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THE EXPANSION OF HEALTHCARE COVERAGE FOR CHILDREN OF PRECARIOUS MIGRANTS IN QUEBEC

An Evaluation of Bill 83's Implementation in Montreal

Dissertation submitted by
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Signature page

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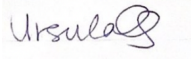
Signature: 
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DEDICATION

To my grandfather Nicolas.

"Those who went to sow seeds have heard my greetings, and those who brought their harvest home or their empty baskets have passed by my songs."

- Tagore

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List of Abbreviations

CA	Contribution Analysis
CLSC	Local Community Service Center
CMQ	Quebec College of Physicians
FMOQ	Federation of General Practitioners of Quebec
GMF	Family Medicine Group
MPS	Migrants with Precarious Status
MSSS	Ministry of Health and Social Services
RAMQ	Health Insurance Board of Quebec
TOC	Theory of Change

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Abstract

This thesis evaluates the implementation of Bill 83, passed in 2021 that expanded health care insurance coverage for children of precarious migrants in Quebec. Utilizing Mayne's 6 step contribution analysis, the bill's contribution to improve healthcare accessibility is evaluated, according to Levesque's conceptualization of accessibility, which encompass dimensions of affordability, approachability, availability, accommodation, and appropriateness of healthcare services. Through purposeful sampling, semi structured expert interviews were conducted with professionals from Médecins du Monde, La Maison Bleu, the CLSC Côte-des-Neiges and the Commission on the Rights of People and Children of Quebec. The analysis revealed that Bill 83 has contributed to enhancing accessibility for the group in question, but this contribution is challenged by a number of implementation and structural issues. Lack of sufficient communication, wrongful charges, administrative burdens, and insufficient linguistically appropriate care persist, undermining the expected causal mechanisms in which Bill 83's implementation was expected to produce intended results. The research underscores the importance of addressing these dimensions of implementation to bridge the gap between legal and realized access to healthcare. By shedding light on the practical challenges that remain, this thesis contributes to a broader understanding of healthcare accessibility issues for precarious migrants and offers insights for improving the implementation of similar policies that expand coverage for vulnerable groups.

Introduction

Up until 2021, the Quebec public insurance board (RAMQ) excluded Canadian-born children whose parents have a precarious migratory status from the public healthcare system. However, with the passing of Bill 83, children of those with precarious migration status can now access the provincial healthcare system free of cost. This thesis investigates the extent to which Bill 83 has improved healthcare accessibility for these children, focusing on various dimensions of accessibility (as defined by the Levesque framework) including affordability, approachability, availability, accommodation, and appropriateness. I ultimately find that this bill has contributed to improved accessibility overall, supported by the modification of eligibility requirements. However, the strength of this contribution has been weakened due to implementation issues, including the communication of the bill, administrative complexity in obtaining the card and wrongful billing of eligible children in Montreal hospitals. These challenge the affordability, approachability and availability & accommodation dimensions of healthcare accessibility, affecting the targeted group's ability to perceive, reach and pay for care. However, community organizations working with precarious migrants in Montreal are found to mitigate a lot of these issues and positively contribute to overall accessibility. Additional issues affecting the affordability and appropriateness of care, notably the communication between the health ministry and its network of health institutions and the access of interpretation services in hospitals. This reveals the limits of Bill 83's ability to improve the accessibility dimensions that are embedded in larger structural issues within the public health system.

The rationale for undertaking this research lies in the sizable population affected by Bill 83 and the importance of the issue. An estimated 15,000 children annually will gain access to public health insurance in the province (Doctors of the World, 2021). They represent a particularly vulnerable group, due to the fact that having precarious migration status yourself or in your family is associated with poor physical and mental health outcomes. Because previous attempts to expand coverage for vulnerable groups across countries have faced challenges in their effectiveness, it is crucial to evaluate the expansion of medical coverage for this group. This research aims not only to evaluate the

implementation of Bill 83, but provide insights on the broader challenges of expanding healthcare coverage for vulnerable populations, contributing to the knowledge pon the gap between access and utilization.

A brief overview of migrants with precarious status and the introduction of Bill 83 in Quebec is provided for context. MPS specifically refers to individuals born in another country who either have no legal status, or their status is considered to be precarious because it is not permanent or guaranteed. (Brabant & Raynault, 2012). There is limited reliable data available on people with precarious migration status in Canada, as many find themselves in situations of illegality. MPS encompasses many different categories of people present on the territory. It includes temporary legal status, including temporary residents (such as foreign students and foreign workers), temporary workers (including seasonal workers, construction workers and caregivers) as well as other temporary residents like visitors. MPS also includes people with no legal status, who have either entered the country illegally or overstayed their legal temporary status. (Goldring et al. 2009). While Canada has universal health insurance, MPS do not qualify to access it and have to pay out of pocket to receive care. This is because in Canada, health insurance is directly linked to immigration status, and only those considered to be residents of one of the provinces have access. In the province of Quebec, the RAMQ is the Quebec public health insurance board and consists of the administrative body in charge of establishing eligibility for the public provincial health insurance, as directed in the Quebec Health Insurance Act. Under the Quebec Act, in order to qualify to be registered for provincial health insurance, a person has to be domiciled in Quebec. This means that they are residing in the province habitually, for a minimum of 183 days out of the year, along with meeting the other conditions in the regulations. (Observatoire des tout petits, 2019). An estimated 50,000 people live in Quebec without access to public health insurance coverage due to their precarious immigration status. (Doctors of the world, n.d.)

In addition to precarious migrants being excluded from the provincial health care system, up until recently the Quebec public insurance board (RAMQ) excluded Canadian-born children whose parents have a precarious migratory status from the public healthcare system. It was the only province in Canada to deny healthcare to children born in the province based on the migratory status of their parents. These children were excluded

from public health coverage until they turn 18, or their parents' migratory status is established, despite being residents of the province. (Doctors of the world, n.d.) This decision had been a point of debate for a long time. Quebec's ability to exclude residents from the health system had been justified by using a very constrained interpretation of the residency requirement under the health insurance act. To be covered under the Health Insurance Act, an individual must live and be domiciled in Quebec. Because it is hard to prove if a child has the intent to grow up and reside in a specific place, it is presumed that minors are domiciled with their parents. So, in order to determine if a child is eligible for health insurance, the RAMQ looked at their parents' circumstances. A child was thus only eligible for health insurance if at least one of their parents was eligible. The change expanding healthcare coverage officially came into effect in September 2021. (Doctors of the World, 2021). Bill 83 amends the Health Insurance Act and the Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec. The amendment allows minor children who match the requirements and possess one of the statuses listed in the Act, to be regarded as having their residence in Quebec and so being covered by the health insurance plan as residents. In order to do so, the latter must be able to show that they intend to stay in Quebec for a minimum of 6 months. (National Assembly of Quebec, 2020)

The structure of the thesis is organized as follows: First a review of the literature on healthcare accessibility, barriers specific to migrant populations, and the expansion of healthcare insurance is presented, along with the expectations derived from it. This is followed by the methodology section, which outlines the research design, sampling technique, ethical considerations and the data collection and analysis. Finally, the results are presented, followed by a discussion of their policy implications and a conclusion.

Literature review

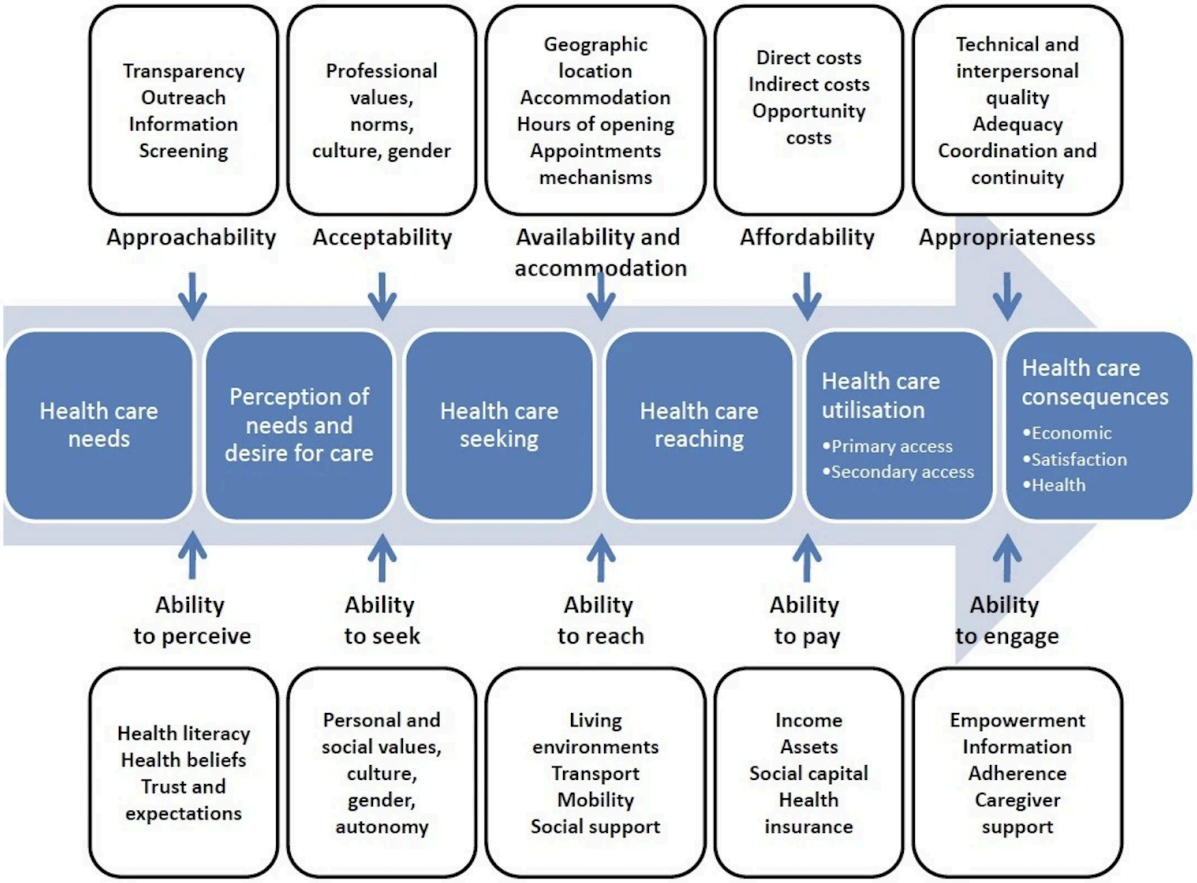
2.1 Literature Review: Healthcare Accessibility

Measuring Accessibility

There have been different approaches to defining and assessing healthcare accessibility throughout the years, including the Levesque framework. It defines access as the chance to identify healthcare needs, seek services, use them and have the need for healthcare services be fulfilled. It was developed after a large review on the literature on healthcare accessibility. The framework presents 5 dimensions of healthcare accessibility on the provider/supplier side, which relate to five corresponding abilities of people seeking care to generate access. The five dimensions on the supplier side are approachability (patients can easily locate, contact, and navigate the healthcare system), acceptability (patients perceive and value the healthcare services available to them), availability/accommodation (provision of healthcare services in a timely and appropriate manner), affordability (economic capacity for people to spend resources use appropriate services) and appropriateness (fit between services and clients need). These five dimensions directly impact patients ability to perceive, seek, reach pay and engage with healthcare, the 5 corresponding dimensions on the health seekers side. (Levesque, 2013) In a scoping review of studies applying Levesques framework, Cu & al (2021) found the framework was effectively applied in research that explored, evaluated and measured healthcare accessibility in various contexts, enabling researchers to examine the complex process of access. This framework is appropriate and helpful because it provides a broader conceptualization of healthcare “access”, going further than the legal or regulatory entitlement to healthcare.

Figure 1

Levesque's Framework of Healthcare Accessibility.



Healthcare Accessibility Barriers for MPS in Canada

Existing literature of health care accessibility for migrants in Canada was reviewed, to understand the Canadian context and the factors that hinder healthcare accessibility for migrants without established status on both the patient and provider side. The main barriers found in the literature are summarized below.

1. Coverage and Cost

The creation of irregular status excludes groups from accessing social services in the Canadian welfare state. Many barriers to healthcare accessibility among this group have been reviewed in the literature and lack of coverage is one of the most common. It is also the most direct barrier to healthcare access, as immigration status is directly related to public healthcare coverage, without which access is limited. However, even in cases where people choose to pay out of pocket or access free social community services there are certain barriers that still remain. In Gagnon & al's (2022) review of literature (between 2008 and 2018) on those in Canada without legal immigration status, they found that cost is a major barrier to accessing healthcare, due to having to pay if one is without status. As a result, many experience debt resulting from healthcare costs. While they acknowledge community clinics remain an option, these may not have the space and capacity to adequately provide healthcare for those without status, which restricts access.

2. Fear of deportation

A barrier to accessing healthcare that is repeatedly cited in studies done on migrants without any legal status is the fear of deportation. While there has not been a country wide study done on migrants without status in Canada, there have been numerous studies focusing on specific regions or cities and people's experience within them. In a study conducted by Campbell et al. (2014) they examined and compared the healthcare access of permanent residents, undocumented immigrants and refugee claimants in Toronto. They conducted 21 semi-structured qualitative interviews and aimed to find the barriers and facilitators to accessing healthcare among the different categories. The experience of undocumented immigrants seeking healthcare was completely different from refugee claimants or those with permanent status. Most of those interviewed had never consulted a walk-in clinic or general practitioner in the country due to fears of being reported to the border authorities. Instead, undocumented immigrants would rely on emergency rooms solely if their condition was life threatening enough. This study is consistent with other findings that fear of deportation prevents undocumented immigrants from accessing healthcare. For example, another study conducted by Hanley et al. (2014), interviewed men and women with a range of precarious

immigration statuses in Canada. When asking people why they did not consult a medical professional when they were sick, 33% of undocumented workers cited fear of being denounced to immigration authorities or employers as a reason.

3. Provider attitude

Another factor influencing the experience of people without precarious status accessing healthcare is the attitude of the healthcare providers. This can both hinder or facilitate the access of healthcare services. While researching the way people lose their legal migratory statuses & the implication it has for their access to social services, Goldring et al. (2009) found that regardless of the policies in place, frontline workers often use discretion in the way services are provided. This can be done by choosing not to document the services provided to someone who does not have a permanent or legal migratory status. This ultimately leads to people having different experiences when trying to use services depending on the practice of the healthcare professional encountered. When care is provided to people without coverage, this ends up being additional and unpaid work for staff, so people's ability to seek care is dependent on both the latter's capacity and views on providing services to those without coverage. For example, Mattatall (2017) Found a large variance in the practices of physicians regarding if they would bill an uninsured migrant patient, leading to disagreements among staff due to differing ethical perspectives. Healthcare professionals are placed in a very difficult position and faced with the legal and moral struggle of whether or not to provide care for uninsured migrants. Ruiz-Casares et al. (2013) aso found varying attitudes of frontline workers in hospitals and primary care centres in Montreal on care provided to undocumented immigrant or refugee children and pregnant women not covered by the provincial health insurance. Due to the large variety in perspectives among healthcare professionals, it illustrates the need for access to healthcare to be properly outlined in policy.

4. Awareness, Navigation and Cultural Sensitivity

Removing the financial barriers of accessing healthcare is seen as a fundamental part of achieving universal health coverage. As a result, there are many examples of health insurance programs or coverage plans targeting poor or vulnerable groups that have emerged. However, It is important to consider that even when appropriate coverage is present for a group, this does not always translate into the utilisation of healthcare services. Even when people without status do have access to healthcare or social services, a lot of literature indicates that technical access to health care does not guarantee its utilisation in practice. Ruiz-Casares et al. (2010) found that even if children are born in Canada and DO qualify for provincial coverage, parents often face continued difficulties. In a review of literature Gagnon & al. (2022) identified remaining barriers to accessing healthcare services when coverage is present. Even those who are legally qualified for a given service might not be aware of their rights and entitlements. People could not be aware of the services offered or how to access them due to lack of experience with the healthcare system. Additionally, it may be challenging to find providers that can provide culturally and linguistically sensitive care.

2.2. Literature Review: Insurance Coverage Expansion

As was discussed in the previous section, access to coverage does not always translate to utilisation. What are the important mechanisms involved in successful implementation of such health policies and insurance programs, that would translate a bill expanding coverage into desired outcomes? Clear communication, administrative burden and the targeting of eligibility requirements are all relevant in the successful implementation of such programs.

As mentioned, a number of health insurance and coverage programs targeting poor or vulnerable groups have emerged. However, there remains a gap between a population's eligibility, and their successful enrollment into the programs to access services they are entitled to. The findings from a meta analysis conducted by Osei et al. (2022) reviewed 48 studies from 17 countries in middle and low income countries, looking at the enrollment rates of vulnerable populations in health insurance schemes. The goal of the study was to calculate to what degree health insurance plans access poor or vulnerable populations.

Ultimately, found that despite attempts from governments, these health insurance programs are not succeeding in reaching poor and vulnerable groups. A review of the strategies proposed to ensure the successful expansion of covered so far have been outlined below.

1. Communication & Outreach

Both communication and outreach strategies are key for the successful implementation of health policies and enrollment uptakes. Kreuter et al. (2014) looked at 40 studies conducted by the Health Communication Research Laboratory between 1996 and 2013, that focused on how reach and effectiveness of health information can be improved for vulnerable, low income and minority groups. The authors attempted to summarise the key findings of this research, to be applied to the problem with the implementation of the affordable care act in the United States, which expanded health coverage significantly. Based on their synthesis of the 40 studies, they concluded with key recommendations that ultimately relied on partnerships, messaging and outreach. Indeed, messaging and outreach are incredibly important and recognized as a key component necessary for the successful implementation of healthcare policies, as established in Friedman's (2014) 6 components of effective health policy implementation.

Health literacy is an important factor in explaining the lack of enrollment rates into various health programs. Health literacy is defined as the extent to which people are able to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. It plays an important role in people's capacity to understand health related information and make informed decisions (CDC, 2023). Both Calderón & Beltrán (2004) and Kreps & Neuhauser (2015) affirm the importance of health literacy and utilising new, effective health communication strategies. They affirm the need for information that is user friendly, easily understandable and culturally sensitive in order to reach vulnerable groups. To ensure the dissemination of health information and meaningful engagement with it, it must be adapted to the needs of the group targeted. Pithara et al. (2012) highlighted additional communication challenges facing undocumented migrants specifically, in a study focusing on Cyprus trying to access care. They found language

barriers and lack of information about rights and health services to be particularly salient.

The importance of partnership and outreach has been recognized as being an important part of effective health communication, including the involvement of non governmental community organisations that have direct contact with the community that is trying to be reached. There is also evidence that one of the most effective ways to mitigate implementation problems is collaborative and community based approaches. In a study by Hatch et al. (2020) that looked at partnerships in six states implementing the affordable care act, they found collaborative strategies and using community resources and organisations that have close ties to the target population and thus established trust was effective in mitigating implementation barriers. States that used such programs were most successful in improving enrollment rates.

The literature considers the various outreach strategies in increasing enrollment, beyond the content of the messaging. Information, Education, and Communication (IEC) campaigns have been used to increase health knowledge and improve enrollment in health insurance schemes. For instance, a study by Cofie et al. (2013) on IEC campaigns in Burkina Faso found that the frequency of communications, the use of multiple media channels, and the participation of community leaders had the largest impact on improving enrollment levels. Both technology and no technology strategies seemed to work. Cousineau et al. (2011) attempted to evaluate the various approaches to outreach for the enrollment in public health insurance, focusing on 25 california countries, specifically with a children's health initiative. The study ultimately found that technology and non technology based approaches were successful in effectively increasing enrollment rates to public health insurance. The largest enrollment increases were seen when numerous strategies were utilised at once, pointing to the potential value of opting for combined approaches and strategies.

2. Administrative Burden

The concept of administrative burden describes a person's experience with the implementation of a given program or policy as burdensome or inconvenient. Administrative burden ultimately restricts the number of eligible individuals from claiming benefits.

There can be many ways in which individuals feel this burden, whether it's through finding out about a program or respecting the rules and bureaucratic processes involved (Herd & al, 2013) Many studies have investigated how this plays out in practice. For example, Mulligan et al. (2019) analysed the obstacles to enrollment and coverage in the context of the Affordable Care Act in Rhode Island. They found the main barriers to enrolling in coverage were bureaucratic barriers, affordability, difficulty calculating income, change in household status, confusion about programs and confusion about rules. They argued that a health system with an easier enrollment procedure would make it more likely people enrolled and obtained coverage.

Many studies have supported the argument that by reducing this administrative burden, enrollment in insurance programs will increase. Herd & al. (2013) investigated the changes leading to the reduction of the administrative burden on the individual, and showed how this led to increased enrollment in Medicaid in Wisconsin. The case study demonstrated that diminishing administrative burden led to a take up in participation in a program. Not only that, they found strategies to reduce the burden and increase enrollment, including auto-enrolment, simple forms, having information available online, online application systems and increased outreach. The ultimate conclusion was that in order to ensure enrollment, the burden must be shifted from the individual to the state, especially when the buren is associated with determining eligibility and the actual process of enrollment. Similar findings by Fox et al. (2020) Ericson et al. (2023) support this, finding that making the enrollment process more simple significantly improved enrollment rates.

This notion of administrative burden is particularly important, not only generally recognized as a barrier to enrollment, but specifically in the case of migrants without established status. Herd & Moynihan (2020) explain that some groups feel administrative burdens more than others, such as the poor or migrant communities. In addition, Hacker et. al (2015) conducted a systematic review of 341 articles over the past years, to identify the obstacles to healthcare of undocumented migrants, and found bureaucratic obstacles such as paperwork and registration processes as significant barriers.

3. Eligibility requirements

Targeting designates a variety of activities undertaken by organisations or institutions to formulate, identify, select and reach populations that are supposed to be included in policies or programs. (INCLUDE, 2022) As articulated by Sommers (2010), for programs that are publicly funded, the capacity to direct benefits to the intended recipients is fundamental to their success, but policies often unintentionally exclude the participation of the true target population. A report by INCLUDE (2022) looked at the targeting process from design to implementation, finding that people can be incorrectly excluded from a program for a variety of reasons, such as communication strategies, delivery mechanism and program components, unsuitable indicators, or misaligned criteria. Importantly, a potential problem for targeting in the design stage is the formulation of eligibility criteria, which can be too restrictive or broad, or formulated using false, general or specific assumptions, leading to the exclusion effects.

2.3. Expectations

Migrants face a number of health barriers including cost, coverage, provider attitude, language and cultural barriers, awareness of rights and health services and navigation of the health system. In order to evaluate whether Bill 83's implementation has contributed to increased access, the strategies established as being necessary to successfully expand health coverage for vulnerable groups will be evaluated. Based on the literature, these are clear communication, effective outreach and enrollment strategies, partnerships, appropriate formulation of eligibility requirements and the reduction of administrative burdens. These are thus the key dimensions upon which the evaluation of the overall implementation is based on.

The most important barrier to accessing health care is cost, and the main way Bill 83 is expected to work is by removing the financial barriers to obtaining healthcare for children of precarious migrants. Thus, in order to assess the implementation of Bill 83, evaluating the removal of financial barriers is crucial. This specifically targets the affordability dimension of healthcare accessibility and peoples availability to pay. By making children of precarious

migrants eligible for free provincial health insurance, this should in theory occur. Are children who should be covered continuing to be charged? Are there other unexpected financial costs of seeking care?

Since the formulation of the bill and the eligibility requirements can unintentionally produce exclusion effects preventing some intended beneficiaries from accessing healthcare, this is a key dimension of the bill on the basis of which implementation should be evaluated. Evaluating this dimension helps identify and rectify these exclusion effects, ensuring that the bill benefits all eligible children as intended in the way it is implemented in practice.This is also directly related to the financial barrier, if a child is unintentionally excluded from coverage, their family will continue to face financial barriers to accessing care. How is eligibility determined? Are there any intended beneficiaries being excluded?

The use of frequent, user friendly, easily understandable and culturally sensitive information delivered through multiple channels was identified as a key strategy to ensure the successful expansion of healthcare coverage for vulnerable groups, in order to ensure the information reaches them. In the case of Bill 83, I expect that the use of such communication is crucial to reach the targeted population with often lower levels of health literacy. Thus, the communication strategies utilized to communicate Bill 83 and its details to the affected group is a dimension on which the overall implementation will be evaluated. Effective communication directly targets the approachability dimensions of healthcare accessibility, ensuring that the beneficiaries perceive and understand the healthcare available to them. This aspect is particularly important to evaluate considering the profile of the affected, whose parents may have low health literacy and face language barriers. What communication strategies have been used? Are families aware of their eligibility status?

In line with the previous aspect, the implementation of bill 83 will also be evaluated based on the use of outreach strategies, recognized as a key component necessary for the successful implementation of healthcare policies and proven to mitigate implementation problems. Thus, the extent to which community organizations working with the group concerned are involved in communicating and accompanying families dealing with the bill and its details is crucial in evaluating its overall implementation. These organisations often have direct contact and established trust with the targeted beneficiaries, and play a crucial

role in increasing enrollment rates. This targets approachability dimension of healthcare accessibility, once again ensuring beneficiaries can perceive the healthcare services that are available to them. Both communication strategies and outreach are particularly important when it comes to precarious migrants, who often face social, language, cultural barriers and low health literacy. What outreach strategies have been tried? How involved are community organizations?

The successful implementation of bill 83 relies on the administrative process being clear, simple and accessible in order for people to actually enroll in the RAMQ. If this process is complex, unclear, has unnecessary procedures, can contribute to administrative burden and lessen the rates of enrollment, despite the legal entitlement outlined in Bill 83. Administrative burden is proven to hinder successful enrollment into insurance schemes, making it an important dimension to evaluate to determine if the implementation has been successful. Bureaucratic barriers to enrollment are heightened in cases of migrants without established status, who feel the effects of administrative burden more than others, especially paperwork and registration. This specifically targets the availability and accommodation dimension of healthcare, affecting people's ability to reach health services. How easy is the registration process? Are people able to successfully register?

These are the relevant dimensions on the basis of which the implementation will be evaluated, as they have been identified as key precursors to the successful expansion of coverage, specifically for vulnerable groups, taking into account specific realities and barriers faced. By focusing on these dimensions and the questions they bring up, the implementation of Bill 83 can comprehensively be evaluated, and the degree to which it has improved healthcare accessibility can be established.

Methodology

3.1 Research Design

This study used theory based evaluation, and more specifically the six steps of Mayne's contribution analysis, to evaluate the implementation of Bill 83's contribution to improved healthcare accessibility for children of precarious migrants. As explained by Astbury & Leeuw (2010), theory based evaluation attempts to address the "black box problem" , referring to the proclivity to view social programs and policies in terms of outcomes, without analysing how these are produced. Theory based evaluation is conducted by looking at the theory of change and mechanisms of a policy or program. The theory of change consists of a theory or framework to understand how a policy is expected to work, while its mechanisms represent the specific processes that translate the activities of the program into desired outcomes. Contribution analysis is a structured approach within theory based evaluation that aims to assess the contribution of policies to observed outcomes. By thoroughly and systematically examining the evidence for and against the theory of change and associated mechanisms, contribution analysis aims to provide a credible evaluation of the intervention's contribution. The CA consists of 6 steps: identification of cause and effect issues, the theory of change is developed based on a review of the literature and existing evidence, the contribution story is assembled, additional evidence is gathered , and the contribution story is revised and strengthened. (Delahais, 2021)

Mayne (2008) argues this approach is particularly useful in cases that seek to evaluate the performance of programmes where it is not practical to design an experiment to assess it. In these cases, CA can credibly assess cause and effect issues. This is an appropriate method to use for this research given the nature of the bill examined. Since the bill affects families with parents who have a precarious migration status, measuring its performance is challenging for two main reasons. First, there is limited data available on precarious migrants. Secondly, it is difficult to gather data by speaking to families with a precarious status directly due to increased ethical concerns as well as potential fear on the part of interviewees about speaking to a researcher due to their legal status. Instead, I can provide reasonable evidence about the contribution the bill is making towards healthcare accessibility

by examining other evidence for and against the developed theory of change. In addition, CA has been used in previous studies in order to evaluate public health interventions, such as those conducted by Choi et al. (2023) and Biggs et al. (2014), showing the applicability of this approach to public health evaluations.

The selection of Montreal as a case study constitutes a local knowledge case (Thomas, 2011), as it is the city I grew up in. Thus I have intimate knowledge of the context, health system and key stakeholders, presenting an opportunity for a well informed and thorough analysis. Additionally, according to the latest demographic report of Quebec, most of the immigrants in the province are concentrated in the Montreal area. (Institut de la Statistique du Québec, 2024). Given this, it is expected that a good number of people affected by this bill will be in Montreal.

Expert interviews were conducted to gather additional evidence in step 5 of the CA. Experts include any person with specialized knowledge or experience on a particular process, including academics, practitioners, managers, etc. (Von Soest, 2023) This data collection method allows the gathering of in depth insight on the implementation of Bill 83 from people with specialized knowledge or experience related to the research question. The experts fell into 3 broad categories: those involved in legal/policy analysis of the bill, those involved with community organizations working with precarious migrants directly, and healthcare professionals working in the public system. The interviews were semi structured, which is considered to be an effective method for expert interviews (Ahlin, 2019). There were predetermined questions developed but the interview was flexible allowing for follow ups and new or unexpected information to arise. Interview guides were created for the 3 categories of experts and the questions differed based on the area of expertise of the participants. All guides included questions on the core research question and the previously identified mechanisms in the theory of change.

3.2 Sampling

Theory based purposeful sampling was used as a sampling technique to identify and select participants for expert interviews.

List of interviewees:

- Élizabeth Sigouin, director and lawyer at La Maison Bleu, an organization supporting pregnant women in vulnerable situations, including those living with precarious migration status.
- Stephanie Harvey, Policy and Advocacy advisor at Médecins du Monde, operating a clinic with free health services for migrants with precarious status
- Mathieu Forcier, Researcher at the commission des droits de la personne et de la jeunesse, an organization that conducted an analysis on Bill 83 to see if it aligned with the Quebec Charter of Human Rights
- Gilles de Margerie, doctor and coordinator of the the clinic for refugees and asylum seekers at CLSC Côte-des-Neiges

Purposeful sampling is a commonly used qualitative research technique. It enables researchers to select and choose cases that are information rich when it comes to the topic at hand. (Palinkas et al. 2015) More specifically, theory based method of purposeful sample is used, which implies picking cases that represent the theoretical underpinning of the phenomenon studied. (Suri, 2011) In this case, interviewees were selected based on their real-world experiences and expertise that could represent the mechanisms previously identified from the theory. Médecins du Monde and La Maison Bleu were identified and selected because as community organizations operating in Montreal providing health related services to migrants with precarious status, they were expected to be well-informed with the phenomenon of interest. This was particularly important to gather information about the effects of the implementation of Bill 83 on the people concerned, without being able to speak to this population directly. This way, I could still evaluate how all the mechanisms involved

in the implementation of Bill 83 are playing out in practice. Dr. Gilles de Margerie was identified and selected due to his position working in a CLSC specifically working with refugee populations. His insights were expected to provide a better understanding of how migrant populations interact with and experience the public healthcare system and evaluate the mechanisms in bill 83's implementation. Finally, Mathieu Forcier was identified due to his involvement in the legal analysis done by the Human Rights and Youth Rights Commission on the proposed Bill 83. His in depth knowledge of the details of the bill and its formulation are particularly useful for understanding the eligibility mechanisms and the newly defined criteria.

3.3 Ethical Considerations

Semi structured interviews were conducted with 4 participants. The interviews do not involve vulnerable populations. While the topic of my research concerns vulnerable populations (children and migrants), the data collection and interviews do not involve speaking to members of this group, but professionals with expertise on the topic. The participants Include professionals at community organizations working with individuals with precarious status, a doctor working in the public system focusing on refugee healthcare, and a researcher working for the commission of human rights who has conducted a legal analysis of Bill 83.There are no identifiable risks to my safety, and no risk to the safety of participants of the research. The research will not cause participants any undue stress, loss of self-esteem, psychological injury or physical harm. Harm is not expected in their future life as a result of participating. My research does not involve collecting, using, or disclosing sensitive data or Information. Participation was entirely voluntary and participants could withdraw at any time. Informed consent was obtained of participants free from coercion. The Informed Consent and Proposal Ethical Review Form documents provided by IBEI were reviewed and accepted by the ethics review board, and used to obtain consent from participants. The main objective, methods, benefits, risks and confidentiality measures undertaken in the research were explained to participants. The consent forms were provided in the language of the participants choice (english or french) and I ensured everything was clear and answered

questions that arose. In order to ensure confidentiality of participants and their data, data obtained from the interview (transcript) was stored securely, using password protection. In addition, only I have access to this data for the research purposes. I will destroy the data once no longer needed following data retention policies.

3.4 Data Collection and Analysis: Contribution Analysis

The six steps of the contribution analysis are outlined below.

3.4.1 Identification of Cause and Effect Issue

The main problem to be addressed is to what extent has the implementation of Bill 83 contributed to its intended outcome of improving the healthcare accessibility of children of precarious migrants in Quebec? The contribution of bill 83 to increased healthcare accessibility is evaluated based on various dimensions involved in the implementation process. Given the size of the intervention, the magnitude and nature of the problem an important contribution by the intervention is likely. The change in the law on paper has led to the inclusion of nearly 15 000 children accessing the public health insurance system each year. Not only that, the children in question face increased vulnerability and increased risk of poor health outcomes. Given the combination of the size of the intervention and the severity of the issue, it would be reasonable to conclude that the introduction of bill 83 has indeed significantly contributed to an increase in healthcare accessibility for this group.

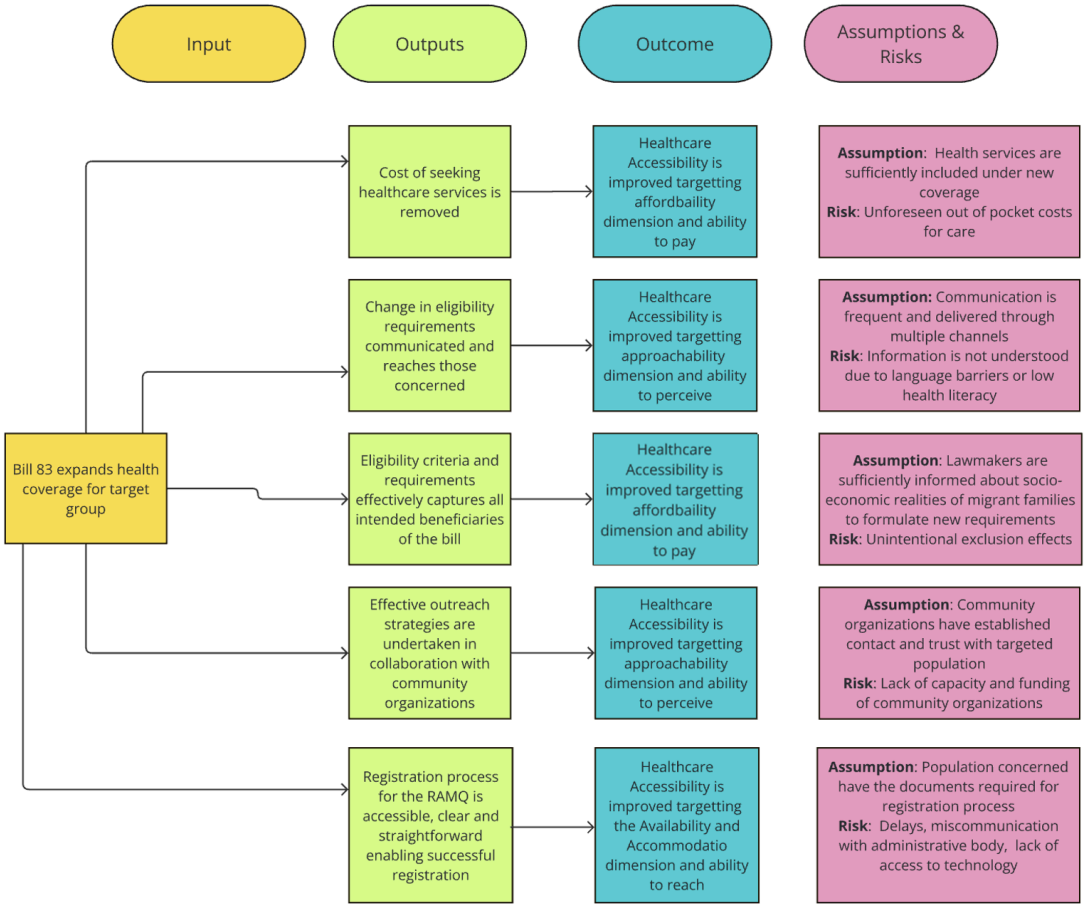
3.4.2 Theory of change and Existing Evidence

A theory of change was developed to explain how the bill is expected to work, and concerns the main activity of the intervention and the expected outcome. In this case, the main activity of Bill 83 is the expansion of healthcare coverage, making children of precarious migrants eligible to register for the RAMQ. The expected outcome is the improvement of this group's access to healthcare. Mechanisms represent the specific processes that translate the main activity of the bill into desired outcomes (Astbury & Leeuw

2010), in other words through what specific processes is bill 83 expected to increase healthcare accessibility? The mechanisms are informed by the literature on healthcare accessibility (including Levesque's framework), insurance coverage expansion and the experience of migrants with healthcare and process informed by Astbury. The expected mechanisms are illustrated in the logic model below:

Figure 2:

Logic Model of Theory of Change



The logic model represents the ways in which Bill 83's implementation is expected to increase healthcare accessibility. The main mechanisms are based on the literature of strategies for insurance expansion, according to which the successful implementation of health policies and insurance programs relies on clear communication, effective outreach and enrollment strategies, partnerships, appropriate formulation of eligibility requirements and the reduction of administrative burdens. Each mechanism is expected to increase healthcare accessibility by targeting a dimension of healthcare accessibility as defined by the Levesque Framework. For example, by removing the cost for health services, the implementation of Bill 83 will increase healthcare accessibility by targeting the affordability dimension of healthcare accessibility, and improving a person's corresponding ability to pay for healthcare. Similarly, by clearly communicating the bill and its details, the implementation of Bill 83 improves healthcare accessibility by targeting its approachability, and a person's corresponding ability of a person to perceive care available to them. The logic model also includes the risks that could undermine the functioning of the mechanisms and assumptions under which the activities are expected to work.

In step 3, available evidence was gathered on the theory of change. This step revealed a large lack of evidence and gaps in knowledge when it comes to the functioning of these mechanisms. No systematic or official evaluation of the law had been conducted, and information availability was limited to secondary data, mainly consisting of comments and concerns raised in the media. The claim faces some initial weaknesses based on the available evidence gathered. The main disputation of the predicted contributions were issues with the eligibility formulation and administrative burden. Concerning the formulation of eligibility, the human rights commission of Quebec published its concerns in April of 2021, claiming Bill 83 would continue to exclude a significant number of children whose parents have precarious migratory status from health insurance coverage. For example, children who are Canadian citizens and whose parents are unable to provide proof of residency authorization issued by Canadian immigration authorities for more than six months in the year following registration with RAMQ, or to attest by sworn declaration to their intention and that of their child to remain in Quebec for that same period of time, would not be eligible for coverage. In addition, children whose parents share custody or who have undergone a change in legal

custody could be excluded by this measure. In addition, children taken into care in Quebec under the Youth Protection Act129 of the Youth Criminal Justice Act130 , placed in substitute care - foster family, rehabilitation center, entrusted to a relative - could be excluded, as they would not be able to demonstrate that they have lived permanently with the parent residing in Quebec. (Commission des droits de la personne et de la jeunesse, 2021). Concerning the administrative process, Doctors of the World Canada, a clinic offering free healthcare for migrants with precarious status in Montreal, warned that even with the new bill there are remaining obstacles to the children in question accessing the health insurance system including the creation of complicated and unnecessary administrative procedures. Similarly, Jill Hanley, an Associate Professor at the School of Social Work and the Scientific Director of the Sherpa Research Institute on Migration, raised the same concerns, that the procedure for children of people with precarious migratory status' remains complicated. (Mazerolle, 2021) The existing evidence gathered refutes the eligibility formulation and registration process dimensions of the intended contribution claim. However, the strength of these refutations are weak, not only because it consists of secondary data, but it focuses on potential issues raised before the official implementation of the law. However, they still represent potential issues with the logic of the contribution claim, that can be revisited once additional data is gathered. At the time that this step was conducted, the rest of the causal links did not have any evidence refuting them.

In terms of evidence confirming or supporting steps in the logic, there is evidence that community organizations initiated outreach activities to spread the information with Bill 83 to the targeted beneficiaries. Médecins du Monde has been very active in posting information, explaining registration procedures and working directly with the targeted population to ensure the information is transmitted. This evidence is strong, considering the mandate of the clinic is to specifically provide services for migrants with precarious status in Montreal, so it can be assumed that their involvement in outreach activities while working with the population directly impacted by the law would have positive effects.

3.4.3 Assembling and Assessing the Contribution Claim

In step 4 the strengths and weaknesses of the steps in the outlined program logic are assessed and the contribution story starts to be assembled. The original contribution claim is that Bill 83 will increase healthcare accessibility by expanding insurance coverage, well communicating the change to those concerned, undertaking outreach activities, appropriately formulating eligibility requirements to target all beneficiaries, and ensuring the registration process is easy and accessible. This is challenged by the review of existing evidence. While limited, it pointed to some potential weaknesses due to issues of eligibility formulation and administrative burden. However, much of the evidence focuses on potential warnings or concerns, and were raised before the official implementation of the law. The majority of the causal links don't have any evidence raised against them, such as the financial barriers, outreach and communication.

3.4.4 Additional Evidence and Revising the Contribution Story

In step 5, additional evidence is gathered to support or refute the contribution story. Based on the lack of robustness and credibility of the contribution story in step 4 due to limited data and information on the implementation of Bill 83 in practice, new data is needed in order to analyse the causal mechanisms involved in the contribution claim. Experts interviews were conducted to gather additional evidence and gain further insight into the implementation of bill 83 and assess the contribution story. Interviewees were contacted via email, written informed consent was obtained and interviews were conducted on Microsoft Teams. They were semi-structured and lasted between 30 and 45 minutes each. Interviews were automatically transcribed by Microsoft Teams and revised manually and adjusted after the interview. 3/4 interviews were conducted in French and translated into English, first using automatic translation, and then revised and edited manually. The data was analysed using NVIVO. Coding was conducted in multiple cycles, as codes were continually reconfigured and refined. Both inductive and deductive analysis were conducted. Deductive codes were

initially developed from the mechanisms set out in the theory of change. An inductive analysis of the interview transcripts was also conducted, in order to see patterns and themes that emerged from the data that weren't previously developed. The final version of the codes were grouped into categories and themes and the relationship to the theory, portrayed in figure 3.

Figure 3

Final codelist classification

A codelist with a description and examples of each code can be found in the appendix.

Upon coding and analyzing the data the contribution story was revisited in step 6. Some contribution claims were strengthened and others were weakened, and the likelihood of the contribution claims were reassessed. In addition, 2 additional mechanisms were identified from the analysis of additional evidence that are added to the TOC.

Affordability

Findings on the extent to which bill 83 to improved healthcare accessibility for this group of children by targeting the affordability dimension of accessibility were mixed. The claim that bill 83's implementation improved healthcare accessibility through the appropriate formulation of eligibility criteria that include all intended beneficiaries was strengthened by the data gathered. While the exclusion from medical coverage based on eligibility formulation was originally identified as a risk, overall findings found that the issues had been addressed between the proposed law and the adopted version. While there could still be unseen exclusion effects, organizations on the ground also did not consider this to be an issue. The claim that the cost of obtaining health services would be removed when people have access to the provincial health insurance is moderately strengthened, supported by the findings that once these children have their RAMQ card the financial barrier is lifted, and they have access to the healthcare system as everyone else does.

However, an additional mechanism was identified through interviews with community organizations that revealed that many children who qualify for coverage under this bill are being wrongly billed. This is predominantly being done in hospitals once a baby is born, ignoring the presumption of admissibility specified in the bill. It is from this that the effective communication of coverage changes to health establishments mechanism was developed and added to the TOC. In order for Bill 83 to improve affordability and remove costs, healthcare professionals and administrative staff in public hospitals and clinics must be aware of the bill and its implications so that patients aren't mistakenly charged. This mechanism, while essential, is ultimately found not to be functioning effectively, undermining the contribution of Bill 83 to improve accessibility through targeting

affordability. Further evidence is required to analyse the extent, method and organization of communication between the ministry and health establishments.

Approachability

The findings on the extent to which bill 83 to improved healthcare accessibility for this group of children by targeting the approachability dimension of accessibility were also mixed. The claim that Bill 83's implementation improves healthcare accessibility by clearly communicating the bill and its details to its intended beneficiaries is weakened by the gathered evidence. All participants raised concerns over the quantity and effectiveness of official communication towards parents with precarious migrants over the newly expanded coverage for their children. Issues of families being unaware of their rights, eligibility and services were raised, hindering their access by ability to perceive healthcare services as available.

In contrast, the contribution claim of outreach strategies was examined and strengthened by the findings. Despite there not being an official collaboration made between the government and community resources, the latter has mitigated a lot of the communication problems and contributed to the increased accessibility of healthcare by targeting the approachability dimensions and increasing families ability to perceive services. Community organizations have demonstrated initiative in undertaking outreach activities and are very involved in informing people of their eligibility status.

Availability and Accommodation

The findings on the extent to which bill 83 to improved healthcare accessibility for this group of children by targeting the availability and accommodation dimension of accessibility are mixed. The evidence for the contribution claim of the clear and accessible registration process is mixed. One one hand, the process for registration is described as having greatly improved, becoming a lot quicker and easier. However, delays persist, short validity periods

are issued on children's health cards leading to further administrative burden, and the navigation of the administrative side of healthcare is complicated by the realities faced by migrant families, such as language barriers and lack of reliable technology. These factors undermine the availability and accommodation of health services, and people's ability to reach care in a timely and appropriate manner.

Appropriateness

An additional mechanism was found through analysis of the additional data and added to the TOC. This is the availability of interpretation services in healthcare facilities, targeting the appropriateness dimension of healthcare, referring to the appropriate fit between provider, care and the patient. This affects a patient's ability to engage meaningfully in their care to contribute to positive outcomes. The lack of systemic interpretation services in Montreal hospitals was identified as a significant barrier to healthcare accessibility for migrant patients with precarious status that may have limited knowledge of French and English.

Overall, the evaluation confirmed that the formulation of eligibility requirements and outreach strategies by community organizations contributed to increase health care accessibility. In contrast, evidence failed to support the contribution of the official communication mechanism. Doubts were raised about the strength of the contribution of the removal of financial costs for healthcare services and the registration process mechanisms, as these were subject to mixed findings. The revised contribution story also includes two new mechanisms, the communication with healthcare establishments and access to the interpretation services, that both found very weak support in the evidence. Overall, it is reasonable to assume the program *has* contributed to the intended impact of increasing healthcare accessibility. However, many of the mechanisms identified in the theory of change are not functioning as intended, pointing to implementation issues.

Results

The 4 interviews with professionals from the Human Rights and Youth Rights Commission, La Maison Bleu, Médecins du Monde and CLSC Côte-des-Neiges provided in depth information on the practical dimensions of Bill 83's implementation. The insights drawn from the interviews allowed the refinement and strengthening of the contribution story. The main results are structured and presented under 4 themes: 1) Financial Barriers and Ability to Pay, 2) Administrative Burden and the Ability to Reach, 3) Communication and the Ability to Perceive and 4) Socioeconomic Barriers and the Ability to Engage.

Theme 1: Financial Barriers and Ability to pay

There were initial concerns raised about the formulation of eligibility criteria and requirements, which were feared to cause unintended exclusion effects, preventing intended beneficiaries from obtaining healthcare coverage. Participants generally did not take issue with the formulation of the eligibility of Bill 83. Community organizations working on the ground did not find this to be a large issue among the people they work with. A researcher from the Human Rights and Youth Rights Commission explained that between the proposed and adopted law, many of the initial concerns were addressed. Changes included the addition of a firewall between health and immigration services, an abolition of the three-month waiting period for children's healthcare services when arriving to the province, an acceptance of alternative proofs of residency such as school attendance records that were more sensitive to the realities of migrant families, and the inclusion of all children residing on the territory, not only Canadian born children.

> In the proposed bill, it's children who are in an irregular situation… children of parents in an irregular situation but not born in Quebec, not born in Canada, were excluded. So that was an important change, between the introduction of the bill and its adoption.

All participants noted the significance of the bill and its expansion of coverage for children of precarious migrants in Quebec.

> I think that since the adoption of the law the ministry said it was almost 20 000 children who are now admissible. And its children who are in situations of vulnerability that are particularly acute, and their inaccessibility to health services adds to a set of social determinants of health that negatively impact their health. So, it's still pretty major the fact that there's children that now, if the parents are able to give the, if the child attended a school, If the parent is able to demonstrate their intention to stay, they have access to health services. It's still pretty, um, it's a major advancement for these children that this was not the case for before.

Once children *have* their RAMQ card they have access to the public system just like anyone else

> it's not so much about access to go to the institution, if you have the card, everything is fine

However, community organizations also reported numerous occasions where eligible children continue to be wrongly billed for healthcare services in Quebec. There is a presumption of eligibility outlined in Bill 83, which posits that healthcare professionals should assume that a child born in Quebec is automatically admissible to the RAMQ and shouldn't be charged for care. However, in practice, many hospitals are not respecting this presumption of admissibility and continue to bill families for their children's care after birth, causing significant financial stress.

> The woman receives a bill in her name for her delivery, but the child is also billed for care given to the child. The child received a bill in his name. So, in my opinion, that's not what the law intended.

Families are often told that once they provide a letter from the Quebec Insurance Board declaring the child as admissible, the bill will be cancelled. However, the process of getting the bill cancelled can be both confusing and lengthy and the financial stress is still present in the meantime, especially with the potential beginning of the debt collection process.

> Except, in the meantime, the family is super stressed, and receives a letter for 40 000 dollars. Sometimes it can take a long time to get this letter from the RAMQ, and depending on if there are issues, if they didn't send the right papers, all this can take time. It's extremely stressful and I don't know at what point, for example, the hospital calls to say hey you have a debt, you have to call us back.

Not only are families given bills for care given to their children despite the presumption of eligibility, there is also a lack of understanding that the bill is temporary at all, even if hospitals have claimed to have communicated it, making the financial stress substantial.

> Often, they're immigrants who don't speak English or French, so maybe they didn't understand. Clearly, they didn't understand, so whether they said it or not I don't know, if it was understood or not, clearly not.

This language barrier not only prevents people from understanding the details of the communication on behalf of the hospital, but also makes it difficult to contest a wrongful charge and uphold your rights in the moment.

> So if you are a mother, giving birth in a hospital, and you don't speak English or French unless the people who are filling out the paperwork at the hospital administration level know what they're doing, I don't know how you could defend yourself.

Regardless of knowing if the bill can be cancelled or not, the hospitals in theory should not be charging at all. This brought up another relevant factor in the implementation of Bill 83, and that is the communication of the law to health institutions. In order for the financial

barrier to be removed, the health establishments have to be aware of the details of bill 83 and the presumption of admissibility, and this isn't always the case.

> The health system also has to be aware and play this role there too when they are in front of a family, I'm not saying that they don't do it, but they themselves are not always aware of it, you know of the details of the law. You know, people hear yes, PL 83, People start yes, Everyone knows about PL 83, but the details of the law, people don't know it, which means that there are billings, there are things that are done when they shouldn't.

There have been newsletters and information sent out to health establishments by the ministry of health, but doubts are mounted over whether these have been sufficient to effectively spread the relevant information. While community organizations have been proactive and taken initiative to spread the word, they ultimately see the government as being in charge of widespread communication within the health system.

> It's clearly a problem of communication, of information, of directives, of MSSS policy that didn't transmit the information properly.

A potential contributor to the lack of knowledge of the law and its details among healthcare professionals is the large proportion (80%) of general practitioners working out of clinics known as family medicine groups (GMF). In contrast to local community services centres (CLSC) which are clinics and public hospitals and clinics run by the government, these GMF's are privately run. While they accept the provincial health insurance (RAMQ) so patients don't have to pay for care, it can be run by a private company or a group of individuals. Because they are not intimately linked with the public sectors like CLSCs are, they do not receive the same kind of information. Referring to his experience with doctors in the public health system being aware of health coverage for asylum seekers, the coordinator of a public clinic specialized in providing care for asylum seekers and refugees attested that knowledge was particularly low amongst physicians working at GMFs.

> I mean, it's 80% of family physicians work in GMF's in Montreal, right? Only 20% are in CLSCs. So because I spend a lot of time trying to educate physicians about IFHP coverage and offering good medical care to asylum seekers, well I realised a couple of years ago that GMFs they just don't know anything about the IFHP coverage right. So I would be giving lunch talks about how… so I think you'll find that there's the same type of difficulty communicating information.

While his example focused on specific coverage for asylum seekers, it speaks to a larger phenomenon of a difference in information received by government run clinics and privately run clinics. It can reasonably be assumed that this gap may exist in the information communicated regarding bill 83 as well. Given the proportion of general practitioners operating out of GMFs, this is a significant factor. Even if emails and communications *are* being sent out the GMFs at the same rate as the CLSCs, doctors often receive large amounts of communications and aren't always aware of all relevant changes in the system.

> So access to care because of clinic administrative personnel and physician ignorance is rampant, right? And that's something hard to palliate because I get it. Doctors are really busy and they're drowning in all the emails that I'm drowning in.But to you know, to get precise, you know sort of very pinpoint information about a percentage of their population that needs care, it can take time, it will be a challenge for sure. And physicians have to they scan their emails like I do and I get like 40-50 a day. So I trash a lot of them. You know, I read the subject matter and I flush them right? So if you don't see a lot of paediatrics and you see a CMQ email that talks about, you know, you know, law change for paediatrics, you could flush it. Right. So you're not aware, so it's very, I mean I think it's a, it's a systemic problem of the difficulty of communicating these types of access to care or new changes to access to care.

This reveals a core challenge in the communication of public health policy changes to healthcare professionals and healthcare institutions, and serves as a barrier to Bill 83 being implemented as intended.

Theme 2: Administrative Burden and the ability to reach

While the registration process initially faced many issues, registration is reportedly quicker and easier and has largely improved over the last 6-8 months.

> well you know, there is a phone number now from the RAMQ that we can call and the registration process is done quickly. In fact, at the beginning, there were a lot of problems with registration, but it's much better, it's really improved.

However, many migrant families targeted by this bill express confusion about the registration process, seeking advice and assistance from community organizations.

> We cannot forget that there are still families who are really in a very precarious situation, who do not necessarily speak the language, they do not necessarily have access to computers, to the telephone. So you know, it's more that, you know we're not faced with someone, you know who speaks French very well, who has full connection at home, there's no problem and they're done in 3 minutes and everything is fine.

The steps, processes, documentation required and communication with the RAMQ are not always understood, and more complex due to facing extra documentation and proof requirements than someone born in Quebec. In addition, the unique realities facing migrant families make it more difficult to navigate the administrative side of the health system, whether that be language barriers, lack of technology and internet connectivity.

> I mean communicating with an anglophone or francophone who's lived in Quebec their whole life can be challenging when you talk about the healthcare system, right, and you say ohh, you just gotta do this and this because it's full of acronyms and and people get dizzy and a little nauseous when you start talking about it.

Community organizations like Doctors of the World play a large role in supporting families with the administrative side of this. Everyone visiting the clinic consults with social workers who can support them in their processes.

> So I would say that we don't see these children anymore from a medical point of view, because they have access now, but we accompany and provide a lot of support to the families for the registration to the RAMQ

Not only can the process be difficult to navigate, when errors are made with registration, this creates delays in obtaining the health card preventing people from reaching health services. Even without error, there can still be a 2-3 month delay before a child receives their RAMQ card, limiting their ability to reach care during this waiting period.

> The child may wait 2 months until, he receives his RAMQ card, but during those 2 months, if the child needs access to care, the family must pay because there is no principle of presumption of eligibility for children who were not born here

Another significant issue is the observed practice of expiry date on these children's health cards being set in accordance with the expiration date on their parents immigration document (for example, work visa). Normally, RAMQ cards issued for children have a duration of 8 years. This practice undermines the intention and formulation of the law, that claims that the child should have access to care regardless of their parents status. As discussed previously, families can experience difficulty with the registration process and face delays in obtaining their child's health card. By having a shorter period of validity, this places families in the position of having to needlessly repeat the same process that may have been a challenge to begin with

> But very often, what we notice is that the date is really at the same time as the end of the parent's work visa and sometimes, it's already long, well now, the registration is faster, but you can receive your card 2-3 months later, then the card expires 8 months

after you receive it. So then you have to restart the whole process again, the parents, because they put the same date when they shouldn't.

Theme 3: Communication and the ability to perceive

Many doubts were raised over whether the official governmental communication of the law and the changes it brought about were effectively communicated to those it effects.

> I think the crux of the matter is all about information and access to information and how transparent the provincial government is about this new access to care. Which is fantastic, like I read it and I said, well, you know, kudos to us were humane.We realised that you know that children need care and there shouldn't be a délai de carence, so that's all well and good, and that's fantastic. But as other things that they've done in the past, how well is it actually delivered to the people that it's targeting, right? Because I mean, I read about it, but you know how many parents or pregnant mothers are aware of it?

Community organizations spoke to the fact that many people aren't aware of the bill and what it entails

> That's it, they aren't informed. To my knowledge, if there were awareness campaigns, they weren't reached.

While the ministry of health did not collaborate with community resources formally for outreach programs or awareness campaigns, community resource were extremely proactive in not only disseminating information, but accompanying family in navigation bureaucracy and health system in order to access care, in a way that seems to mitigate some of the issues from the lack of official collaboration or communication on behalf of the government.

> I think there is a big communication issue in terms of the access for children, even when going to the RAMQ website this morning, isn't it super clear the information that's being communicated as to the fact that kids now are eligible. Especially for

parents in this situation, I think it takes information that's very, very clear. And fortunately, there are organizations like Médecins du monde with their clinic that does that work.

Community organizations generally recognize their potential to raise awareness and communicate information, and recognize that community organizations are usually the first point of contact with vulnerable families, so they are able to inform them.

So we're just telling them what it is right now, but it's clearly not the government that's going to explain it. It's more the organizations on the ground, the people who provide services, who are going to explain it, who, who are taking charge of it.

Despite the crucial role and initiative of community organizations, the need for accessible and clear communication from the government is still needed. The issue of awareness of services available and eligibility are compounded by language barriers and precarity, and the accessibility of the information is an issue, given that it is not available in several languages.

Or even the information, the information to say that what the law exists should be in several languages and yet it’s not.

Theme 4 Sociopolitical barriers

Although not originally developed in the theory of change and initial contribution story, it became clear when analysing the data that socio-political barriers presented a large barrier to realized access. Most significant of which is the language barrier. Despite the availability of budgets for interpretation services in hospitals, these resources are underutilized and hospitals in Montreal do not have systematic access to interpretation, despite 13-15% of its population being allophone, speaking neither English or French.

Because the orthopaedic surgeon opened the door and the patient looks at them.And they just say Iran, Iran, I come from Iran, I can't speak.And the doctors like “oh my God, how am I gonna do this?” And then says, hey, can somebody get me an Iranian

> interpreter? right, so they shoot it on the overhead. And the guy who's passing the mop down in the second basement says he's an immigrant from Iran. And he says I can go do this and he'll go upstairs. It's completely unprofessional and it's completely ad hoc, right? It's it's, it's improvised, and this has been going on forever.I mean, as long as I've been practising medicine, when you're in a hospital, you hear this.

The random and unreliable nature of current interpretation practices in Montreal hospitals significantly hinders effectively the ability of patients to receive quality informed healthcare. Not only that, it hinders the continuation of their care. One doctor describes receiving consultation reports from specialists apologizing for a lack of medical history because the patient didn't speak English or french.

> It's something that I mean, if I think if immigrants did know their rights better, they would have sued, you know, hospitals a long time ago.

In reference to asylum seekers specifically who do not speak English or French, this doctor found that patients were often unaware of their care, follow ups, diagnosis and not able to engage meaningfully with their own care. When speaking about his patients who are majority asylum seekers, said:

> My patients don't know what specialists told them, right? I said "oh so you saw the cardiologist. What did he say?" "I don't know." You know, "he said he'd see me again.And he asked for tests". So they don't know what the diagnosis is.

This speaks to a larger issue of the appropriateness of healthcare accessibility, referring to the fit between provider, care and the patient. This affects a patient's ability to engage meaningfully in their care to contribute to positive outcomes. It speaks to limits of Bill 83's ability to increase healthcare accessibility in face of such structural issues that persist regardless of expanded coverage.

Empirical discussion

The findings add to the literature on strategies to improve the implementation of healthcare coverage expansion policies and bridge the gap between access and utilisation. More specifically, there are a few practical takeaways and recommendations that can be drawn from the results.

Strategies for Communication within Health Establishments

One of the key takeaways from the findings is that in order for an expansion of coverage to be successful in contributing to increased accessibility, the details and practical changes must be well communicated to health establishments. A lack of knowledge around the details of expanded coverage lead to confusion, wrongful charging, and financial stress, limiting the effectiveness of such policies. The communication between the ministry of health and their large network of healthcare establishments proved to be a challenge, and future policies focused on expanding health coverage should consider this challenge and enact preemptive strategies to address it. In addition to working on the method, delivery and strategy underpinning the communication, consideration should also be given to the structure and administration of different health facilities (public vs private) and the communication channels they have access to when disseminating information.

Communication & Administrative Burden

According to findings many people were not aware of the status of their eligibility and had difficulties navigating the registration process. This adds to the body of evidence that communication of health changes should be user-friendly, accessible and available in multiple languages. In addition, despite the simplification of the registration procedure, individuals in situations of precarity still faced difficulties due to factors such as language barriers, lack of access to technology. Both the experience with the communication of the bill and the registration process points to the need for healthcare policies to consider the additional barriers vulnerable groups face in navigating health information and administration, and adapt accordingly.

Investment in Community Organizations

When policies are being implemented to expand healthcare coverage for vulnerable groups, investments should be made into community resources on the ground that have established a relationship of trust with the intended beneficiaries. Findings from this study have shown the strong evidence of the positive role of community organizations on enhancing the contribution of Bill 83 on healthcare accessibility by assisting with the communication of the bill and making people aware of their eligibility, as well as assisting with the registration process. By formalizing ties with community organizations and ensuring they have the financing to raise their capacity, policymakers would be increasing the likelihood that their policy change contributes to its intended outcome.

Interpretation Services

In order for all dimensions of healthcare accessibility to be realized, patients must be able to engage meaningfully in their own care, which can't be done unless the services provided are appropriate and fit the needs of the patient. The findings from the lack of interpretation services in Montreal hospitals shows the consequences of lack of systematic access, where patients cannot communicate with their healthcare provider and their continuity of care is jeopardized. While expanding healthcare coverage for specific groups is a start, sufficient resources must be invested into the health system to fix structural issues that stand in the way of appropriate health services being delivered. Not only should resources be invested into healthcare, but how these budgets are used should be monitored transparently to ensure sufficient investment is made into resources that improve the suitability of care for a diverse patient base.

Conclusion

The adoption of a law like bill 83 is a large advancement in itself. The legal and regulatory allowance for a group of children to register for the provincial health system makes in itself a massive contribution towards their access to healthcare. This study aimed to evaluate Bill 83's contribution to healthcare accessibility defined more broadly, beyond this legal access. By evaluating evidence for and against the theory of change after gathering additional data from expert interviews, I was able to assess this contribution. Ultimately, it is reasonable to assume Bill 83 did contribute to increasing healthcare accessibility, specifically its affordability. By allowing children to obtain a RAMQ card, these children can access the public system free of cost. This was supported by the reformulation of eligibility criteria that were more sensitive to the realities of migrant families. However, this contribution was weakened by a number of implementation problems. For one, an additional identified mechanism, the communication of the law between the health ministry and health institutions, weakened this contribution by leading to wrongful charges causing financial stress. In addition, while issues were found with the communication of the bill and the registration process, the presence of community organization and their outreach activities mitigate a lot of these effects, maintaining a moderate overall contribution to the approachability and affordability & availability of healthcare services. An additional mechanism was also identified, that of the availability of interpretation services resulting in improved appropriateness of healthcare, which Bill 83 had no effect on. This last point reveals the potential limits of policies expanding healthcare coverage. It may only be feasible to target certain dimensions of healthcare accessibility through such public health policies. Appropriateness, for example, may involve structural issues that need to be addressed separately. From the findings, the expansion of legal access seems most suited to improve the affordability, approachability and availability & accommodation dimensions of healthcare accessibility. It is realistic to aim to include the mechanisms within these as part of the decisions and strategies undertaken as part of a public health policy. Accordingly, further study can be undertaken on the limits of expansion of coverage on improving healthcare accessibility, how to address structural issues within health establishments, and how to accommodate multiculturalism in public health systems to ensure the appropriateness of healthcare services and how to improve

health policy communication on a large scale between central governments and public health establishments.

Many sources of uncertainty remain. For one, because I only had access to "outside experts", there is a potential risk of bias among the sample of experts interviewed. (Von Soest, 2023) A more comprehensive analysis would include a mix of inside and outside experts, for example by also interviewing someone from the ministry of health or administrators at the RAMQ. Another source of uncertainty is the lack of consideration of short and long term effects. The implementation of the law is dynamic and changes may occur in the short vs long run, something that has not been accounted for in this study. While this study presents an overview of the implementation this far, it doesn't specifically address its evolution over time. Additionally, some additional data would be useful in strengthening the contribution story. For example, speaking to families registering their children for the RAMQ directly about their experience, an analysis of the difference between emails sent to GMFs and CLSCs by the ministry of health, etc.

Nonetheless, both the successes and challenges of Bill 83's implementation identified within the scope of this research present an opportunity to improve not only this policy's implementation, but others like it. Through continued research, policy adjustments, and strategies, the persisting gap between legal access to care and realized access can slowly be bridged, improving healthcare accessibility.

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Appendices

Codebook

Code	Description	Example
Communication with health establishments	This code includes statements related to the communication of information on Bill 83 to health establishments	"Clearly it wasn't well communicated to all the hospitals and the establishments"
Exclusion from coverage due to eligibility formulation	This code relates to the formulation of eligibility criteria in Bill 83 and mentions of groups that are excluded as a result	"In the proposed bill, children of parents in an irregular situation but not born in Quebec, not born in Canada, were excluded."
Child billed for care	This code includes mentions of children who should be covered by RAMQ under the new law getting billed for health services received	"And so, at that moment, the woman receives a bill in her name for her delivery, but the child is also billed, for care given to the child. The child received a bill in his name. So, in my opinion, that's not what the law intended."
Financial stress	This code encompasses mentions of financial stress caused to families due to their experience with the healthcare system	"Except, in the meantime, the family is super stressed, and receives a letter for 40 000 dollars."

Coverage for pregnant women	This code includes mentions of the medical coverage for pregnant women	“we highlight the particular vulnerability of irregular migrant pregnant women by pointing out that there are risks of not having access to prenatal care”
Language barrier	This code includes thoughts and statements regarding language barrier experienced by patients	“I get consults back from specialists all the time and all they just it's like there's a mea culpa up on the top corner saying poor historian only speaks Farsi or accompanied with by daughter who speaks minimal English.”
Fear of immigration authorities	This code includes statements related to families fear of being reported to the immigration authorities or being deported due to their status	“and then they know, it's also difficult when you don't have a status to fight back because you’re always afraid of being deported or whatever it is”
Socio-economic realities of migration	This code encompasses mentions of unique socio-economic realities faced by migrants, such as family structure, technology access and housing.	“it really misunderstood the realities of migrant families who often one parent leaves with the child, then the other parent joins.Then there are separations, and the paths aren't linear”
Collaboration between health actors	This code refers to collaboration between actors involved in the health system, such as hospitals, clinics, and health NGOs.	“so we have a lot of partnerships with a lot of establishments, so we're going to, we're going to direct them to the establishments that we know well”
Role of community organizations	This code includes statements about the role of community organizations and their activities	“it's clearly not the government that's going to explain it. It's more the organizations on the ground, the people who provide services,

		who are going to explain it, who, who are taking charge of it.”
Awareness campaign	This code refers to any statements mentioning the presence of awareness campaigns about Bill 83 and its details	“That’s it, they aren’t informed. To my knowledge, if there were awareness campaigns, they weren’t reached.”
Awareness of services	This code includes statements about individuals awareness of health services available to them	“I mean people and it's quite easy to imagine that if you come from anywhere, except Canada And even if you are Canadian, you don't really understand the the mechanisms of the the the services that are available.”
Awareness of eligibility	This code includes statements about individuals awareness of the status of their eligibility for health coverage	“then this can contribute to a fear and make it so they think their children are not eligible”
Clear communication with migrant families	This code includes statements about the communication of Bill 83 and its details to targeted families	“how well is it actually delivered to the people that it's targeting, right?”
Administrative complexity	This code includes statements about the complexity of navigating the administrative side of healthcare system	“They receive documents, they have to resend others, so just like sending the documents at the post office, putting in the right address, it's all a bit complex. It sounds crazy, but that's it”
Difficulty with registration process	This code includes statements about the experience of relevant families in completing the registration process for the RAMQ	“Yes, he finds it difficult. They often come to see us about it. They don't understand what they have to do, Yes, it's very complicated”

Proof required for registration	This code specifically refers to statements regarding the proofs of intention to reside required to submit in order to obtain the RAMQ card	“I think they can show a lease, for example, of a dwelling, a lease in their name, but there are a lot of people who live in people's homes, so they don't necessarily have a lease in their name.”
Waiting period and delays	This code refers to statements regarding the delays and waiting periods for obtaining the RAMQ card	“where there is a delay, you know, between the time when parents have to prove that they want to settle down and getting the RAMQ”
Expiry date of RAMQ card	This code refers to statements about the expiry date put on the RAMQ cards.	“On the other hand, for these children, often what we have noticed is that the date of the expiration for the RAMQ, will coincide with the end of the visa”

Interview Guides

Human Rights and Youth Rights Commission

1. Can you introduce your name, role and the role of the commission?
2. The mémoire starts by introducing what led to the formulation of bill 83, can you briefly explain what the main problem was?
3. What was the main objective of bill 83? By what means was it supposed to achieve it?
4. What were the new proposed "proofs" that would need to be submitted to the insurance board to prove residence in the province?
5. What are some of the main issues you identified with these new proposed alternatives?

   a) proof of authorization by official authorities

   b) declaration of intention to stay in Quebec despite irregularity

   c) proof that the child has lived with the parents permanently since birth
6. Do all the children targeted by this law have access to insurance coverage in practice? Do any categories of children remain excluded?
7. In what ways did the proposed law not align with the charter of human rights of Quebec?
8. In addition to finding the gaps in the bill's alignment with the charter, the mémoire also mentions 3 other preoccupations with the proposed bill. Can you elaborate on these? What are the main concerns with these aspects of the bill?

   -Délai de carence (3 month wait for coverage to start)

   -Need to declare irregular status

   -Incorporation of the right to health into the charter
9. The mémoire mentions 4 recommendations for the proposed law to adhere to the charter, can you elaborate on the importance of these? Are there other

10. recommendations or suggestions that would improve this law?
11. To your knowledge, have any of the recommendations of the commission been adopted?
12. While the mémoire primarily focuses on the challenges of the bill, are there aspects of it that have been positive or succesful?
13. In your opinion, does this bill successfully improve healthcare accessibility for the children of precarious migrants?
14. Do you have any further comments or reflection on this proposed bill and

Community Organizations

1. What is the main goal of your organisation/clinic? Who does your clinic provide services for?
2. What role does your organisation play in supporting children whose parents have precarious migration statuses?
3. What is your role within the organisation?
4. Can you explain the situation children of people with precarious migration statuses found themselves in, prior to the introduction of bill 83?
5. What were the main healthcare barriers facing this group before the bill?
6. What were the consequences of this exclusion from insurance coverage?
7. What is the biggest change that bill 83 brought about for this group?
8. How has Bill 83 impacted the clinic's functioning and provision of services to this population?
9. How was the bill communicated? In your experience are families aware of this change in coverage?
10. What was your organizations role in the outreach and communication of the coverage change?
11. What is the relationship between your organization and the health ministry? Has there been any official collaboration in relation to this bill?
12. What is the process for registering and obtaining the RAMQ for these children now? What are the new documentation requirements? How have migrant families found this process?
13. Do some families continue to seek care with you despite being eligible for public coverage? Why do you think this is the case?
14. In light of this expansion of coverage, are you aware what the experiences of parents and families have been like that are now accessing the public healthcare system?
15. In your opinion, has the bill successfully improved healthcare access for children of precarious migrants? What have been the main benefits and challenges?

Doctors working in the public healthcare system

1. Can you introduce your name and profession?
2. Do you have experience with uninsured migrant families as part of your job?
3. If so, what are the main difficulties in providing healthcare services to this group?
4. Have you heard of Bill 83 ? Was this communicated to healthcare professionals? Through what channels?
5. What do you know about bill 83 and the changes it brings?
6. How has its implementation impacted your work? Have there been any changes to
7. Processes?
8. If a parent brings in their child that does not have insurance coverage, what is the
9. process for seeing them as a patient?
10. Does the clinic/hospital operate under a presumption of coverage for young children?
11. Is there sometimes confusion over coverage and billing for children who present with parents who don't have coverage?
12. What is the process if there is a language barrier with a patient who speaks neither
13. English nor French?
14. How do you approach working with patients from different cultural backgrounds?
15. What are the confidentiality procedures when dealing with a patient who has irregular status? Is there any contact between healthcare institutions and the immigration authorities? Do you have any obligation to disclose information to them?

Interview Transcript Participant A

UGS 3:49

So to begin with, can you tell me a little more about

About The Maison Bleu's objective and who are services primarily aimed at?

Participant A 4:01

Well, la maison bleue, we are a non profit organization, the maison bleu is a OSBL that helps pregnant women in vulnerable situations, so pregnant women come to the maison bleue, have their pregnancy monitored, then we follow her and the whole family, until the child is 5 years old.

So we're an interdisciplinary team where there is a doctor, midwife, so doctor, midwife work together, nurse social worker, psychoeducator, so I said nurse, midwife, social worker uh and lawyer also we've been added to the service, so we do all that everyone together in one small warm place. We don't do the deliveries at the Maison Bleue, it's not a nursing home, it's really for follow-up. They come for their pregnancy, but after that, we catch them for lots of other things. The aim is really to ensure the child's development, the best possible development of the child, and to promote equal opportunities for children to reach the same level. So the women who come to us all have one or more vulnerability criteria. We have a list of vulnerability criteria, which can be social isolation, a precarious financial situation, a mental health problem, domestic violence, Precarious immigration situation, or just recent immigration. So there are several criteria, not just one, often there are several, so there's an initial meeting to assess whether the person, because we have a limited number that we can take anyway. And we have 5 maisons bleu open right now, in Verdun, Saint-Michel, Montreal North parc extension et Côte-Des-Neiges.

UGS 5:38

Ok great, and in your experience, for families with a precarious migratory status, have you seen the impact of this new law and this expansion of coverage for the families concerned?

Participant A 6:01

Personally, I wasn't there, I wasn't working as a case worker, a lawyer at the Maison Bleue before the bill was implemented, so I wasn't there, I can't tell you what it was like.
I can't tell you what it was like. But my teams, the teams talked about it a lot, and I can imagine that all the services that children need but weren't covered, it must have had a major impact, but I can't tell you about the before and after.

UGS 6:12

OK. You mentioned a story in the article of one of a family who is, who went to seek care in the public system and technically, the child should have been covered under like the new regulations, but they were billed.
Can you talk a little more about this or similar experiences?

Participant A 6:47

Yeah well that's the thing, it was one that is typical, it happens to others, we have seen others like that too. Um, the mom goes to delivery at the hospital, she isn't covered, so she's not a refugee, she's not anything, she doesn't have a medical coverage so she goes to deliver. And her baby upon birth needs care, so in that case, there was, I think the child was in intensive care or something like that there was a small complication, it wasn't a lot of days but it was maybe 3 days, but the tariffs increase a lot, a lot. And so, at that moment, the woman receives a bill in her name for her delivery, but the child is also billed, for care given to the child. The child received a bill in his name. So, in my opinion, that's not what the law intended. And what happens in these cases, we were accompanying the family and we checked and the hospital said no but no we send the bill, but once the person has the letter from the RAMQ for the child that said he is declared admissible, they just need to bring that, and we will cancel the bill. Except, in the meantime, the family is super stressed, and receives a letter for 40 000 dollars. Sometimes it can take a long time to get this letter from the RAMQ, and depending on if there are issues, if they didn't send the right papers, all this can take time. It's

extremely stressful and I don't know at what point, for example, the hospital calls to say hey you have a debt, you have to call us back. I don't know if they talk to each other, this I didn't see because us in this file we had intervened, and right a way had said hey you know, leave them be. But me, I wouldn't be surprised that they would be stressed, that they get called back, and I'm not sure they will know that oh no we are just waiting for a X and it's a false bill, it's a temporary bill. You know, it's like the weight is on the person to go show the letter, while it shouldn't be the case in my opinion.

UGS 8:55
And do they give an explanation of why he gives this invoice just to cancel it afterwards? like why there's this process?

Participant A 9:01
Well, they say it's… they sent me.. I communicated with the directors and they said it was a directive, I need to look at this, they told me, that's its, it's a directive of the MSSS..

UGS 9:15
Okay, but they don't communicate with the family?

Participant A 9:16
Yes they communicate with the family, saying, give me money, yeah.

UGS 9:23
OK, but they don't explain the process, their rights, the rules?

Participant A 9:27
No. But they say yes, yes, yes, we explained it, but you know they're immigrants who often don't speak English or French, so maybe they, when they gave the bill, the lady, the accounting clerk said, I don't know, no, no no no it's going to be cancelled, I don't know

what, but you know they didn't understand. Clearly, they didn't understand, so whether they said it or not I don't know, if it was understood or not, clearly not.

UGS 9:54
OK, and is that, is that a common thing you hear?

Participant A 9:57
It's still a bill, it's still a bill, you know, it's it's, even if they said it doesn't matter nana, you know, they shouldn't be given a bill.

UGS 10:05
Yeah, why give it at all. Ok you mentioned the language and the language barrier, is that something common that you hear that people go looking for services and they're not able to communicate with the...?

Participant A 10:05

Yes, well, you know, they're capable as much as they can be, but the person in accounting isn't going to bring in an interpreter to explain.

UGS 10:30
OK.

Participant A 10:31
If he speaks neither French nor English, well, he'll speak a little English, a little French, but you can't understand someone who speaks Punjabi.
You try as hard as, you can, you'll understand yes, no, pay, but you know, the detail won't be understood there.

UGS 10:46

Yeah. And in your opinion, are there, are there other challenges that remain despite this law, you mentioned a bit like billing and then the language barrier... Are there other things that you often see happening?

Participant A 11:04

Well, it's still, there are still documents to send, still more steps than a person who was born in Quebec, like me, my child, I have 3 children, the RAMQ card it's like it arrives pretty simply. You know, I notify the director of the civil codei take a, you know it's a little thing to check off. They, you know still have, they receive a letter, they've got to send some documents, I think they've got a lot of paper to send. Anyway, they've got some sort of proof to do, you know, it's not automatic that your child was born here and you've got it. So that can make it complicated, but it can also cause delays. You know, if they haven't understood everything, what they needed to send exactly, back and forth, communication with RAMQ is never easy, so there you go.

UGS 11:54

Okay, do you know this registration process, to get RAMQ,
like the new documents it requires for this population, do you know a little bit about it, what's the process now?

Participant A 12:08

For refugees as a whole, we've drawn up a little document, here, with CERDA, then PRAIDA. We drew up a kind of document to explain the problems involved, which I can also send to you, so it's a document that we give to the families.

UGS 12:18

Yes, that would be great.

Participant A 12:23

I know, I don't know, maybe there's something in it.

I know they're asking for brown paper, I don't know what else he's asking for, maybe there's something in this document I can look at.

UGS 12:33

OK.

Participant A 12:35

Yeah, wait.

We translate this document into several languages, but that's really for asylum seekers.

So, in principle, the law is a bit different, because here they have the RAMQ, but anyway, before he was covered by the PSSI.

UGS 12:51

OK.

Participant A 13:00

Perfect.

UGS 13:00

And as for this process, as for getting the card, are you aware of how in general the families targeted where concerned find this process, what difficulties are reported?

Participant A 13:14

Yes, they find it difficult. They often come to see us about it. They don't understand what they have to do. Yes, it's very complicated.

UGS 13:27
OK.

Participant A 13:29
They receive documents, they have to resend others, so just like sending the documents at the post office, putting in the right address, it's all a bit complex. It sounds crazy, but that's it.

UGS 13:37
Yes, yeah

Participant A 13:43
What's this here?
We put the document from the asylum seeker's document.
They often send a list of documents, you know?

UGS 13:59
OK.

Participant A 14:05
Yeah,
You see, it’s that…
Wait, for a child to Benefit from the RAMQ, you must provide a proof of intention to reside for more then 6 months in Quebec.
The asylum document is admissible proof. When you're an asylum seeker, but that's easy enough, but when you have another status, say you have no status, I don't know what proof of intent to stay for 6 months is, can you imagine?

UGS 14:32
OK, and they don’t mention it?

Participant A 14:35
Well, I don't know, I haven't seen it, we drew up this little document, and I don't have all the information, but....

UGS 14:36
OK.

Participant A 14:42
And what if you've been in status imagine you're illegal, I don't know what's your proof of intent to stay here?
You don't have a work permit, you've got nothing, I don't know what happens.

UGS 14:52
Yeah.

Participant A 14:55
but you can ask that question to médecins du monde, who have many more than we do. We don't have as many undocumented migrants at the Maison Bleue, but we do have a lot of refugees, so médecins du monde has more.

UGS 15:02
OK.

Participant A 15:04
They might be able to tell you what's going on, what documents are required.

UGS 15:08

OK Yeah that's a good idea, I'll make sure to ask them. Kind of related to that, like knowledge of the process in general for families that don't have an established status, Like the communication of the changes brought about by this law in general, are people aware of these changes?

Are you at the Maison Bleu, is that part of what you're doing, kind of explaining to people the changes that their family may now be covered, how is that part going?

Participant A 15:50

But you'd like to know for the families, you'd like to know about workers, or you'd like to know how it's known by families?

UGS 15:58

Yeah, and do the workers themselves have to do some of the communication and awareness-raising about these changes?

Participant A 16:06

Yes, well, it's true that the new workers don't know what the situation was beforehand, so we're just telling them what it is right now, but it's clearly not the government that's going to explain it. It's more the organizations on the ground, the people who provide services, who are going to explain it, who, who are taking charge of it.

UGS 16:27

Ok, yeah I was also wondering if..

Participant A 16:28

That's it, they aren't informed. To my knowledge, if there were awareness campaigns, they weren't reached.

UGS 16:40

OK, Yeah, that's what I was wondering if the Ministry of Health or the government is there like partnerships or cooperation with organizations like in the Community to disseminate information or?

Participant A 16:53

I didn't have any, and I think it's a problem that the doctors of the world report raised, and I think it's really a problem of communication.

UGS 16:58

Ok

Participant A 16:59

You know what I was talking about earlier, it's clearly a problem of communication, of information, of directives, of MSSS policy that didn't transmit the information properly.

UGS 17:11

Yeah.

OK, uh.

And for the new eligibility requirements, the eligibility for children - are there any groups of children that you're aware of that continue to be excluded because of the way that these are formulated or the new eligibility requirements?

Participant A 17:42

I couldn't tell you, I didn't see any, but I don't know if maybe someone couldn't prove the intention to stay 6 months, I can't tell you I didn't see any.

UGS 17:45

OK because I've seen a few people mention something like if, for example, the child is in joint custody or it's under youth protection, they may not be able to prove it.

Participant A 18:07
Maybe, but like I said that I didn't…

UGS 18:11
Okay, that's ok. In your opinion, what change could be made to make this law more effective in really improving access to care for the children involved?

Participant A 18:25
I'd say better communication with hospitals so that they don't charge anything.
So there's a clear directive from the MSSS to the hospitals.They shouldn't charge. That there's a presumption, that presumption of eligibility applies.
That hospitals don't charge.

UGS 18:42
Hmmm.

Participant A 18:46
So let them bill RAMQ. And make it clear, it's the communication between RAMQ, MSSS and hospitals.

UGS 18:46
Okay

Participant A 18:52,
Why do they add the step of giving a customer an invoice?

UGS 18:57

Yeah OK so according to you, the biggest challenge is like this, billing and communication is the biggest problem with it?

Participant A 19:06

That I see, yes.

Why doesn't the RAMQ refund, then after if there's a problem, then go get the money back, why, the presumption is inversed in fact.

UGS 19:20

Yeah. And have you observed any aspects of the law or its implementation that have gone well or are working well in your, in your opinion?

Participant A 19:34

Well just the law itself is very good, it's a good, it's a great advancement, so that's already good. There are delays and all that, but after that it's still better than what it was like because I was, I wasn't involved in the intervention at the time, but it's certain that the law itself has nice effects there.

UGS 19:55

Yeah.

I'll see if I have other questions, but do you have any other examples of families who have had difficulties with access to care? I know you mentioned the family that was billed the 40000, do you have any other examples of that?

Participant A 20:18

There are others, but that's how it is.

Well, that's it, I'd say it's the same type of cases, cases of people, there are women also without any papers, but that unfortunately that still happens. And even for their own delivery,

you know, it's like um You know they receive threats while they are at the hospital. I have seen some, but this isn't to do with children, it's about the women, because they aren't covered yet. Maybe they will be, we hope, but we tell them, you have to leave a deposit, you have to pay during your delivery.

UGS 20:48
Yeah.

Participant A 20:56
And if not, we don't give, I can't believe it happens but it's happened again, we won't give you the green paper, the notice of birth if you don't pay, give an amount for the thing, but it's not true they aren't allowed to do that, you just have to call them and they say no no no it's not what I said, but clearly it's what they said the girl didn't invent that, it's something that's brought back to us. So there is still that, doctors that threaten, to say I won't give you this thing if you don't pay.

UGS 21:05
Oh my god

Participant A 21:22
There you go, you won't have your leave also, I won't sign for your leave so you can leave the hospital If you don't pay.

UGS 21:28
Yeah and the health of the child it doesn't start once they're born, so if a mom is experiencing this kind of stress…

Participant A 21:35
Yeah, it's yeah.

UGS 21:41

That was most of my questions, but do you have any other reflections or things to add on this subject?

Participant A 21:43

Yeah, me, like I said, it's pretty much that. I think you did the round on what's essential for me. I think you'll have a lot more juice with the 2 other girls, but it it's really my pleasure. If you have other questions, if you have anything, don't hesitate, write to me we can exchange by email also. It's a nice subject, good luck.

UGS 22:12

Thank you so much and thank you for your time I really appreciate it.

Participant A 22:17

Thank you, good luck, bye.

UGS 22:18

Thank you, thank you, bye.

Interview Transcript Participant B

UGS 4:50
Ok, can we start?

Participant B 4:55
Yes.

UGS 4:56
OK, well first, you already introduced your role and the role of the commission, but can you speak a little bit on the mémoire published on bill 83 and introduce hat the main problem was, that led to this bill being proposed?

Participant B 5:23
Well as you know, it's a bill of law that followed the report from the "Protectrice du citoyen". So, at the time, it was a woman who was the "protecteur", its the "protecteur" but at the time it was the "protectrice" who did a did a report in 2018 on the application by the RAMQ of a rule on admissibility, that considered that kids even those who are Canadian citizens were not admissible because they were linked the admissibility of their parents, so already the "protectrice" had said that the application of the RAMQ of this rule was problematic. And after that there was the report by the RAMQ that identified different propositions. Then, when the bill was proposed, we at the Commission are mandated to analyze all bills to ensure their compliance with the Charter. We do a preliminary analysis of all bills. Then when some bills are identified as containing provisions that would be contrary to the Charter, then we do a more detailed analysis, and in this case, if we had also been invited to take part in the consultations, we would have produced a brief. Uh, well, it contains a fairly limited number of recommendations, and our angle was to say that all children usually residing in Quebec should be covered by the health insurance plan, regardless of their parents' qualifications. And then the argument that was made was based on compliance with the Charter, but also in light of the rights of the child enshrined in international law, i.e. the Convention on the

Rights of the Child and also in the light of the right to health, which is enshrined in the ICESCR, the International Covenant on Economic and Social Rights. So it's really these 3, these 3 angles that led the analysis. So, maybe to explain a little bit the analysis that was done. We did an analysis in terms of a proof of discrimination. You need to know that In the Quebec Charter, for there to be discrimination, there are 3 steps: first, there has to be a distinction, exclusion or preference. So if we were able to demonstrate that, some children in order to be eligible for RAMQ, they would be treated differently from other children who were born in Quebec, who were born in Canada, whose parents were also Canadian citizens. So, that was a distinction which was there. Then 2nd step for the proof of discrimination is that this distinction must be based on a ground prohibited by the Charter. So prohibited grounds, a prohibited ground of discrimination. They are set out in section 10 of the Quebec Charter of Human Rights and Freedoms, which enshrines the right to equality. So there are 14 prohibited grounds, and in our analysis, we argue that the distinction in treatment made against children in the bill, as it was drafted, is based on 3 prohibited grounds of discrimination, the first being civil status. This is most often understood as the relationship between 2 people in a conjugal relationship, i.e. being married or in a common-law relationship, and so on. But it can also be understood in the sense of affiliation. So that's how we understood it, in other words, the distinction is founded on, the differential treatment of these children, is founded on affiliation, so on the fact that their parents have a special status. So that was the first ground of discrimination invoked. The 2nd was of ethnic or national origin. So, even if formally there's no discrimination, we couldn't say that there's direct discrimination in the sense that the rule doesn’t formally say that certain, certain categories of people or of national origin are, are discriminated against. The fact remains that we were able to show that the vast majority of the people concerned were immigrants, racialized people, and that the distinction was made on the basis of the, the status, the immigrant status, so the fact of coming from abroad. And the 3rd, the 3rd, was social condition, so that's a ground/motive/reason that, that has, that has 2 parts, so an objective part and a subjective part. We were making the argument that the social condition motive was implicated by the fact that migrants in an irregular situation, uh, form a specific group in terms of objective characteristics, in terms of socio-economic situation, for example, who are particularly

vulnerable at the socio-economic level, then in terms of status on the territory, but also at the level of their social representation, so people who are perceived through the lens of the Stigma of illegal immigrants therefore, who are seen as being an inferior social group within society. So that was the, the analysis in the sense of the Charter, so this distinction, exclusion, preference based on a prohibited ground. Then step 3, which has the effect of destroying or compromising the exercise of a right. Then, what we were arguing was that it's the right to equality in the exercise, of the right enshrined in section 1 of the charter, so the right to life, safety and integrity, physical and psychological integrity, which are recognized in the charter, and also the right to the preservation of one's dignity, which is enshrined in section 4 of the charter. So that's really the summary analysis in the sense of the Charter, and then the other angle, the 2nd angle of analysis, was the approach based on the rights of the child, so in the sense of the Convention on the Rights of the Child, that imposes obligations to the state, and Quebec has declared itself bound by these conventions. So, we were looking at the principles of non-discrimination, the best interests of the child and the child's right to life, survival and development. So, to see how this piece of legislation had specific impacts on children, and to remind Quebec lawmakers that they must place the best interests of the child at the forefront when developing legislation. And then there was the right to health, a right not officially recognized in the Quebec Charter, but which is enshrined in various conventions of international law in the case of Quebec, it and Canada have agreed to. Yes, then we recalled a historic recommendation of the Commission, so the Commission has been, for at least more then 20 years, recommending that the Charter be amended to include the right to health, so the right to enjoy the best, I can't remember the exact wording in international law, but it's basically a reiteration of the right to health in the Charter. So that was the 3, the 3 angles and our argument was to say that all children, regardless of their parents' situation, should be able to be covered by the Quebec health insurance plan. So that's it in a nutshell. You can ask me some more questions.

UGS 16:22

Thank you very much. So you mentioned the discriminations based on prohibited reasons. So

these are discriminations hat the commission judges are a part of this formulation of this new bill, the bill 83?

Participant B 16:31
Yes. Well, it's you know, you have to understand that we analysed the draft, we can't analyse the law once it's applied, once it's adopted. .

UGS 16:51
OK.

Participant B 16:54
We look at if our recommendations were followed, and now we can say that there are certain recommendations that were followed, at least in part.

UGS 17:01
OK.

Participant B 17:10
For example the fact that it is now possible to, well, first of all, the fact that children, that it's not only Canadian children who are, who are now covered, but all children, independent of the status of their parents. That is one, that's really an advancement. We had made a recommendation for the instauration of a firewall between health services and the immigration services, because we come to the conclusion that many parents don't seek our health services for themselves but also for their children because they fear contact with public institutions, and they are scared that their information will be passed on to the Canada Border Services Agency, in other words the immigration service. So, we had made a recommendation that there should be a very clear separation between the 2, and that's a modification, an amendment to the bill that's been adopted. Even if it doesn't go as far as we

had recommended, it's still interesting. Because they've actually, they've taken on the wording of what had been added to the Education Act, so what is already intended for educational services in Quebec. This ensures that the RAMQ and health professionals, can't communicate information to verify immigration status or the legal status on the territory. But if, for example, the border services agency initiates a deportation procedure against a person, and then asks the RAMQ to communicate, the RAMQ will be obliged to do so, so they can't voluntarily communicate with the border service. But then, I think it can if it's communicated well, I think it can be reassuring for parents.

Uh, you know, our argument was also to say that what we're observing is that children who aren't covered, who weren't covered, well, that also affects their long-term development. So it’s not only the fact that the situations there of health problems were getting worse, but it's also the long-term development, tat we know that the first years of life are the most important for development, so the long-term repercussions are significant.

UGS 20:35

And were there any other recommendations that you know of that were adopted?

Participant B 20:43

Well, there was, there was also a recommendation to abolish the waiting period, which is a period of 3 months, I believe, that is applied to migrants, particularly those leaving Quebec for more than 6 months, I believe. So, the waiting period has been abolished for children, it remains for parents, but it was abolished for children.

In the past, we had already formulated an opinion on the waiting period, saying that it was discriminatory on the basis of national origin.So that's a recommendation that was partly followed in the sense that it wasn't abolished for all people, for adults too, But it has still been abolished for children, so that's good.

We also said, we also recommended, wait, I'll look at the other recommendations.

Yeah, we recommended that all children who are usually on the territory be considered as being a person who resides, regardless of the migratory status and residence of the parents, so, then what we saw was that in the bill as it was proposed,

Children's eligibility was conditional on the parent's intention to stay for more than 6 months. For us, it was problematic in the sense that we were asking people who don't have legal status in Canada to either give their authorization, which they don't have or which has expired, or to demonstrate their intention to stay for more than 6 months. It was problematic in the sense that we were asking people who didn't have status to say that they were going to continue to stay in the country. Which is like an admission of continuing to break a law.
So what's been done is that they've added the possibility of, uh, giving proof of school attendance. So there are different organizations that have made recommendations to say that different proofs of residency or of not, of residency.
But in fact it's, To show that people are established in the country who usually reside in Quebec. So it can be done in ways other than by the parent's intention to stay, so proof of school attendance interesting. However, for preschool-age children, their eligibility depends on the fact that parents must demonstrate their intention to stay for more than 6 months. But as I was saying, if we add, if we take into consideration the fact that RAMQ is now clearly indicated that it cannot communicate on its own Information to the immigration department, that can, that can still reassure, because that's our fear, it was that of the parents, because they're afraid of the public services, of being identified and then ultimately deported, they don't register their children than their children.
Basically, you know, that's what it means to think about the best interests of the child, to make sure that the rights of the child depend, not on the actions of the government, but on the interests of the child.
on the actions of their parents, and that we should give primacy to the rights of the child.

UGS 25:37
OK and with the wording of the bill, what were the groups of children who were, who continued to be excluded? Was it only those who weren't Canadian, or what was the differentiation between the different groups that were excluded by the wording?

Participant B 26:03
Well that remained excluded, the children, wait.

When was the bill introduced, It was only the children born in the country who were targeted, that we wanted to admit. So children who weren't born…Wait, am I wrong, wait we had a nice table where we.. yeah that's it, In the proposed bill, it's children who are in an irregular situation… children of parents in an irregular situation but not born in Quebec, not born in Canada, were excluded.

UGS 27:11
OK.

Participant B 27:13
So that was an important change, between the introduction of the bill and its adoption. In the sense that the proposed bill wanted to clarify what was already intended for in the rules, that children born in Canada should have access. They should be considered residents of Quebec, regardless of their parents' domicile, whether or not their parents are domiciled according to the meaning in the civil code. So they were excluded, So if, for example, a person comes to Canada and asks for asylum, he's with his children, his asylum application is refused, and then he stays in the country. Well, those children, and he was without status, their children wouldn't be eligible. There were the children with an open work permit of 6 months or less who were excluded. Children with a visitor's permit of at least 6 months as well. Children of parents with a study permit of 6 months or less who were excluded. For those I'm not sure, because we're less focused on study permits and visitor's permits, as to knowing what was adopted in the end.

UGS 28:54
OK.

Participant B 28:59
But it's clear that we've really focused on those who are in an irregular situation, and that's one of the major changes we've made.

UGS 29:11
OK, and can you tell me a little more on these proof sto demonstrate residency? I think there was the sworn declaration, authorization proof, and something to prove the child has lived with their parents since birth, and all these new proposed proofs.

Participant B 29:36
Yeah.

UGS 29:39
And what are the potential problems with these proposed alternatives?

Participant B 29:46
Well we, if I'm not mistaken we didn't have any, we didn't propose any alternatives in a clear way, we just said we needed to remove all administrative barriers to access.

UGS 30:00
OK.

Participant B 30:08
And there could be other…I know that in the brief we didn't write it, perhaps in the exchanges in the parliamentary committee, that I could go and see, then I could, I could tell you. There are other organizations If I'm not mistaken, that were talking about a proof, for example of electricity, electricity bills that prove that you've been here for more than 6 months. I'm not going to say which alternative is better than another, the commission didn't take a position on this, but it's clear that the more you require administrative proofs, the more it imposes a specific burden for the eligibility/admissibility of children, which is in itself problematic in the sense that it's a child who I, if I'm a Canadian citizen, and I have a child

here, that burden of eligibility for the child isn't present. So I couldn't go into detail about what could be a better, a better proof. Uh, but the school attendance one, was well received by us.

UGS 31:37
Ok but the alternatives that were presented by the proposed bill, did you discuss the major problems with these or the implications?

Participant B 31:50
Well, as I told you, it was the sworn declaration one, by which the parent states that he or she intends to stay for more than 6 months, that for us, without having the firewall was problematic, because like I was telling you it implicates saying I am infringing on the law, and I will continue to do so. It could be a barrier to access to care for children.

UGS 32:32
Ok, right. And the 4 recommendations that were included in the mémoire

Participant B 32:38
Yeah.

UGS 32:39
Are there other recommendations or suggestions that in your opinion could improve this bill?

Participant B 32:51
Uh-huh.
Well the proposed bill, it was adopted so it's more… are there recommendations?
Well, as I was saying about the waiting period, it's been partially followed, so we're going to continue to ask for and recommend that the waiting period be abolished for adults as well. Otherwise, there's another, well we haven't formulated a recommendation on the accessibility for pregnant women, but we still deal with this in the mémoire. So we didn't go as far as

making a recommendation, in the future I don't know if this will be the case, so this doesn't engage the Commission, but still in the mémoire even if we don't formulate a recommendation we highlight the particular vulnerability of irregular migrant pregnant women by pointing out that there are risks of not having access to prenatal care, and that this has a detrimental impact on their health, it has a detrimental impact on their own health and that of their child, and on the child's development, pointing out particularly the prohibitive costs and overcharging and overpricing. It is extremely expensive for a pregnant woman to give birth here without insurance. So we didn't make a recommendation, but we did highlight this problem. Then there are other organizations that have made recommendations so that pregnant women should be exempt. But for them to be eligible for perinatal health services. After that, it was discussed in consultation with the minister, who then mandated a committee at the RAMQ to study the possibility of including pregnant women. Then they tabled a report, the RAMQ one or 2 years ago with different options in connection with that, but since then, no changes have been made. then in the minister's speech, you could tell he understood what was at stake, but his speech was, a lot of it had to do with the fear of obstetric tourism.

UGS 36:16
OK.

Participant B 36:18
He Wanted to know how much it would cost.

UGS 36:20
Okay, yeah.

Participant B 36:22
That's what it was.

UGS 36:26
And talking about migrant families in general, in the section that talked about discrimination

based on marital status, it talks a bit about the possibilities of children who would be excluded, for example if they were, how in shared custody or because of certain things like that.

Participant B 36:38
Yeah.

UGS 36:49
Yeah so…

Participant B 36:50
Yeah well, they made a change because in the bill, what was written was that the child had to have lived permanently with the parent since birth.

UGS 37:03
OK.

Participant B 37:05
But...
But that's what we were saying, what we were saying was that it was problematic in the sense that it really misunderstood the realities of migrant families who often one parent leaves with the child, then the other parent joins. Then there are separations, and the paths aren't linear. It's not something that's, so it was a, a request, then a differential treatment that wasn't, that wasn't justified in our opinion.
And then there was a modification that was made in that sense.
The child must continue to remain permanently with his or her parent, but for children born outside Quebec, the obligation to remain permanently with the parent has been addressed.

UGS 38:14
Ah OKOK that’s interesting.

Participant B 38:16
Yeah.

UGS 38:21

So I just have 2 final questions.
First, as you read the bill, were there any positive aspects or aspects that you felt were well done? As for the contribution of improving access to care.

Participant B 38:45
Well yes, but, especially, especially with the law that was adopted in the end. With the modifications that were brought. Um and now we see there's problems at the level of implementation. Clearly it wasn't well communicated to all the hospitals and the establishments, but the fact remains that it's still pretty major that now there are children, I think that since the adoption of the law the ministry said it was almost 20 000 children who are now admissible. Um and its children who are in situations of vulnerability that are particularly acute, and their inaccessibility to health services adds to a set of social determinants of health that negatively impact their health. So, it's still pretty major the fact that there's children that now, if the parents are able to give the, if the child attended a school, If the parent is able to demonstrate their intention to stay, they have access to health services. It's still pretty, um, it's a major advancement for these children that this was not the case for before. And, then for us, the distinction upon reading the proposed bill between children who would be born or not in Canada, it was a problem. Now, it's no longer there, so it's no longer just children who are Canadian, because there was this argument of saying well, there are Canadian children who aren't covered by the health system, but we were saying well, all children, regardless of their citizenship, their nationality, should have access to public health services.

UGS 40:50
Yeah.

Participant B 40:57.
It's a major step forward. And after there's problem that we see, it's really shocking to see that even after legislative advances like this, there are still parents who are being billed.

UGS 41:25
Hmmm.

Participant B 41:25
and then this can contribute to a fear and make it so they think their children are not eligible, and for that to be communication, I think there is a big communication issue in terms of the access for children, even when going to the RAMQ website this morning, isn't it super clear the information that's being communication as to the fact that kids now are eligible. Especially for parents in this situation, I think it takes information that's very, very clear.And fortunately, there are organizations like Médecins du monde with their clinic that does that work.

UGS 42:13
Yes and would you have any recommendations of who else to talk to as well? Other organizations or clinics or doctors who are a little familiar with what you're talking about, the implementa™tion barriers

Participant B 42:29
Well, I thought it might be interesting to see complaints commissioners in health care facilities.

UGS 42:37
Yeah.

Participant B 42:37
Uh, for example in Montreal, I don't know if you're familiar with the
CIUSS and CISSS etc, which have complaints commissioners that I imagine there are organizations that help people file complaints with these commissioners, and it might be interesting to see how they react to these complaints.

UGS 42:59
OK.
OK, that's a good idea, I wrote that down. Well that was all my questions, but do you have any comments, thoughts or anything else to add on this topic?

Participant B 43:31
Ummm no, no. I hope that this helped, and I am looking forward to Reading your thesis.

UGS 43:43
Great, thank you very much for your time.

UGS 4:50
Ok, can we start?

Participant B 4:55
Yes.

UGS 4:56

OK, well first, you already introduced your role and the role of the commission, but can you speak a little bit on the mémoire published on bill 83 and introduce hat the main problem was, that led to this bill being proposed?

Participant B 5:23

Well as you know, it's a bill of law that followed the report from the "Protectrice du citoyen". So, at the time, it was a woman who was the "protecteur", its the "protecteur" but at the time it was the "protectrice" who did a did a report in 2018 on the application by the RAMQ of a rule on admissibility, that considered that kids even those who are Canadian citizens were not admissible because they were linked the admissibility of their parents, so already the "protectrice" had said that the application of the RAMQ of this rule was problematic. And after that there was the report by the RAMQ that identified different propositions. Then, when the bill was proposed, we at the Commission are mandated to analyze all bills to ensure their compliance with the Charter. We do a preliminary analysis of all bills. Then when some bills are identified as containing provisions that would be contrary to the Charter, then we do a more detailed analysis, and in this case, if we had also been invited to take part in the consultations, we would have produced a brief. Uh, well, it contains a fairly limited number of recommendations, and our angle was to say that all children usually residing in Quebec should be covered by the health insurance plan, regardless of their parents' qualifications. And then the argument that was made was based on compliance with the Charter, but also in light of the rights of the child enshrined in international law, i.e. the Convention on the Rights of the Child and also in the light of the right to health, which is enshrined in the ICESCR, the International Covenant on Economic and Social Rights. So it's really these 3, these 3 angles that led the analysis. So, maybe to explain a little bit the analysis that was done. We did an analysis in terms of a proof of discrimination. You need to know that In the Quebec Charter, for there to be discrimination, there are 3 steps: first, there has to be a distinction, exclusion or preference. So if we were able to demonstrate that, some children in order to be eligible for RAMQ, they would be treated differently from other children who

were born in Quebec, who were born in Canada, whose parents were also Canadian citizens. So, that was a distinction which was there. Then 2nd step for the proof of discrimination is that this distinction must be based on a ground prohibited by the Charter. So prohibited grounds, a prohibited ground of discrimination. They are set out in section 10 of the Quebec Charter of Human Rights and Freedoms, which enshrines the right to equality. So there are 14 prohibited grounds, and in our analysis, we argue that the distinction in treatment made against children in the bill, as it was drafted, is based on 3 prohibited grounds of discrimination, the first being civil status. This is most often understood as the relationship between 2 people in a conjugal relationship, i.e. being married or in a common-law relationship, and so on. But it can also be understood in the sense of affiliation. So that's how we understood it, in other words, the distinction is founded on, the differential treatment of these children, is founded on affiliation, so on the fact that their parents have a special status. So that was the first ground of discrimination invoked. The 2nd was of ethnic or national origin. So, even if formally there's no discrimination, we couldn't say that there's direct discrimination in the sense that the rule doesn't formally say that certain, certain categories of people or of national origin are, are discriminated against. The fact remains that we were able to show that the vast majority of the people concerned were immigrants, racialized people, and that the distinction was made on the basis of the, the status, the immigrant status, so the fact of coming from abroad. And the 3rd, the 3rd, was social condition, so that's a ground/motive/reason that, that has, that has 2 parts, so an objective part and a subjective part. We were making the argument that the social condition motive was implicated by the fact that migrants in an irregular situation, uh, form a specific group in terms of objective characteristics, in terms of socio-economic situation, for example, who are particularly vulnerable at the socio-economic level, then in terms of status on the territory, but also at the level of their social representation, so people who are perceived through the lens of the Stigma of illegal immigrants therefore, who are seen as being an inferior social group within society. So that was the, the analysis in the sense of the Charter, so this distinction, exclusion, preference based on a prohibited ground. Then step 3, which has the effect of destroying or compromising the exercise of a right. Then, what we were arguing was that it's the right to equality in the exercise, of the right enshrined in section 1 of the charter, so the right to life,

safety and integrity, physical and psychological integrity, which are recognized in the charter, and also the right to the preservation of one's dignity, which is enshrined in section 4 of the charter. So that's really the summary analysis in the sense of the Charter, and then the other angle, the 2nd angle of analysis, was the approach based on the rights of the child, so in the sense of the Convention on the Rights of the Child, that imposes obligations to the state, and Quebec has declared itself bound by these conventions. So, we were looking at the principles of non-discrimination, the best interests of the child and the child's right to life, survival and development. So, to see how this piece of legislation had specific impacts on children, and to remind Quebec lawmakers that they must place the best interests of the child at the forefront when developing legislation. And then there was the right to health, a right not officially recognized in the Quebec Charter, but which is enshrined in various conventions of international law in the case of Quebec, it and Canada have agreed to. Yes, then we recalled a historic recommendation of the Commission, so the Commission has been, for at least more then 20 years, recommending that the Charter be amended to include the right to health, so the right to enjoy the best, I can't remember the exact wording in international law, but it's basically a reiteration of the right to health in the Charter. So that was the 3, the 3 angles and our argument was to say that all children, regardless of their parents' situation, should be able to be covered by the Quebec health insurance plan. So that's it in a nutshell. You can ask me some more questions.

UGS 16:22

Thank you very much. So you mentioned the discriminations based on prohibited reasons. So these are discriminations hat the commission judges are a part of this formulation of this new bill, the bill 83?

Participant B 16:31

Yes. Well, it’s you know, you have to understand that we analysed the draft, we can’t analyse the law once it’s applied, once it’s adopted. .

UGS 16:51
OK.

Participant B 16:54
We look at if our recommendations were followed, and now we can say that there are certain recommendations that were followed, at least in part.

UGS 17:01
OK.

Participant B 17:10
For example the fact that it is now possible to, well, first of all, the fact that children, that it's not only Canadian children who are, who are now covered, but all children, independent of the status of their parents. That is one, that's really an advancement. We had made a recommendation for the instauration of a firewall between health services and the immigration services, because we come to the conclusion that many parents don't seek our health services for themselves but also for their children because they fear contact with public institutions, and they are scared that their information will be passed on to the Canada Border Services Agency, in other words the immigration service. So, we had made a recommendation that there should be a very clear separation between the 2, and that's a modification, an amendment to the bill that's been adopted. Even if it doesn't go as far as we had recommended, it's still interesting. Because they've actually, they've taken on the wording of what had been added to the Education Act, so what is already intended for educational services in Quebec. This ensures that the RAMQ and health professionals, can't communicate information to verify immigration status or the legal status on the territory. But if, for example, the border services agency initiates a deportation procedure against a person, and then asks the RAMQ to communicate, the RAMQ will be obliged to do so, so they can't voluntarily communicate with the border service. But then, I think it can if it's communicated well, I think it can be reassuring for parents.

Uh, you know, our argument was also to say that what we're observing is that children who aren't covered, who weren't covered, well, that also affects their long-term development. So it’s not only the fact that the situations there of health problems were getting worse, but it's also the long-term development, tat we know that the first years of life are the most important for development, so the long-term repercussions are significant.

UGS 20:35
And were there any other recommendations that you know of that were adopted?

Participant B 20:43
Well, there was, there was also a recommendation to abolish the waiting period, which is a period of 3 months, I believe, that is applied to migrants, particularly those leaving Quebec for more than 6 months, I believe. So, the waiting period has been abolished for children, it remains for parents, but it was abolished for children.
In the past, we had already formulated an opinion on the waiting period, saying that it was discriminatory on the basis of national origin.So that's a recommendation that was partly followed in the sense that it wasn't abolished for all people, for adults too, But it has still been abolished for children, so that's good.
We also said, we also recommended, wait, I'll look at the other recommendations.
Yeah, we recommended that all children who are usually on the territory be considered as being a person who resides, regardless of the migratory status and residence of the parents, so, then what we saw was that in the bill as it was proposed,
Children's eligibility was conditional on the parent's intention to stay for more than 6 months. For us, it was problematic in the sense that we were asking people who don't have legal status in Canada to either give their authorization, which they don't have or which has expired, or to demonstrate their intention to stay for more than 6 months. It was problematic in the sense that we were asking people who didn't have status to say that they were going to continue to stay in the country. Which is like an admission of continuing to break a law.

So what's been done is that they've added the possibility of, uh, giving proof of school attendance. So there are different organizations that have made recommendations to say that different proofs of residency or of not, of residency.
But in fact it's, To show that people are established in the country who usually reside in Quebec. So it can be done in ways other than by the parent's intention to stay, so proof of school attendance interesting. However, for preschool-age children, their eligibility depends on the fact that parents must demonstrate their intention to stay for more than 6 months. But as I was saying, if we add, if we take into consideration the fact that RAMQ is now clearly indicated that it cannot communicate on its own Information to the immigration department, that can, that can still reassure, because that's our fear, it was that of the parents, because they're afraid of the public services, of being identified and then ultimately deported, they don't register their children than their children.
Basically, you know, that's what it means to think about the best interests of the child, to make sure that the rights of the child depend, not on the actions of the government, but on the interests of the child.
on the actions of their parents, and that we should give primacy to the rights of the child.

UGS 25:37
OK and with the wording of the bill, what were the groups of children who were, who continued to be excluded? Was it only those who weren't Canadian, or what was the differentiation between the different groups that were excluded by the wording?

Participant B 26:03
Well that remained excluded, the children, wait.
When was the bill introduced, It was only the children born in the country who were targeted, that we wanted to admit. So children who weren't born…Wait, am I wrong, wait we had a nice table where we.. yeah that’s it, In the proposed bill, it's children who are in an irregular situation… children of parents in an irregular situation but not born in Quebec, not born in Canada, were excluded.

UGS 27:11
OK.

Participant B 27:13
So that was an important change, between the introduction of the bill and its adoption. In the sense that the proposed bill wanted to clarify what was already intended for in the rules, that children born in Canada should have access. They should be considered residents of Quebec, regardless of their parents' domicile, whether or not their parents are domiciled according to the meaning in the civil code. So they were excluded, So if, for example, a person comes to Canada and asks for asylum, he's with his children, his asylum application is refused, and then he stays in the country. Well, those children, and he was without status, their children wouldn't be eligible. There were the children with an open work permit of 6 months or less who were excluded. Children with a visitor's permit of at least 6 months as well. Children of parents with a study permit of 6 months or less who were excluded. For those I'm not sure, because we're less focused on study permits and visitor's permits, as to knowing what was adopted in the end.

UGS 28:54
OK.

Participant B 28:59
But it's clear that we've really focused on those who are in an irregular situation, and that's one of the major changes we've made.

UGS 29:11
OK, and can you tell me a little more on these proof sto demonstrate residency? I think there was the sworn declaration, authorization proof, and something to prove the child has lived with their parents since birth, and all these new proposed proofs.

Participant B 29:36
Yeah.

UGS 29:39
And what are the potential problems with these proposed alternatives?

Participant B 29:46
Well we, if I'm not mistaken we didn't have any, we didn't propose any alternatives in a clear way, we just said we needed to remove all administrative barriers to access.

UGS 30:00
OK.

Participant B 30:08
And there could be other…I know that in the brief we didn't write it, perhaps in the exchanges in the parliamentary committee, that I could go and see, then I could, I could tell you. There are other organizations If I'm not mistaken, that were talking about a proof, for example of electricity, electricity bills that prove that you've been here for more than 6 months. I'm not going to say which alternative is better than another, the commission didn't take a position on this, but it's clear that the more you require administrative proofs, the more it imposes a specific burden for the eligibility/admissibility of children, which is in itself problematic in the sense that it's a child who I, if I'm a Canadian citizen, and I have a child here, that burden of eligibility for the child isn't present. So I couldn't go into detail about what could be a better, a better proof. Uh, but the school attendance one, was well received by us.

UGS 31:37

Ok but the alternatives that were presented by the proposed bill, did you discuss the major problems with these or the implications?

Participant B 31:50
Well, as I told you, it was the sworn declaration one, by which the parent states that he or she intends to stay for more than 6 months, that for us, without having the firewall was problematic, because like I was telling you it implicates saying I am infringing on the law, and I will continue to do so. It could be a barrier to access to care for children.

UGS 32:32
Ok, right. And the 4 recommendations that were included in the mémoire

Participant B 32:38
Yeah.

UGS 32:39
Are there other recommendations or suggestions that in your opinion could improve this bill?

Participant B 32:51
Uh-huh.
Well the proposed bill, it was adopted so it's more… are there recommendations?
Well, as I was saying about the waiting period, it's been partially followed, so we're going to continue to ask for and recommend that the waiting period be abolished for adults as well. Otherwise, there's another, well we haven't formulated a recommendation on the accessibility for pregnant women, but we still deal with this in the mémoire. So we didn't go as far as making a recommendation, in the future I don't know if this will be the case, so this doesn't engage the Commission, but still in the mémoire even if we don't formulate a recommendation we highlight the particular vulnerability of irregular migrant pregnant women by pointing out that there are risks of not having access to prenatal care, and that this has a detrimental impact on their health, it has a detrimental impact on their own health and

that of their child, and on the child's development, pointing out particularly the prohibitive costs and overcharging and overpricing. It is extremely expensive for a pregnant woman to give birth here without insurance. So we didn't make a recommendation, but we did highlight this problem. Then there are other organizations that have made recommendations so that pregnant women should be exempt. But for them to be eligible for perinatal health services. After that, it was discussed in consultation with the minister, who then mandated a committee at the RAMQ to study the possibility of including pregnant women. Then they tabled a report, the RAMQ one or 2 years ago with different options in connection with that, but since then, no changes have been made. then in the minister's speech, you could tell he understood what was at stake, but his speech was, a lot of it had to do with the fear of obstetric tourism.

UGS 36:16
OK.

Participant B 36:18
He Wanted to know how much it would cost.

UGS 36:20
Okay, yeah.

Participant B 36:22
That’s what it was.

UGS 36:26
And talking about migrant families in general, in the section that talked about discrimination based on marital status, it talks a bit about the possibilities of children who would be excluded, for example if they were, how in shared custody or because of certain things like that.

Participant B 36:38
Yeah.

UGS 36:49
Yeah so…

Participant B 36:50
Yeah well, they made a change because in the bill, what was written was that the child had to have lived permanently with the parent since birth.

UGS 37:03
OK.

Participant B 37:05
But...
But that's what we were saying, what we were saying was that it was problematic in the sense that it really misunderstood the realities of migrant families who often one parent leaves with the child, then the other parent joins. Then there are separations, and the paths aren't linear. It's not something that's, so it was a, a request, then a differential treatment that wasn't, that wasn't justified in our opinion.
And then there was a modification that was made in that sense.
The child must continue to remain permanently with his or her parent, but for children born outside Quebec, the obligation to remain permanently with the parent has been addressed.

UGS 38:14
Ah OKOK that’s interesting.

Participant B 38:16
Yeah.

UGS 38:21

So I just have 2 final questions.
First, as you read the bill, were there any positive aspects or aspects that you felt were well done? As for the contribution of improving access to care.

Participant B 38:45
Well yes, but, especially, especially with the law that was adopted in the end. With the modifications that were brought. Um and now we see there's problems at the level of implementation. Clearly it wasn't well communicated to all the hospitals and the establishments, but the fact remains that it's still pretty major that now there are children, I think that since the adoption of the law the ministry said it was almost 20 000 children who are now admissible. Um and its children who are in situations of vulnerability that are particularly acute, and their inaccessibility to health services adds to a set of social determinants of health that negatively impact their health. So, it's still pretty major the fact that there's children that now, if the parents are able to give the, if the child attended a school, If the parent is able to demonstrate their intention to stay, they have access to health services. It's still pretty, um, it's a major advancement for these children that this was not the case for before. And, then for us, the distinction upon reading the proposed bill between children who would be born or not in Canada, it was a problem. Now, it's no longer there, so it's no longer just children who are Canadian, because there was this argument of saying well, there are Canadian children who aren't covered by the health system, but we were saying well, all children, regardless of their citizenship, their nationality, should have access to public health services.

UGS 40:50
Yeah.

Participant B 40:57.

It's a major step forward. And after there's problem that we see, it's really shocking to see that even after legislative advances like this, there are still parents who are being billed.

UGS 41:25

Hmmm.

Participant B 41:25

and then this can contribute to a fear and make it so they think their children are not eligible, and for that to be communication, I think there is a big communication issue in terms of the access for children, even when going to the RAMQ website this morning, isn't it super clear the information that's being communication as to the fact that kids now are eligible. Especially for parents in this situation, I think it takes information that's very, very clear.And fortunately, there are organizations like Médecins du monde with their clinic that does that work.

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Yes and would you have any recommendations of who else to talk to as well? Other organizations or clinics or doctors who are a little familiar with what you're talking about, the implementa™tion barriers

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Well, I thought it might be interesting to see complaints commissioners in health care facilities.

UGS 42:37

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Uh, for example in Montreal, I don't know if you're familiar with the
CIUSS and CISSS etc, which have complaints commissioners that I imagine there are organizations that help people file complaints with these commissioners, and it might be interesting to see how they react to these complaints.

UGS 42:59

OK.
OK, that's a good idea, I wrote that down. Well that was all my questions, but do you have any comments, thoughts or anything else to add on this topic?

Participant B 43:31

Ummm no, no. I hope that this helped, and I am looking forward to Reading your thesis.

UGS 43:43

Great, thank you very much for your time.

Interview Transcript Participant C

UGS

Do you have any questions before we start?

Participant C

No, it is good, all good.

UGS

Ok good, perfect.

Well, to begin with, can you explain a little bit the objective of the World Medicine Clinic, and who the services are targeted towards?

Participant C

Yes, well Doctors of the World, so it's a humanitarian organization focusing on the access to health, but access to health for the, precarious populations, so there are doctors of the world around the world in 17 countries, so it's an international network But each organization is independent. So we, Doctors of the World Canada, we have international actions, but our actions here in Canada are mainly in Montreal. So indeed, we have, we have a clinic where we welcome migrants with a precarious status, so they have no medical coverage, so it's really, I insist on the, the, the, precarious status. That is to say, we don't welcome tourists, it's not just people without medical coverage, here we welcome people according to their precariousness.

So there you have it, it's mostly people without status and without medical coverage that we welcome in our establishments, so I think, that's more the purpose of the meeting, but I can also say that on top of that we have a mobile clinic, where we work a lot with people experiencing homelessness in Montreal and we see more and more people without status who are becoming homeless. The populations intersect and we work a lot with the Indigenous populations Montreal in Montreal in a situation of homelessness.

UGS

OK, and do you play a big role with children whose parents have a precarious migration status, so for children, do you have a lot of contact with this population?

Participant C

Well, much less since the implementation of Bill 83. But yes, yes, before, we received a lot of families there, so often the parents with the children.

UGS

Okay

Participant C

Well, so, we still get them here,

I don't know if there are other more specific questions about that, but there are less but there are still some there. But it's certain that the Bill 83 has still changed a lot at this level.

UGS

Oh ok. And what do you think would be the biggest change that the law has made?

Then also for the operation of the clinic, then the provision of care. What is the the biggest impact you've observed?

Participant C

Well, in fact, for these children, we don’t see them anymore. That is to say that they no longer admissible to our clinic because they have medical coverage now.

UGS

Ah OK

Participant C

On the other hand, that's in theory, but in practice there are still a lot of barriers to access the RAMQ, even if they are entitled to it. So, there are a lot of problems with the implementation of Bill 83. So I would say that we don’t see these children anymore from a medical point of view, because they have access now, but we accompany and provide a lot of support to the families for the registration to the RAMQ. There are still many, many fees that are asked of families, for children for example, children who are born here. In principle, they automatically have RAMQ, or at least they're supposed to. For health professionals they have what's called a presumption of eligibility.

In other words, if children are born here, healthcare professionals should tell themselves that they have access to RAMQ, until the parent proves that they are really entitled to RAMQ, so they shouldn't have to pay for care, when in fact this is not at all the case.
There are many, many women who give birth here and are charged for their babies' care when they shouldn't be. So there are still a lot of billing issues, and a lot of children are being charged.Of course, they'll be reimbursed later on, but it still creates stress and a financial burden on families. So there are still a lot of implementation issues.
I'd say don't deal with these children on the medical side, but we do a lot of support, whether it's for billing methods. We do all that with the families.

UGS

OK, and if the child technically is maybe covered by there RAMQ, but for some reason, whatever it is, they fail to do the registration process, then they don't have the card. Do you still see them in the clinic, are there situations like that?

Participant C

No, no, no, because in fact the Health institutions are obliged to accept them.
So in fact, we have, you know, doctors of the world, we work with, we receive far too many people in relation to the capacity we can accommodate, whether it's adults, you know at all levels, so we have a lot of partnerships with a lot of establishments, so we're going to, we're going to direct them to the establishments that we know well, but in fact often what we are going to do is that we will make sure that they have the RAMQ before sending them. In fact, we still have contacts where… well you know, there is a phone number now from the RAMQ that we can call and the registration process is done quickly. In fact, at the beginning, there were a lot of problems with registration, but it's much better, it's really improved.
So the registration itself is fine, it's more like, it's a lot of children who are born here, basically where there's bills, were still charging the parents a lot. Or the children who weren't born here, where there is a delay, you know, between the time when parents have to prove

that they want to settle down and getting the RAMQ, well, there can be fees that are billed, but at that point, since they're covered, we don't see them at the clinic anymore.
And if there's an emergency, anyway, we don't see emergencies, we send them to the emergency room, so we don't have a doctor on site, we have volunteer doctors who come once a month or we only have nurses, so we can't deal with anything urgent, so if it's not urgent, we have time to take the necessary steps to register.

UGS

And you mentioned in for the registration process, that they have to show evidence like the intention to stay and everything is how is this experienced by the families? Are there any difficulties with this new evidence, how does it work?

Participant C

Well at the beginning, yes.
At the beginning, in fact, I think it's the RAMQ that he had to adjust there. The RAMQ agents, there were a lot of questions that were really… in fact the proof of wanting to stay on the territory, now I'd have to look at what exactly…
I think they can show a lease, for example, of a dwelling, a lease in their name, but there are a lot of people who live in people's homes, so they don't necessarily have a lease in their name. Everything related to visas also because sometimes the parents have work visas but they don't have access to health insurance, so it's also a work visa, it can show that you want to stay in the territory but not everyone has them.
They may also make an sworn declaration, that's also valid..
However, at the beginning of what was happening, the RAMQ was asking a lot of quite intrusive questions, you know, digging into the status and everything when it wasn't necessary, so that the families were a little fearful. But that's it, it's much improved, right now, the RAMQ is really asking questions that need to be asked, so the registration process at this level is really improved, so it's much less intrusive. So the families are much less fearful because often, they were afraid that it would have an impact on their humanitarian request, their whatever request, but this is better, I would say.

UGS

OK.

OK and to your knowledge, is there a firewall like a separation between public health institutions and immigration services? Do you know what the relationship is there, the relationship between it and when it comes to the to the fears that the status will be denounced.

Participant C

No Well in principle no, they are not supposed to, In principle, they are not supposed to ask questions, In fact, on the status, the person and everything so they shouldn't, they do it less, much less then before. so that's why the families didn't answer in fact that now they do it more so they don't have to ask these questions. So, even if they ask these questions, the families, they don't have to answer, they don't have to answer that to be able to access the RAMQ.

after the I don't know what the dynamics are between the different institutions, there if I don't know if the health talks with immigration, sometimes between them they don't talk to each other, because I don't know within an institution they have trouble to talk to each other, the fact that between institutions I don't know the mechanisms, There, for example, I couldn't say.

UGS

Okay and when it comes to the communication as official of the law and the changes that it brought, were the families concerned generally aware that their children will now have access to the public system? How did it go in terms of the communication of the law?

Participant C

Well, I don't think there has been a lot of awareness raising towards the families. There has been communication that has been done with health institutions, health institutions. Again, we would have, excused me I'm looking at a document at the same time because we had

documented it a little. There were information letters that were sent to the health establishments. Maybe not enough but who are we to judge that, In any case, we find that at the beginning, the information was not going through quickly enough, so we were very very proactive there to contact the Ministry of Health and there RAMQ to tell them there were still a lot of implementation problems, That the health institutions were not aware, that the families were not aware, the community organizations were not aware either. Because often families go through community organizations, so the work had been done more at the level of health institutions. Then, little by little, I think that community organizations started to spread the word, to communicate with each other to be aware of this law because there have been many organizations, including Doctors of the World, that have been very, very active in advocating for this law to exist, infact since 2016 we have been working on this, and so these organisations also did a little communication work, but more of word of mouth, because it's not necessarily our job to do a widespread large communication on this. So, it still took some time, but now, I know, it's been since 2021, so it's been 3 years now that the law has passed, it's starting to really be more and more known, but it was still pretty long before it was known by everyone, and it's not yet known by everyone.

UGS

Ah, and was the ministry or the government in general receptive to your feedback and suggestions for implementation?

Participant C

On implementation issues?

UGS

yes**.**

Participant C

Yes, we've had yes, yes, we still have a good relationship in general with the Ministry of Health and the RAMQ, uh. Between listening to what we say and then implementing it,

sometimes, there is a delay.

In our opinion, I mean for sure they're big machines, The ministries, the RAMQ, so,. But you know, we've had many, many interactions there, whether it's with the Minister of Health, the RAMQ, we've had meetings, we've sent letters too, a lot of letters that we signed with several signatories to for a little, well, yes, to denounce the implementation problems. we're not aware of everything that's been done, but we can see that there is an improvement that has been made so they don't keep us updated on what they're doing, but you know, we notice on the ground that there has been an improvement, so all the better. . But it's certainly been a very long process. Now, we've had ties with them for years, and I would say that it's been since 6 or 8 months that we've noticed an improvement with registration. We are still, there is still a lot of progress to be made in terms of billing, but in terms of registration, things are much better. So, little by little.

UGS

OK, so once the kids are registered with the RAMQ And they have access to the public system, are there still challenges or barriers like once they are in that situation, as accessing public care?

Participant C

No, no. After that, it's like everyone else, it's about having a family doctor and having access. That's it, it's like it is for everyone. So once they have the RAMQ, access is restored. However, the problem there is is that the RAMQ card is supposed to be valid for 4 or 8 years for kids as of a certain age for the population in general. On the other hand, for these children, often what we have noticed is that the date of the expiration for the RAMQ, will coincide with the end of the visa, for example the parents' work visa, when it shouldn't, because it's children who are here, who should have access, regardless of their parents' status.

UGS

Ah OK

Participant C

But very often, what we notice is that the date is really at the same time as the end of the parent's work visa and sometimes, it's already long, well now, the registration is faster, but you can receive your card 2-3 months later, then the card expires 8 months after you receive it. So then you have to restart the whole process again, the parents, because they put the same date when they shouldn't. So it's more at that level, it's not so much about access to go to the institution, if you have the card, everything is fine, but it's rather after in the renewal and in the duration of validity of the RAMQ card that we find that he has a bit of injustice at that level because there shouldn't have a different treatment because it shouldn't be based on the status of the parent. And they do it finally.

UGS

yes, and once they do this renewal process, do they still have problems with this process?

Participant C

But much less there now, since registration is faster, but we cannot forget that there are still families who are really in a very precarious situation, who do not necessarily speak the language, they do not necessarily have access to computers, to the telephone. So you know, it's more that, you know we're not faced with someone, you know who speaks French very well, who has full connection at home, there's no problem and they're done in 3 minutes and everything is fine. So it's rather that, the registration process is rather easy and fast, but they still encounter barriers, so you ask them to renew every 6 months because the work permit is valid for 6 months for example, it makes it so the families well they miss the deadline, so they arrive at the hospital with a card that is no longer valid, and then they can be charged even if they shouldn't be, so there you go it's all that that adds barriers.

UGS

OK, and have you touched on this a little, but Doctors of the World is what you are very involved in the communication of this administrative part, and then accompanying the families with this process.

Participant C

Yes, we actually have the clinic, there are 2 social workers and then 3 nurses, so everyone who goes through the clinic sees the social worker and the nurses. So often, they come for a medical problem, but they always go through the social worker, so that the social workers can support them in their procedures.

UGS

OK**.**

Participant C

We really can't accompany everyone there, so those we can there in relation to the capacity we have.

UGS

yes

Participant C

Yes, yes the social worker accompanies families in these processes.

UGS

OK, and I was reading something about the wording of the new law in as to how the new conditions to be eligible and some people raised concerns that maybe some children would continue to be excluded because of the way the law and its new conditions are worded for example, Like if a child is in shared custody or under youth protection, are you aware of it, are there situations like this or children?

Participant C

We didn't, we didn't witness that on the ground at Doctors of the World.

UGS

OK.

Participant C

You know, Of course we, everything that is foster care, you know, the children on youth protection, we don't see them there, you know, us, it's the families who come to see us, So I imagine the foster system They, they have their network in terms of medical care, I don't know. What is the other example? Ah in shared custody, well, we haven't witnessed that. I mean, it wouldn't surprise me because that's what you have to prove, that's what I was saying, you have to, you still have to prove that the, that the, the family intends to settle here, in fact what they want to avoid is obstetric tourism. Well, let's see, I'm thinking pregnant women there, but the fact that people come to be treated here, for free, there which is not at all our population that we serve there, so it's a bit of a misconception. But so they have to prove that they want to settle here, so it's quite possible that when there are divorce situations, for a family, it's difficult to prove. But we haven't witnessed that so I couldn't testify too much about that, but it can be.

UGS

OK.

And in general, what will you say are the biggest challenges to the problem with the implementation right? Is it billing?

Participant C

yes, billing is still really, really a big problem for women who, women who give birth here. I am looking a little bit at what we had, what we had said. That's it, So that's it's, it's the non-compliance with the presumption of admissibility. You know, to use the exact terms, the

law says that when a child is born on the territory, there should be a presumption of eligibility for care, as long as the has not proven the contrary, that is to say that they did not want to settle, so a child who is born here, care should be free. After 6 months, they can say Ah well no. In the end, the family doesn't want to move here, so we bill for care, but there is a presumption of eligibility in the law for children who were born here, so there's still a lot, a lot of billing for children born here.
So that's really a big problem. Then I would say, the other implementation problem that I mentioned is the validity of the insurance card, health of children who should be 8 years, when in fact, it is mainly related to the often work permit of the parents who create barriers of access in the end.

UGS
OK and for the billing for the children who were born here alone there because of the problem, is it like the lack of communication with the hospitals, is this why they do this?

Participant C
Well that's a good question, we don't really know.
That's what we often ask ourselves here. Yes, I think again, they have a fear of obstetric tourism, so the women come, the women just come to give birth here so that the children get nationality, and then, after 2 months, they leave again. But in the law, in fact, it is the law. It is written that you know, we should apply the principle of presumption of admissibility, so in the law we don't really know in fact why maybe it's that we also think that there may still be a lack of knowledge of certain establishments of the details of the law precisely.

UGS
Yes

Participant C
Then you know, families are often not necessarily super informed about the details of the law either, so they don't say much there, you know, and then they know, it's also difficult when

you don't have a status to fight back because you're always afraid of being deported or whatever it is, that the families anyway it's not on them, to do anything, it's more establishment, so I think that ignorance of the law and a fear of obstetric tourism then. But yet, it's written in the law, so I don't really know, it's a good question.

UGS

OK.

Participant C

You should ask them.

UGS

and do you know If the Ministry of Health makes efforts to disseminate this information to these changes as well as to health institutions, or is it just like no one is talking about it?

Participant C

yes yes, a year ago that's it**,** they made newsletters, we don't know about everything that is transmitted there, so we know that there has been some.

UGS

OK.

Participant C

You know, when we have, we've gone to harass several times, now you know, they've told us, some, sometimes with some, our partners, some of them have said Oh yes.
Precisely, we received a newsletter from the Ministry of Health so that it was forwarded to us. There are some that are public too, but we don't have the details of each one, but yes, there are some efforts that are made, but not enough in our opinion.

UGS

yes, and you mentioned the validity of the RAMQ card usually, it's supposed to be 8 years so that's the RAMQ, who does that? When they are in the process of processing applications they change the expiration date for those cases specifically?

Participant C

Yes, that's right.

And then I don't know what the dynamic is between, um, we don't understand exactly, you know, why they are doing this? Is it a directive of the health ministry that is telling the RAMQ to do this. We don't really know why finally. But yes, clearly, it's the RAMQ because often probably the parent will give a work permit to say they want to settle, as proof of intention to settle. So there you have it, they will put the same expiry date as the permit, but we don't know why.

UGS

OK.

And in general, do you have any suggestions for what should change so that this law is more effective in improving access to health?

Participant C

Yes, well for us it's to inform, to continue the communications, to really increase the communications with the establishments when it comes to billing, so that everyone applies the law as it's written.

UGS

yes.

Participant C

But there's another thing that we, well, it's also organizations, community organizations, public health, to maybe better communicate to families that this law exists so that families are better informed too. And for sure the question of the validity of the RAMQ card. I mean, right off the bat, to not to ask themselves the question, and to know that it's 8 years for everyone, as soon as you get a health insurance card, that it should be for 8 years. You know because in itself, we find that it's quite simple, the things to change are quite simple- there is also something that I haven't mentioned, it's the children who were not born here but who arrive on the territory with their parents, there is no principle of presumption of eligibility for these children, that is to say that, When they come arrive, you know, the parents have to really, you know, send all the documents, prove that they're going to stay more than 6months, send all that. The child may wait 2 months until, he receives his RAMQ card, but during those 2 months, if the child needs access to care, the family must pay because there is no principle of presumption of eligibility for children who were not born here so that we would like this principle to be put in place for children who were not born on the territory, so as soon as they arrive, that they can have access to care for free until well, the parents prove or not that they want to stay. Then, if they don't stay well then, the care is billed afterwards to the family, so that's also something, but hey, it's something that we would find, that it would be fairer to ask.

UGS

OK. Yes.

Participant C

And then I'm looking at what we had proposed, yes basically, that's about it, the biggest ones, I'd say.

UGS

And speaking of people who continue to be excluded from coverage, I know that pregnant women are still not covered.

Sh

yes.

UGS

How does it affect the health of children?

Participant C

Well, it has very big consequences because women don't do their pregnancy follow-up because they don't have the money to pay, so it already creates a situation where children are already born with problems. Then after that, it's children who will require much more care than if the women had had a pregnancy follow-up, that could have been prevented.In fact, there are 0 preventions, so basically it results in children that are born with problems that must be followed by the health system, therefore paid for by the health system, because these children are covered. Then it has repercussions, we know it, eh, the period In the mother's womb and then the 0-2 years old, it's the nerve period for the health of the children, so there, we create health problems for these children in the long term and therefore costs for the, If I speak the language of the ministry, which they like to use to convince people, it has costs in fact for society in the long term that are much more expensive than if we had provided prenatal care to pregnant women so it's a bit of nonsense to cover children when they are born but not to cover them when they are in their mother's womb because it really creates a lot of problems because we have women arriving in hospitals, you know in catastrophic situations there who have never seen the doctor, who can have diseases that we could have protected the child from, but now we can’t because they arrive, they give birth, they haven't been followed at all in any case, so it's really Situations that could really be avoided, which would cost much less to the health care system to cover women as soon as they learn that they are pregnant, they could have prevented this.

UGS

Yes, yes.

Participant C

Then there is the whole question of abortion. That is all included in care for sexual and reproductive health, contraception, abortions that also is not covered.

UGS

Hmm.

Participant C

And that's the same, I mean, the government has a little opening to cover pregnant women, but not abortions, so that's also nonsense.

UGS

OK**.**

Participant C

Now we're forcing women to, you know that, it's going to raise one of the ethical issues for women themselves.

UGS

Yes.

Participant C

Now you know to say to yourself if I keep my baby, all my care will be covered, but I don't want to keep him, so now I have to pay 1000 dollars so we're you know, it's like a bit of nonsense to not cover everything that is sexual and reproductive care, so for sure this has big consequences.

UGS

yes

Yes.

Participant C

Us, since the beginning, in our advocacy we put all of this together, you know. Covering women, sexual and reproductive health and children, for us this all went together. It was the government that said, well, us, we will just cover children, so we continue our fight for women, but for us that all went together since the beginning.

UGS

Yes, so that access to care starts when the child is still in the womb.

Participant C

Absolutely.

UGS

I think that was the majority of my questions.

I was wondering about communication, the process of registration the collaboration between the different actors. Do you have any other thoughts or comments on this subject or are there any issues that you know of that are important?

Participant C

No, no, no, I think I said quite a bit, the essentials, of course. We also had recommendations, you know broader recommendations, you know like translating, making information guides for families and translating them in multiple language. You know here's that whole aspect there also, the access for families like I was saying because. Its families that are often very precarious, but anyways, maybe it's less important, but it's also important. But already it's more relevant for families. But already I think that would facilitate things a lot. And no no I think I covered everything.

UGS

Ah OK, so right now access to care in a language that families understand, that's still a challenge that remains.

Participant C

Oh yes, yes, absolutely.

UGS

OK**.**

Participant C

Or even the information, the information to say that what the law exists should be in several languages and yet it’s not.

UGS

yes and without the raising awareness of organizations like Doctors of the World and others, do you think that people would be aware of this law or the changes or that they are covered or not?

Participant C

Well, that's it I think community organizations play a big role in this.
There, you know, we, in the, we had a lot of community organizations that had rallied with us for the cause, so it's certain that they have a nice… And at the same time
it's normal because often families go through community organizations first because that's where it's the first door, you know that the organizations inform the families.
I think, it could, you know, it can be part of our role, but the health system also has to be aware and play this role there too when they are in front of a family, I'm not saying that they don't do it, but they themselves are not always aware of it, You know of the details of the

law. You know, people hear yes, PL 83, People start yes, Everyone knows about PL 83, but the details of the law, people don't know it, which means that there are billings, there are things that are done when they shouldn't.

UGS

OK and last question sorry you mentioned that you have like links or communications with the Ministry of Health, but has there been any kind of formal collaboration to disseminate information or as a collaboration for this law or the people involved, or is it more informal this relationship?

Participant C

Yes, well there was no, we had 0 role to play at the level of communication and that's ok because I think that's really up to them to do it. You know,
once the law was put in place, it was to us really their role, it's up to them to communicate in their network. You know, it's up to the government to communicate this law, however, in the "before", in the work that has been done to make the law exist.
Yes, there were formal links with the Ministry of Health, reports that we issued, not just the world's doctor with lots of partners, coalitions, partners. There were interministerial committees that was set up by the Ministry, on which Doctors of the World and the observatoire des tout petits were also very active. By the way I don't know if you've contacted them, but it could be a good one.

UGS

Yes, but no one answered me, I don't know if you know anyone who works there, that you can connect me

Participant C

Ok, Ah, I could try to see there because they have also been very active in this file, the Observatoire des touts petits. So yes, there were links before, for the law to exist. There were

really formal and informal links that have been made, But yes, yes, there have been, they know us well The Ministry of Health.

UGS

OK that's perfect. Well I think that's all my questions, but if you think of other people who have knowledge on this subject who might be open to talking to me, it would be really great to be connected. But otherwise, I really appreciate your time and for answering all my questions. Every person I talk to, they tell me, well yes, I can answer your questions, but you really have to talk to the doctor of the world, they are the most important, so I appreciate this very much.

Interview Transcript Participant D

UGS 6:43

So you said in your email that you mainly work with adult asylum seeker, can you tell me a little bit about what your job will entails and the population that you're working with?

Participant D 6:44

Yeah.

Yeah, sure.

So our clinic is a clinic that's been around for about 35 years and we our mandate is to give short term family medicine, follow up care to asylum seekers.

So, um, basically to be eligible to be followed in our clinic you can't have a RAMQ card and you have to be you have to be an asylum seeker.

UGS 7:15

Okay.

Participant D 7:20
Who is who has or will be getting soon their IFHP coverage.
I don't know if you know the interim federal health programme, it's the medical insurance that covers all asylum seekers.

UGS 7:26
OK.

Participant D 7:32
Well, I mean that proves it's also an ID card and it proves that they are an asylum seeker. So if you're an asylum seeker, and I mean, we're sort of, we've become sort of a secondary level clinic in the sense that we don't.
Our patients are all referred to us from primary care physicians or social workers that that have had contact with asylum seekers and we've sort of asked people just to sell us, send us very, very, very sick people because we're only five doctors and there's like 80,000 asylum seekers in Montreal.

UGS 7:54
OK.
And.

Participant D 8:10
So we'd never be able to, we can't take, Unfortunately, we can't take care of bumps and bruises and sore throats and stuff. We only take care of the heavier stuff and and you know it's a good question as to why we're seeing mainly adult populations because I don't actually have the answer to that the the referral system to get to us goes through an organisation called PRAIDA.I don't know if you've heard of them.
It's Regional Program for the Settlement and Integration of Asylum Seekers, And there there,

there are mandated by the government, the provincial government, to facilitate the arrival of all asylum seekers. Right.

UGS 8:46
Okay.

Participant D 8:57
So when you get to the border and you say I want to be recognised as a refugee or as a refugee, so you I want temporary asylum status.
They are referred to PRAIDA and PRAIDA is or network, not network, it's a it's a group of about 40 social workers and they evaluate, they lodge, actually they have housing, temporary housing and in two to three weeks they explain to asylum seekers how to get on to social welfare, how to get a work permit, how to get a lawyer, how to get your kids in school, how to network in Montreal, how to find an apartment if possible and then they, they you know, they send them off on their own during that period of time.If the social workers suspect any health issues, or if the people themselves manifest that they need healthcare, they have a series of nurses who will evaluate the people.Now, if it's bumps and bruises and sore throats, they send them to walk in clinics, and if they're really sick, they sent them to us, right. They refer him to us for long term care, so it's a lot of psychiatry.

UGS 10:09
Okay.

Participant D 10:13
It's a lot of, you know, you know, chronic medical conditions and what not.
So I mean, it's up, I should ask them why we're not seeing a lot of paediatrics.
I mean I my guess would be that most are most bumps and bruises and sore throats we don't see, right?

UGS 10:30
Hmm.

Participant D 10:36
So that's the minor things.
And there are a few clinics, specialised clinics in Montreal, Children's Hospital and Hôpital Maisonneuve Rosemont, they have transcultural paediatric clinics, right?
So if they see a family of asylum seekers and they see a child that clearly has very serious medical issues, they won't send them to us, they'll send them to those specialised clinics, right, children that have advanced handicaps that are on the autistic spectrum or any type of quite obvious severe chronic illness will not be referred to us. They'll be referred to more specialised care, which is probably why we don't see that many.

UGS 11:21
OK.

Participant D 11:28
We don't see that many very young children, we do see, we do see adolescence because, because um PRAIDA, apart from their mandate to orient asylum seekers, they also have the mandate to help unaccompanied minors find foster homes.

UGS 11:49
Hmm.

Participant D 11:52
And also, I mean we sort of have an implicit agreement with them that if they have unaccompanied minors we will follow them, they can, they can refer them to us anytime because they're it's often a complicated situation.

UGS 11:54
OK.

Participant D 12:07
They're adolescence and they're often psych issues.
And anyway, so, so we will see adolescence.

UGS 12:11
Yeah.

Participant D 12:13
But there again it's, I mean, my youngest patient is, you know 14.

UGS 12:19
OK.
And so, because it goes through PRAIDA and this is specifically for asylum seekers, do you ever see anyone who doesn't have this interim federal coverage and might have like a different migratory status and doesn't have an asylum claim or it's just?

Participant D 12:34
No, I mean like you know that it's very compartmentalised before 20, I'd say before 2010, we were just a walk-in clinic, and we would see whoever and we would see children and we would see U we would see migrants without any status.

UGS 12:40
OK.

Participant D 12:56
Interestingly, it after 20 I guess it was anywhere and maybe it was 20, 2008, 2009 um.

The upper echelons of the CLSC um made it quite clear to us that the government, because we are a public clinic, the government did not want us to be seeing people with irregular status.

UGS 13:24
Ohh ok.

Participant D 13:25
They just, they basically forbade us to see anyone who didn't have a status unless upon seeing them, you know, if we ask them like, but do you want to regularise their status? Do you want, are you, you know, because sometimes people, sometimes people, are just in limbo because they don't understand the immigration system, and if they are clearly in a position where they could ask for asylum, well then we would orient them to PRAIDA and then they would make an asylum claim.

UGS 13:44
Right.

Participant D 13:55
And then we would continue following him. But since that time, and we're talking well over 10 years ago, we haven't seen any patients with any type of irregular status.
We don't see students we don't see. Um, a temporary workers or our mandate is quite narrow.

UGS 14:09
OK.nI imagine that there's still some overlap just with dealing with migrant patients in general though. Can you tell me a little bit about some of the challenges and providing care to people coming like from migrant backgrounds or there any specific challenges?

Participant D 14:30

Well, I I mean the first one I just alluded to, it's the complete you know it's the, it's the quagmire of our immigration status, right?

UGS 14:34
Ok.

Participant D 14:38
I mean people and it's quite easy to imagine that if you come from anywhere, except Canada and even if you are Canadian, you don't really understand the mechanisms of the the services that are available.

UGS 14:52
Yeah.

Participant D 14:55
I mean, before our meeting, I was looking at Bill 83 and some of the just the broad lines and I mean, I think the crux of the matter is all about is all about information and access to information and how transparent, the provincial government is about this new access to care, which is fantastic. Like I read it and I said, well, you know, kudos to us were humane. We realised that you know that children need care and there shouldn't be a délai de carence So that's all well and good, and that's fantastic.
Um, but as other things that they've done in the past, how well is it actually delivered to the people that it's targeting, right? Because I mean, I read about it, but you know how many parents or pregnant mothers are aware of it, and if their that's why I think it might be interesting to speak to some of the the doctors that are delivering babies at Maison Bleu because the mother's can be in precarious situations. And I find with asylum seekers, I am often in the awkward position one where I'm telling them about their legal rights as asylum seekers. I'm trying to let them know the the non expert information I have, my take on their rights right, which is not how it should be. A doctor shouldn't be explaining a patient their immigration rights and the immigration law, so I would. I would think that that is probably

where the issue stands with this you know, albeit on paper, very, very generous amendment to a law is how is it trickling down, how is it trickling down to the people? That, and particularly in situations where you know very young children exceptionally but may need emergent care very quickly, right cause that's where, that's where the problem always is, right?

UGS 17:06
Yeah.

Participant D 17:09
That's in this situation where there is emergent care that's needed, and if you don't have the document or if you don't have the proper insurance, it can delay care or parents might delay their care. Sorry.

UGS 17:23
Yeah. So the communication to the people that are targeted by these laws and these changes if is lacking.™

Participant D 17:29
Yeah, absolutely.
Well, I don't you know.
And there again, I'm not.
I'm not intimate with the the NGOs that are working with, with the migrant populations, but it would be interesting to know through them, you know, like la maison de l'amitié, let me see.
I mean, do they?
Do they have pamphlets about it?
Are there are there their frontline people who are meeting with the migrants?

Are they talking about this, right?
I mean it cause I don't expect the the ministry to you know have like a whole publicity campaign on this but because they'd have to do it for every law they change.

UGS 18:01
Yeah.

Participant D 18:13
But they would. I mean, I would assume that they would still, you know, informed certain NGOs that work with the migrant population, that this change has taken place and how they can tell people how to access information.

UGS 18:23
Yeah.

Participant D 18:28
I would assume so, but I don't know how well if that's been done and how well.

UGS 18:34
Yeah.
And for the patients that you work with, um, in general, how do you find they experience kind of the navigation both health system and finding resources and the administrative part are people generally aware of what the processes are, how to do them or maybe that's out of your kind of everyday?

Participant D 18:55
Well, no, we see it cause that's I mean we see people with a lot of uh anxiety issues and you know, once they've actually arrived in Canada, the number one angst, eugenics stressor in their life is migration, is immigration, right?
It's the whole process and so I would say it's a very heterogeneous profile and it would go a

lot with the level of education of the people and they're there, their knowledge of English or French, because I would say that typically a French or English speaking, a migrant or an educated migrant, I find often that the Latino population is very, very politicised.
You know, They often had to leave Peru and Chile because they were all about human rights. And so they're the first one to come and saying, yeah, you know, “MI ABUELO” And you know, they're, like, freaking out and there. And it's good, right?
Because they're it's like they arrive and they start studying Canadian immigration law and, OK, this is what my rights are, which is great, whereas the unilingual Punjabi from India, um, I mean, I ask them who their lawyer is and they don't know and ask about their lawyer or their legal counsel they have no idea, right so they don't speak English or French there you know.

UGS 20:04
Yeah.
OK.

Participant D 20:29
And they often get very poor legal counsel, unfortunately.
So the that's you know about the administrative part, that's a huge barrier, um.
And for the question of medical literacy, there again, it's in general, it's very poor.
No in general it's poor, And again, if you take the unilingual Punjabi, it'll be very poor.They have not consulted or they've consulted, someone has found a physician in their community and that's the only go to point they've had, whereas someone that is a little more literate with the medical system, they will have found.
I mean, everybody goes to emerge when they have a problem that's pretty universal across the world. So, but they will have learned to at least access that care.
But it's now I'm only speaking about asylum seekers.

UGS 21:26
OK.

Participant D 21:29
But the IFHP insurance they have is it's very comprehensive.
It's extremely generous, more so than the RAMQ card, but um patients and most physicians don't know anything about it. Right?

UGS 21:41
Okay.

Participant D 21:46
So, so the physician, the, the, the patient doesn't know what they're entitled to.
And if they're sitting in front of a doctor, the if the doctor doesn't have experience with IFHP they won't know how to optimise the care that they can get with it.

UGS 22:04
OK.
You kind of touched on a a point that's come up in some of the previous interviews.
Just about communication to healthcare professionals and health establishments.

Participant D 22:14
Hmm.

UGS 22:15
So in addition to communicating the law and like having, you know, the families who are are concerned, be aware there is also mention of a lot of hospitals and clinics not knowing about the law, the details of the law, knowing that people should be covered and still charging people.

Participant D 22:32
Yeah.

UGS 22:33
So I'm curious, do you know anything about how it's been communicated?
Like, has your clinic received any information or just do you have any awareness of how the ministry, or does it even communicate, you know these changes?

Participant D 22:46
Well, I mean, we got communication simply because we are, you know everything migration oriented in health. We get communications right and I mean certainly PRAIDA is sort of like a conduit for us.

UGS 22:55
OK. Ohh.

Participant D 23:00
Um, but I have the either the good fortune of the or the misfortune of being in two CIUSSS medical territories and affiliated to the University of Montreal, and with PRAIDA. So I get four sources of incoming emails all the time, which is not necessarily good, but I'll get the I will get the information.

UGS 23:16
OK.

Participant D 23:28
But I mean, one thing that I realised is that you know 80% of physicians found first line frontline family physicians work in, privately run clinics, not the public system like not in CLSC's.

UGS 23:46
80%?

Participant D 23:47
Yeah, they're they're not in the private sector, right?
There in you know, you know how Quebec is screwed up.
A private clinic is not a clinic where you go pay.
I mean, there's there's less than 1% of physicians that are in a private pay as you go healthcare system, right that's completely off RAMQ, but um, I and a buddy physician, we can decide to open a clinic and it's therefore poorly called private clinic.

UGS 24:18
Hmm.

Participant D 24:22
But we get paid by RAMQ, right?
But the only difference between us and a CLSLC is that the CLSC the the government pays for the roof and the heating and the nurses and everything.

UGS 24:25
Okay.

Participant D 24:33
Whereas if I and my buddy open a clinic, we pay for the nurse and the Secretary, right?
So there's overhead that we have to take care of, but it's still RAMQ coverage, right?

UGS 24:38
OK.

Participant D 24:43
So and the term used in the last 10 years is GMF, The groupe de medecins familiale, so there are a lot, most private clinics are GMFs.

UGS 24:52
Ok

Participant D 24:53
So these groups of doctors, um, have organised themselves or they are affiliated to a private company, but it's RAMQ access, right?

UGS 24:57
OK.

Participant D 25:10
Right.
So it's it's so anyone with a RAMQ can go there free, but these clinics don't get.
They they're not intimately linked to the public sector, so they don't get information like we do right and 80%.

UGS 25:26
Ohh well that's huge.

Participant D 25:28
Yeah, it's crazy.
I mean, it's 80% of family physicians work in GMF's in Montreal, right?
Only 20% are in CLSCs, so because I spend a lot of time trying to educate physicians about IFH coverage and offering good medical care to asylum seekers, well I realised a couple of years ago that GMFs they just don't know anything about the IFHP coverage right.

UGS 25:38
Yeah.

Participant D 25:57
So I would be giving lunch talks about how so I think you'll find that there's the same type of difficulty communicating information.
Uh, and it's not always the physician.
It's not just limited to the physicians.
You know, as you might have heard, you know, the first step is getting through past the secretary at the front desk, you know, and my patients are regularly turned away, even though physicians will have you have their appointments to see them, but they go and, you know, they you know, automatically the Secretary asks for the RAMQ card.

UGS 26:21
Yeah.

Participant D 26:34
And if they don't have it?
Ohh well, pay up .and it's like no, I have this other medical coverage.
And if she doesn't know what this paper is about, you know you're either charged and my patients don't have money, so they walk away.
So access to care because of clinic administrative personnel and physician ignorance is rampant, right? And that's very, It's something hard to palliate because I get it.
Doctors are really busy and they're drowning in all the emails that I'm drowning in.
But to you know, to get precise, you know sort of very pinpoint information about a percentage of their population that needs care, It can take time, It will be a challenge for sure.

UGS 27:20
Yeah, I think that's huge.

If 80% of doctors aren't receiving, to at least to the same degree, communication about a change in coverage or eligibility, so if someone comes and they might not be completely aware, and then the clinic isn't either and just people getting turned away.

Participant D 27:28
Yeah.
Yeah.
Yeah, but I mean I, I mean, and I can't say that they don't get information, right?
I don't work in a GMF, so I don't know what type of information I mean, I mean, all physicians in Quebec, we all get a family physicians, we all get information through the FMO which is our professional body, right, that represents us to the government.
So we all get FMO communication, and we all get CMQ the college des Médecins du Quebec. So I would not be surprised and I would assume because it's probably part of their mandate that the CMQ and the FMO have sent out information letters about it, I would swear by it.

UGS 28:25
OK.

Participant D 28:26
I mean I I can.
I can check I can go on and CMQ and fmo and just, you know, search Loi 83 and I'm sure something will pop up.

UGS 28:30
Yeah.
Hmm.

Participant D 28:36
So it's probably pushed out in an email.

UGS 28:39
Right.

Participant D 28:39
Um, you know, so I I wouldn't necessarily, you know, it's it's really hard to you know it's hard.It's not a question of pushing blame out there, right?
I mean, I think the ministry probably contacted the FMO and the CMQ and said listen, uh, this laws changing your health professionals should know about it.

UGS 28:50
Yeah.

Participant D 28:59
So they said, OK, we'll push it out there and then push it out.

UGS 29:01
Yeah.

Participant D 29:02
And physicians have to they scan their emails like I do and I get like 40-50 a day.
So I trash a lot of them. You know, I read the subject matter and I flush them right?

UGS 29:13
Yes.

Participant D 29:17
So if you don't see a lot of paediatrics and you and you see a CMQ email that talks about, you know, you know, law change for paediatrics, you could flush it. Right.

UGS 29:21
Hmm.
Yeah.

Participant D 29:33
So you're not aware, so it's very, I mean I think it's it's a systemic problem of you know the difficulty of communicating these types of access to care or new changes to access to care.

UGS 29:47
Yeah, for sure.
And bringing it back to a little bit like directly providing medical service to people who are experiencing migration, I was wondering about, I guess like the language and cultural barriers that might arise when trying to provide medical services and how you kind of have experienced that?

Participant D 30:09
Hmm, that's a whole Pandora box.
You say language issues.
I mean communicating with an Anglophone or francophone who's lived in Quebec their whole life can be challenging when you talk about the healthcare system, right, and you say ohh, you just gotta do this and this because it's full of acronyms and and people get dizzy and a little nauseous when you start talking about it.
But um with migrants, and particularly and this is has been my pet peeve since I've been working here, but the issue of interpretation, access to information outside of English and French is just it's, I find it scandalous in the sense that, I mean, years for years and years and years and years, and it's still the reality.
Hospitals in Quebec and hospitals in Montreal, where 13 to 15% of all people are allophone, They don't speak English or French. They don't have a systematic access to interpretation, right? You don't.

UGS 31:11
Ohh.

Participant D 31:12
Yeah, it's amazing.
I mean, if you walk through the corridors of a hospital and I was there yesterday and I heard it again on the overhead, it's like, does somebody who speak Farsi, could a member of the personnel speaking Farsi please present to the Orthopaedics?
Uh out clinic outpatient clinic.
Right.Because the orthopaedic surgeon opened the door and the patient looks at them.And they just say “Iran, Iran, I come from Iran, I can't speak.”
And the doctors like “ohh my God, how am I gonna do this?”

UGS 31:40
Yeah.

Participant D 31:42
And then say, hey, can somebody get me an Iranian interpreter, right, so they shoot it on the overhead. And the guy who's passing the mop down in the second basement says he's an immigrant from Iran. And he says I can go do this and he'll go upstairs.It's completely unprofessional and it's completely ad hoc, right?
It's it's improvised, and this has been going on forever.
I mean, as long as I've been practising medicine, when you're in a hospital, you hear this. I know that the Montreal Children's at one point had their own little Bank of interpreters. It was disbanded, For whatever reason, there is an A Bank of interpreters that is theoretically available to all public healthcare facilities. Administrators don't want to spend money on it. Doctors don't know about it. Admin staff don't ask for it.

Um, I mean, it's really and it's it's an eye sore. It's something that I mean, if I think if immigrants did know their rights better, they would have sued, you know, hospitals a long time ago.

UGS 32:48
Yeah.

Participant D 32:48
But they don't, and I don't know.
I find it just very pathetic. Mean we've always had interpretation just because as a clinic we need it, we require it.

UGS 32:58
Yeah.

Participant D 33:01
So our CLSC has never asked questions about it because all CLSCs all public facilities have a budget for interpretation, right?But hospitals prefer not, to use it for other means, right? If they can save on interpretation,

UGS 33:15
Ohh, they have a Budget for it? .

Participant D 33:17
Sure, sure. there's a Budget, right?
But it's not a it's not a closed envelope for interpretation.
It's a broad envelope for interpretation and other things, right?
So if they can buy a photocopier with it, which, I don’t know what they do with the rest of the money, but they certainly don't spend it on interpretation.
So we've been spending hundreds of thousands of dollars a year on interpretation and it's

huge amounts of money.
So you know, we're just a clinic with PRAIDA, right?
Cause we're affiliated to PRAIDA, so I mean, we spend hundreds of thousands a year and we were part of a pilot project. And we've since adopted a video interpretation system that's on demand.

UGS 33:59
Yeah.

Participant D 34:00
And it's fantastic, right?
It's it's a little iPad on wheels that you can wheel around and you just punch in the the language you want and within a minute you have an interpreter on the screen, right? So we've actually managed to convince the hospital next door to put one of those machines in their Emerg Department, where they obviously need, you know, ad hoc, immediate interpretation and another one in an ID clinic ,infectious disease clinic ,because they see a lot of immigrants, right. So the hospital next door has just barely in 2023, started opening itself to the possibility of spending a little bit of money on interpretation. Right, and this is rampant through all the hospitals.

UGS 34:44
Wow.

Participant D 34:45
It's pathetic.
It's truly pathetic.
So if you are a mother, a giving birth in a hospital, um, and you don't speak English or French unless the people who are filling out the paperwork at the at the hospital administration level know what they're doing.
You I don't know how you could defend yourself.

UGS 35:09
That's pretty shocking.
I had no idea that this was so rampant.

Participant D 35:12
Ohh yeah, it's it's.
Yeah.
I mean, I find it very embarrassing, especially in Montreal, because I have a colleague in Quebec City who championed interpretation access a lot.

UGS 35:22
Hmm.

Participant D 35:26
And there's actually an interhospital committee there.
I don't know how active they are, but at least it exists.
And they look at their expenditure on interpretation.
So they're actually A) they're a talking about it and B), they're actually, you know, pointing out, hey, you, the cardiac institution, you've only spent $20,000 this last year on interpretation. What's up? Why are you not spending more?
You're not offering enough, so there's finger pointing going on between hospitals to those that are clearly not spending enough because they should be spending, right.
Whereas here I think hospitals are quite proud to spend nothing on interpretation because it saves them money, yeah.

UGS 36:07
Yeah. That’s crazy.
I was working in Greece on one of the islands, Samos, where and they have a lot of asylum seekers and even there I mean it's a tiny island with like a run down hospital and even there

all the asylum seekers who go seek care are entitled to an interpreter.
And obviously there's some problems with implementing that, but even even there, which, like compared to Montreal, has way more services and way more resources.

Participant D 36:36
Hmm.
Yeah, but you know, but that that tells you that for me, that's not surprising.
Right.
Because I mean, we only see it asylum seekers, so we get the Budget right, that island receives 10s of thousands.

UGS 36:47
Yeah.

Participant D 36:55
So the first thing everyone that's involved in their care says is get us interpretation right. Whereas in the hospital, you know, it's one out of 10-15 patients you know, see, I get consults back from specialists all the time and all they just it's like there's a mea culpa up on the top corner saying poor historian only speaks Farsi or accompanied with by daughter who speaks minimal English.

UGS 37:23
Right.

Participant D 37:29
Right.
So it's the the physician is basically just saying I did what I could.

UGS 37:30
Yeah.

Participant D 37:33
You know, this really sucks.
I really did what I could, but here we go instead of and I and, but I think this is just generational. Also, I mean, I don't think doctors are used to asking for interpretation, right, whereas I mean, we're a Teaching clinic, so I trained the residents and the medical students to complain about this and to demand interpretation.
When they do hospital rotation, because if you don't ask for it, if doctors don't ask for it, the admin people are just gonna say well, no need expressed is not a need, right.

UGS 38:02
Yeah.

Participant D 38:12
So, you know, I think, I mean, the budget's there.

UGS 38:12
Okay.

Participant D 38:15
So if doctors ask for it, it'll be used.
But anyway, coming, so all that to say that I think that even the well informed migrant who a but who doesn't speak English or French is at a clear disadvantage to try to just, I mean understand what's going on.
I mean, most of I, like I say, I can't speak directly to to Bill 83, but my patients don't know what specialists told them, right?
I said “ohh so you saw the you saw the cardiologist?”

UGS 38:46
Yeah.

Participant D 38:48

“What did he say?”

“I don't know”

You know,

you know, “he said he'd see me again.

And he asked for tests”.

So they don't know what the diagnosis is.

So I mean, if it's that level of communication that comes out of medical consultations, I don't expect it to be better with the admin staff in hospitals about RAMQ queue coverage or that.

UGS 39:12

Yeah.

Well, well, the language thing is, is huge.

Participant D 39:14

Yeah.

Ohh my it's it's it's awful.

UGS 39:18

Yeah, I'm like still a little bit shocked.

Participant D 39:22

It's awful.

It's just it's a complete embarrassment from my perspective.

UGS 39:28

Yeah, I'm trying to look at like access not only in like the legal entitlement but the different dimensions of healthcare accessibility, and I think being able to actually understand the care that you're receiving and everything is a huge part of that.

So that's super helpful to know.
I think those were the majority of my questions.
If you have any other thoughts on the bill in general or just improving healthcare accessibility for this population, I'm happy to hear it, but that's all on my end.

Participant D 39:58
Hmm, I'm trying to.
I'm still trying to think of someone who could give you more insightful information on the specifics of that. I mean, I can't think of anything intelligent to say hahaha

UGS 40:13
it's very high pressure haha

Participant D 40:14
I'm sure I said enough silly things.

UGS 40:17
No, no, this was super helpful.
And I know that you're clinic mainly is with asylum seekers, but I think that there's still a lot of overlap and just insight into how the healthcare system works with things like this is super helpful. So I really, really appreciate it.

Information Sheet & Consent Forms

Information Sheet

Title of the research project: "The Expansion of Healthcare Access for Children of Precarious Migrants In Quebec: an Assessment of Bill 83's Implementation"

Principal Investigator: Ursula Greig-Steinmetz ugreig@student.ibei.org **Institution:** Institut d'Estudis Internacionals de Barcelona

Funding body: N/A

Objectives and duration of the project: The aim of the study is to carry out an in-depth analysis of Bill 83 and its implementation. The duration of this project is 12 months.

Methodology and participation: I will conduct semi-structured interviews with participants with expertise on the subject, during a single 30-45 minute interview session. For the analysis, I will use theory-based evaluation and contribution analysis to assess the implementation of Bill 83, using a mix of deductive codes and inductive reasoning.

Inclusion criteria for participation:

- Over 18 years of age
- Having knowledge or expertise on Bill 83

Privacy: To protect your confidentiality, we will not identify your data with your name, but rather with a code that will only be known to members of the research team. To ensure that data is only accessible to members of the research team, digital data will be stored with access control systems.

Compensation: This participation is unpaid. The final research can be shared with you at the end.

Risks and benefits: Participating in this study does not entail risks greater than those ordinarily encountered in daily life. Describe benefits associated with participation. If no benefits have been identified, you may use the following text: We cannot and do not guarantee that you will receive any benefits from this study.

Voluntary nature of participation: Your participation in this study is on a voluntary basis and you may withdraw from the study at any time without having to justify why.

Contact information: If you have any question about this study, you may contact the IP (Ursula Greig-Steinmetz, ugreig@student.ibeio.org)

If you have doubts, complaints, or questions about this study or about your rights as a research participant, you may contact UPF's Institutional Committee for the Ethical Review of Projects (CIREP) by phone (+34 93 542 21 86) or by email (secretaria.cirep@upf.edu). CIREP is not part of the research team and will treat any information you send confidentially.

Informed Consent Form

Title of the research project: "The Expansion of Healthcare Access for Children of Precarious Migrants In Quebec: an Assessment of Bill 83's Implementation"

Principal investigator: Ursula Gregig-Steinmetz

Institution: Institut d'Estudis Internacionals de Barcelona (IBEI)

I HEREBY CONFIRM that:

- I have read the information sheet regarding the research project,
- I have been able to formulate questions on the project,
- I have received enough information on the project,
- I fulfill the inclusion criteria, and I am above 18 years of age

I UNDERSTAND that my participation is voluntary and that I can withdraw from or opt out of the study at any time without any need to justify my decision.

☐ I GIVE MY CONSENT to participate in this study.

☐ I GIVE MY CONSENT for the interview to be recorded and the transcript kept for the duration of the analysis and writing of the thesis.

☐ I GIVE MY CONSENT for my name, role and the organization to which I belong to be mentioned in the final version of the thesis.

First and last name(s):

Signature:

Place and date:

Completed Consent Forms

INSTITUT BARCELONA ESTUDIS INTERNACIONALS

Formulaire de Consentement Informé

Titre de la these de maitrise: "The Expansion of Healthcare Access for Children of Precarious Migrants In Quebec: an Assessment of Bill 83's Implementation"

Chercheur Principal: Ursula Greig Steinmetz (ugreig@student.ibei.org)

Institution: Institut Barcelona d'Estudis Internacionals (IBEI)

JE CONFIRME PAR LA PRÉSENTE que:

- J'ai lu la fiche d'information concernant le projet de recherche
- J'ai pu formuler des questions sur le projet
- J'ai reçu suffisamment d'informations sur le projet
- Je remplis les critères d'inclusion et j'ai plus de 18 ans

JE COMPRENDS que ma participation est volontaire et que je peux me retirer de l'étude à tout moment sans avoir à justifier ma décision.

JE COMPRENDS que la recherche est menée dans le cadre d'un projet individuel de thèse de maîtrise, et mes données personnelles ne seront pas conservées, ou traitées de quelque manière que ce soit.

☒ JE DONNE MON CONSENTEMENT pour participer à cette étude.
☐ JE DONNE MON CONSENTEMENT pour que l'entrevue soit enregistrée et la transcription conservée pour la durée de l'analyse et de la rédaction de la thèse.
☒ JE DONNE MON CONSENTEMENT pour que mon nom, rôle et l'organisation à laquelle j'appartiens soient mentionnés dans la rédaction de la thèse dans la liste des personne rencontrées
☐ JE DONNE MON CONSENTEMENT d'être cité directement dans la rédaction de la thèse, utilisant mon nom, rôle et l'organisation à laquelle j'appartiens.

Prénom(s) et nom(s) : Elizabeth Siguin
Signature :
Lieu et date : 15 juillet 2024

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Prénom(s) et nom(s) : Stephanie Harvey
Signature : SHarvey
Lieu et date :

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Prénom(s) et nom(s) : Grace Sade MARGERIE
Signature :
Lieu et date : Mtl, Q. 23/07/2024

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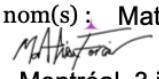
Prénom(s) et nom(s) : Mathieu Forcier
Signature : 
Lieu et date : Montréal, 3 juillet 2024