not interviewed during their actual ED visit due to concerns about engaging with patients when they are in an especially vulnerable state. Because of this,



interview data may be subject to recall bias. The study team decided on an inclusion criteria of up to 3 years since participants received ED care to allow for increased study participation as the study took place within the COVID-19 pandemic which may have limited ED visits during this period.

### Health system implications

To find a way forward, our health system must find ways to improve care for equity-deserving populations at the organization and health policy levels. A summary of suggestions for improving the ED care of non-insured patients at an individual, organizational, and governmental level can be found in Table 3. Individual staff who want to improve the ED care of non-insured patients may consider engaging in cultural safety and implicit bias training as well as building an understanding of their organization's policies on non-insured payments. Organizational changes that would improve care include improved clerical training, clearer policies regarding payments, enhanced health system navigation, and fostering connections to community organizations. Other strategies to work towards a more equitable ED care system for marginalized communities include improved co-design of ED policies with community members [31]. Other studies have also described the importance of increased patient education and health literacy as well as shorter distances to the nearest safety net providers [32, 33]. Even in a publicly funded health system, financial concerns expressed by non-insured patients still impact their healthcare accessibility [28, 34, 35]. At a governmental level, health outcomes in

other countries improved in non-insured patients after they were provided healthcare coverage [34, 36, 37].

### Research implications

Future studies should seek to further delineate the experiences of non-insured individuals within the Canadian healthcare landscape. The non-insured population is comprised of a group of persons that move between different precarious legal status trajectories with varying degrees of healthcare coverage at one time [38]. By mapping the different trajectories of these persons and exploring their healthcare linkages, we can better understand if and how these trajectories may influence healthcare experiences.

### Conclusion

This qualitative study explored the experiences of non-insured patients in the ED through their own lens around the COVID-19 pandemic, a socially and medically challenging period. Many of the themes in our study may be applicable to other equity-deserving populations. Our study is a call to action for individual, health organizations, and governments to practice patient-centered care by listening to our patients and addressing the systemic inequities that contribute to health disparities. The most effective way to do this is to extend health insurance to all those residing in Canada, regardless of immigration status.

**Table 3** Suggestions for improving the ED care of non-insured patients

#### Individual level

*Individual staff in healthcare organizations can consider the following suggestions to help improve the ED care of non-insured patients:*

- Build an understanding of your organization's policies on payment for non-insured individuals and help communicate this to patients in your care
- Continue to practice compassion for the challenges that non-insured patients may encounter when accessing ED care. One non-insured interview participant described a positive encounter with a provider who simply told them "Okay no problem. We are going to help you."
- Take advantage of cultural safety and implicit bias training that may be available through your employer or other reliable third-party organizations

#### Organizational level

*Healthcare organizations can consider the following suggestions to help improve the ED care of non-insured patients:*

- Co-design ED policies with non-insured community partners
- Improve staff, including registration and clerical staff, training on cultural safety and implicit biases
- Establish and communicate to all appropriate staff the organizational policies around payments for non-insured individuals
- Reform the healthcare system navigation experience for non-insured individuals. Examples of this may include the use of patient navigators and improving signage
- Ensure structural supports are in place to ensure the privacy and confidentiality of patient conversations especially around sensitive topics such as insurance status and in non-clinical areas such as registration

#### Governmental level

*Governmental systems can consider the following suggestions to help improve the ED care of non-insured patients:*

- Extend health insurance to all those residing in Canada, regardless of immigration status
- Expand clinical and non-clinical community supports specifically available to non-insured individuals including community health centers and other primary care clinics that provide care to non-insured individuals
- Enable and fund community supports to educate non-insured individuals about healthcare coverage, access points, and navigation

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**Data availability** A collection of quotations representing patient data within this study is present within the included Appendix B.

## Declarations

**Conflict of interest** The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

**Ethical approval** All the procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the University of Toronto Research Ethics Board [Protocol #33384]. Informed consent was obtained from all individual participants included in the study. Patients signed informed consent regarding publishing their de-identified quotes.

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