The Consequences of Precarious Care:

An exploration into the reliance on walk-in clinics in Ontario's healthcare system

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Introduction

It is no secret that the healthcare system in Canada has its own array of issues; long wait times, precarious access to treatment, and a stark lack of primary healthcare providers have had lasting impacts. A large proportion of Canadians rely on walk-in clinics to replace their needs for a primary healthcare physician (Terpou et al., 2024, pp. 1-2). While sometimes convenient, these clinics often lack the regulations offered by public medical institutions (Lett, 2008, p. 896) and cause patients to be forced to seek out more radical interventions in the future (Lapointe-Shaw et al., 2023b, p. 9).

Students are but one population that experiences precarity. As is reflected in the current literature, the intersections of the stresses of financial strain, the fluctuating structures of university life, and lack of access to all or part of the healthcare system in Ontario contributes to an ongoing experience of vulnerability. This qualitative sociological study aims to address these structural issues through the use of one primary research question: *What are the impacts of the Ontarian healthcare system's current reliance on walk-in clinics on university students living in Ottawa*? Additionally, there are supplementary research questions that aim to elaborate further. *What are the financial impacts that come from a lack of a primary healthcare physician? How does a person's identity contribute to their quality of care within walk-in clinics in Ottawa?* These questions can provide more nuance to the results of the interviews, allowing a holistic understanding of wellbeing that goes beyond the isolated experiences within the clinics.

This study has synthesized the context of the existing knowledge around the Canadian healthcare system, sociological understandings of precarity and vulnerability, and a qualitative, social-constructivist theoretical framework. Through a thematic analysis assisted by NVivo, the

intersections of identity, ability, and financial class with health and wellbeing are understood to be linked in the context of both access and quality of care experienced by interview participants.

Literature Review

A lack of access to "continuity in care" through primary healthcare physicians is an issue that impacts an estimated 17% of Canadians, with 2.2 million people living in Ontario without an assigned family doctor, many of which face some form of vulnerability. Walk-in clinics have served as a substitute for ongoing care in these populations (Terpou et al., 2024, pp. 1-2). This is not a new issue, either. From 1986 to 1988, the number of walk-in clinics within Ontario went from 11 to 100 (Bell & Szafran, 1992, p. 507). While at the time, the overall satisfaction of patients utilizing these clinics was high due to the convenience of the clinics at the time (p. 508), it was still acknowledged that "family doctors [act] as the 'gatekeeper' to the healthcare system". A lack of consistency that comes with the utilization of walk-in clinics over primary care physicians leads to "fragmented", "inappropriate", and "inadequate" quality of care for those with ongoing needs (p. 509).

A cross-sectional study conducted in 2019 by Lapointe-Shaw et al. (2023a) found that even among patients who *do* have a primary health care physician, there is a high utilization of walk-in clinics due to a desire for "convenient, timely care for acute issues". It is noted that this might be due to patient's inability to get urgent appointments with their own doctors, and a value-based assessment on their own conditions being urgent, but not serious enough to warrant a visit to a family doctor (p. E353). In a cross-sectional study conducted in 2020 by the same research team, patients who used virtual care as a form of walk-in clinic were often young adults who were subjected to a "lack of continuity of care" that resulted in a reliance on emergency rooms for physical exams (Lapointe-Shaw et al., 2023b, p. 9). Additionally, this study also cites

convenience as a major contributing factor towards patients relying upon virtual appointments; a lack of a need to travel made this option highly appealing (p.9).

Lastly, in a 2008 journal article by Lett (2008), there was a lack of regulations and monitoring of private walk-in clinics in most provinces in Canada, Ontario included, with Alberta and British Columbia being the only provinces with a structure of rules for private clinics to follow (p. 896). As of 2007, the government of Canada reported that a majority of private clinics simply "do not even report the number of facilities involved or the total amount of billings", and wait until they are audited to report. This creates barriers for statistical analysis of just how many people are using these services in provinces like Ontario (p. 896). This is why large scale studies, such as the ones conducted by Lapointe-Shaw (2023a) and Lapointe-Shaw (2023b), have proven to be necessary in understanding the scale of reliance on these clinics within Ontario.

While this form of precariousness in care is not directly elaborated on in social research, there are sociological explorations of precarity in other forms. Han (2018) explores the historical experience of precarity and how it can be perpetuated in social circumstances over generations through the identification of the "precariat" (p. 331). From an anthropological standpoint, Han (2018) identifies precarity as a "bounded historical condition" (p. 332), acting as an underlying common condition that has existed in the lives of the "lumpenproletariat" identified by Karl Marx (p. 333) and the modern "precariat". Those fighting for survival lack the time, energy, or resources to achieve class consciousness and awareness of the current state of politics (p. 334). The precariat, as explained by economist Guy Standing, is "a 'class-in-the making' characterized by labor insecurity, the lack of any stable occupational identity, and thus the lack of a collective voice" (p. 336). This economic class was identified by Standing in the context of a post-WW2

Britain, through an understanding of a lack of "labour-related securit[ies]" that still impact the Western world today (Choonara, 2020, p. 428). For the past 80 years, the general definition of precarity remains somewhat the same. Choonara (2018) cites it as "precariousness or instability; esp. a state of persistent uncertainty or insecurity with regard to employment, income, and living standards" (p. 427). Sociologically speaking, the definitions of precariousness have been looser, sometimes not being solely "limited to the realm of work" in theorizing by sociologists such as Pierre Bourdieu (p. 429).

Misra (2021) takes these foundations further in the context of intersectionality, claiming that, in the context of labour, women, immigrants, and racial minorities are more likely to experience precariousness (p. 106). Misra (2021) also states that the intersections of vulnerability within "household formation is magnifying economic insecurity for some groups and economic security for others" (p.106). These sentiments are mirrored in Ghaffari (2024)'s systematic review, that highlights the impacts of certain socio-demographic and socio-biographic factors, such as ethnicity and economic class that have a direct influence on the "health and well-being" of hospital users (p. 405). It was also noted that "safety and security as psycho-logical components in hospitals are critical to health outcomes, job motivation, behavior patterns, and social communication" (p. 406). López & Gadsden (2017) provide deeper connections on the social determinants of ill-health and vulnerability, stating, "we continue to see significant disparities in the quality of health and life options that children in racial and ethnic minority, low-income homes and neighborhoods experience" (p. 10). Additionally, they discuss the individual responsibility of health, highlighting the issue of "blaming the victim" through "the simplicity of explaining health or educational outcomes by attributing problems to individuals' genetics or cultural and social behaviors alone" (p. 11).

While the existing literature establishes the current failings of the healthcare system, theoretical understandings of precarity, and intersection frameworks, a concrete connection between the intersections of vulnerability, precarity, and wellbeing have yet to be established in the context of walk-in clinic usage in Ontario. It can be extrapolated through medical sociology that certain vulnerabilities can lend to an increased usage of walk-in clinics, a lack of access to healthcare, or negative experiences in medical settings. Despite this, solid evidence has yet to be collected on the impacts. This study aims to contribute to the existing knowledge; a small qualitative piece of the puzzle that can kickstart deeper understandings of vulnerability and precarity.

Methods

Social constructivism, as defined by Creswell (2013) identifies that the subjective ontologies that are held by an individual can socially construct their own reality and help to create an overarching culture (p. 51). This is the basic foundation of the theoretical framework that informs the methods in this study. Bourdieu's theory of practice, primarily the understanding of habitus, builds upon social constructivism and critiques it as a potential source for the perpetuation of neoliberalism in the upper economic classes (Jain, 2015, p. 76). While this economic perspective is removed from the intersection of lower economic class and precarity in this study, the understanding of perpetuation of social circumstance can help to inform the theoretical framework in analysis.

These social circumstances will be understood in the context of medical sociology and environmental sociology. Ghaffari (2024) defines medical sociology as "the study of health, disease, and medicine sociology, which considers the impact of social and structural factors on disease and illness processes" (p. 396). Environmental sociology is defined as focusing "mainly

on the issue that ‘physical environments can have an effect on human societies and behavior’” (p. 397). With these two epistemologies in mind, this study aims to provide an understanding of the intersections of the environment, the social world, institutional structures, and wellbeing in considering the health of the individual, as is illustrated within Ghaffari (2024)’s article (p. 398). It is with this context that this study aims to operate under a heuristic “theory of reality”. As illustrated by Riley et al. (2021), “phenomenalism”, “holism”, and “interactive kinds” as “forms of knowing” (p. 317) in this study are created through seeking out a postmodern understanding of the lived experience of utilizing the healthcare system in Ottawa. The contexts of participants' lives are considered alongside their responses.

The primary research question, *“What are the impacts of the Ontarian healthcare system’s current reliance on walk-in clinics on university students living in Ottawa?”*, will be addressed through the lens of this theoretical framework. This also informs the recruitment of participants in this study and methods used for data collection and analysis.

Participants for this study are four different individuals in their early twenties, either currently in university studies or recently graduated. They were recruited through word of mouth within the researcher’s friend group. One interviewee is the researcher’s current partner, though this does not pose as a limitation in the context of this study, given the nature of the questions being far removed from the context of their relationship. Upon recruitment for interviews, participants were informed of the uses of AI in the transcription of their responses and given the opportunity to partially or fully opt-out at any time. All four interviews were completed within thirty to forty minutes and followed a loose interview guide with the option for unscripted probing questions to facilitate a natural “narrative” to be established within the data.

This study utilizes mesolevel thematic analysis conducted with the assistance of the qualitative coding software NVivo. This is to understand the lives of the interview participants as illustrated in the limited scope of the interviews about their healthcare. After the first interview, open coding was conducted with the existing literature in mind to identify key themes in the data indicated as parent codes, while subthemes and contributing factors to the key themes in the data were indicated as subcodes. After conducting the other three interviews, the codebook created through the initial open coding was tweaked, and all four interviews were re-coded for thematic analysis.

The steps of the thematic analysis conducted follow a model identified by Braun & Clarke (2006) as "a method for identifying, analysing and reporting patterns (themes) within data" (p. 79). This method of analysis was inductive in nature, meaning that a broad research question was first utilized with the existing literature in mind, and the data collected in the interviews served to inform more concrete research questions once themes were identified (p. 83). The process for thematic analysis was informed by the steps outlined by Naeem et al. (2023). These steps are outlined as "transcription, familiarization with the data, and selection of quotations", "selection of keywords", "coding", "theme development", "conceptualization through interpretation of keywords, codes, and themes", and "development of a conceptual model" (pp. 3-6). The conceptual model has been supplemented through visualization of the data in a hierarchy chart (see Appendix A) created through NVivo.

Other software, primarily "AI" assisted GPTs, have been utilized for supplementary purposes, though not relied upon in the hard analysis of the existing data in the literature review or dissemination of the results of the data. ChatGPT was utilized in the early steps of the literature review process to help to identify patterns in the existing body of knowledge and

search for additional sources. These patterns and additional sources were manually checked for "hallucinations"[1], and if verified to be accurate, presented in this study in the researcher's own words. Samsung AI and Otter.ai were used solely for the purposes of transcription. Samsung AI was utilized in conjunction with the voice notes app on the Samsung S24 Ultra, where Samsung AI auto-transcribed the audio recording of the first three interviews. Otter.ai was used for the transcription of the fourth interview, as this interview was conducted online via a Discord call and screen recorded on the Samsung S24 Ultra.

The identity of the researcher as a tool in the research has been taken into account in both the data collection and data analysis. The sole researcher in this study is also a university student, with their own reservations about the healthcare system as an immigrant subject to precariousness in their own life. Additionally, the researcher was born a woman and is a person of color, which contributes to the quality of care they have experienced. Lastly, the relationship that the researcher has with most participants being close in nature (either through being friends or partners) facilitates the researcher to use some of their knowledge about the context of participants' lives in asking probing questions throughout the interview process. While these aspects of the researcher's identity may pose the potential for bias, they also can be supplementary in the research, facilitating easier connections that allow participants to feel more comfortable discussing the details of their own health and allowing the researcher to understand participants' life experiences more holistically in the analysis of the results.

Results

The results of these interviews have been coded into three different primary themes; "Problems with the system", "Personal Beliefs", and "Positive Sentiments" (Appendix A1).

[1] Fabricated or inaccurate pieces of information crafted by GPT language models, symptomatic of their inability conceptualize their own potential for making mistakes (Christou, 2023, p. 1971).

These were the primary themes identified across all four interviews, with the contributing codes categorized within each theme. Additionally, the interviews were coded for social determinants of health to understand the most common aspects of a participants' identity and lived experiences that might contribute to their wellbeing (Appendix A2). These two sets of codes were visualized into hierarchy charts, where the most prevalent codes within each theme can be seen as the largest boxes on the chart, organized from largest to smallest from the top left to the bottom right.

What are the financial impacts that come from a lack of a primary healthcare physician?

Financial strain in the lives of the participants have negatively interacted with their capacity for access to care through walk-in clinics and other forms of healthcare. As can be seen in Appendix A, "Money" (having to spend money on care) and "No insurance" (a lack of access to health insurance in any form; private or publicly funded) are the second and third largest subcategories within the "Access" category.

Karelle (she/they), one of the interview participants in this study, mentioned that her ability to work and make money directly conflicts with their ability to seek out medical treatment. In regard to walk-in clinics, she said,

> *No, I can't do it. The wait times- and like I have to go to work. I get paid hourly, like I don't necessarily have time, I don't. Because of the nature of my job, like I'm on contract I don't get vacation days or like sick days or whatever they just like, see, take it out of my paycheck and I can't afford to be doing that, so. And walk-ins, you have to come early morning and then it's like you're there all day and I can't do that. So, I just- I just don't go.*

This instance in particular highlights an intersection between the unstructured nature of seeking care at these clinics and its indirect impacts on employment. Outside of this, a large portion of Karelle's interview was focused on the ongoing struggle they had experienced with finances and access to care. They mentioned several aspects of their overall health needs, such as accessing

medications after they turn 25, vision care, dental care, and even mental health care, as a financial concern. OHIP only covers so much, and before their current employment, they had no access to private insurance to help with cost.

This difficulty was also illustrated in the interview with Yannis (he/him), another interview participant who is a current university student. He cited a lack of access to insurance beyond the student coverage provided by the school as a primary contributing factor, due largely to the fact that he is an international student. Yannis struggles with pain in his knee and ankle, inhibiting his ability to participate in sports. When it comes to seeking out medical interventions, however, Yannis opts to do nothing but rest. He said that he cannot afford to go to the clinic, stating, "*I didn't plan to pay like, $250. Or, like two- two times with the kind of like, those $250 every time you wanted to go to the clinic. I was too tired"*. Yannis has had to rely on walk-in clinics his entire time in Ontario, though he prefers not to go unless absolutely necessary.

All of the interview participants experience a lack of access to a primary healthcare physician in some way. One participant, Gianluca (he/they), was discharged as a patient without notice upon moving cities. Karelle is technically enrolled with a family doctor, though they experience extreme difficulty in obtaining in-person care and relies on walk-in clinics for the time being. Yannis and Yoann (they/them), the other two participants, have never had a family doctor in Ontario as they are both in the process of immigrating into Canada. All participants have cited that certain aspects of their care require financial costs that they cannot afford in some capacity.

How does a person's identity contribute to their quality of care within walk-in clinics in Ottawa?

Three of the participants in this study are people of color, specifically black people, living in Ontario. Additionally, two of those three participants are non-men. Lastly, two of the four participants are not citizens with a lack of access to OHIP. Though much of the interview answers given did not directly attribute participants' identity as a direct cause of their lack of access to care or other barriers, one participant did openly discuss this topic.

Karelle has experienced a lack of feeling heard or being listened to in their healthcare. In both walk-in clinics and emergency settings, Karelle has expressed that she feels as if their health issues are not seen as being concerning enough to warrant attention, forcing her to need to advocate for herself more in order to be taken seriously. They have experienced a wide variety of issues, spanning from issues of discomfort to concerns about their heart. Upon being asked why they believe that they aren't being heard, they said,

> *Well, they look at me, right? They see, like they see a young person. They see a black woman and it's just a whole lot of like, you know… it's complacency. It's just like… "How seriously do you want to take this case?" You know, like these doctors are trying to get people in and out. And so yeah, the seemingly healthy, a black woman, who comes in complaining about these things, and there are no like priors… Is this the person you're gonna spend 20 minutes on? No, you know, you're gonna save up on time. You're gonna give her whatever little- whatever little exams, she begged you for and then you're gonna show her the door.*

These sentiments are reflected throughout the interview with Karelle, where she feels as if she needs to be insistent on receiving care or interventions. Even in regard to their mental health care, they had to continually beg their family doctor over the phone to obtain a diagnosis for ADHD, which they ultimately had to seek out on their own, and pay out of pocket for. They did mention that they generally have positive experiences with their family doctor by virtue of having the same cultural background. But, in regard to other medical settings, Karelle experiences difficulties, such as this example, in being listened to.

Yoann and Yannis have both mentioned a lack of access to care and being forced to find ways to be mindful of their own health at home, due to their status as non-citizens. Though the quality of care that they have experienced has been a mixed bag. Yoann's experiences have been relatively good, though Yannis has noted that he also did not feel heard in regard to his knee. He said,

> *The last time I went to a clinic, I showed him my problem with my knees, and the doctors say that it wasn't nothing crazy. They just said I need to- to, like, go by my day or something. Like, actually, I knew something was wrong. I know my body. I know something's wrong, but, like, they told me that everything is okay. How do you know everything's okay?*

Though Yannis has not explicitly mentioned that this was symptomatic of his racial identity, he still did not feel adequately listened to in the clinic.

What are the impacts of the Ontarian healthcare system's current reliance on walk-in clinics on university students living in Ottawa?

Overall, the interview participants have mentioned that walk-in clinics are difficult to access, and they have little to no access to a primary healthcare physician. As a result, they have all mentioned needing to seek out alternatives in terms of their care. Gianluca mentioned that in working in kitchens, he experiences constant cuts and burns. When asked if he ever received stitches, he said,

> *I don't think so. All my cuts have healed. There have been a few cuts where I've cut like almost to the bone, and I probably should have gotten stitches for those, but I was able to kind of just, like again, just like tough it out for lack of a better word.*

When pressed further, such as instances where he has experienced road rash from wipe-outs on his board, or being hit by cars, his sentiments have remained the same. They would rather deal with it themself.

Yoann has mentioned they are very mindful of their own health since they do not have a family doctor to do it for them. When asked how they manage their own health conditions, such as osteoarthritis and asthma, they said, "*I'll say I rely on my pharmacy at home…And I also sometimes ask my mom*". Other forms of healthcare that they provide to themself exist in the form of "being careful" to prevent emergencies.

Lastly, Karelle's sentiments reflect the problem of healthcare in this province, not only in the fact that they aren't heard, but that they don't feel as if they're important at all. She said,

> *I guess like I just feel like- I feel like there are just no other people who are invested in me being alive… I'm like this new adult, who's just kind of left to her own devices in terms of finding healthcare, paying for healthcare, just it- just kind of felt like I was the only person invested in keeping me alive sometimes.*

The intersections of financial strain and identity collide with the structure of healthcare in Ontario to the detriment of the interview participants.

Discussion

The data collected over the four different interviews has unfortunately mirrored the issues highlighted in the literature that exists on the usage of walk-in clinics within Ontario. Participants have identified barriers to access as the primary "problem with the system" (Appendix A1). The majority of the largest barriers to access mentioned were rooted in a "lack" of something; a lack of a family doctor, a lack of money, a lack of insurance coverage, or a lack of education about their own healthcare and bodies. However, the most prevalent barrier to access mentioned were incredibly long wait times that the participants could not afford. The data presented by Bell & Sazfran (1992) and Lapointe-Shaw et al. (2023a and 2023b) highlights these issues in the general population, dating back to the late 1980s.

Additionally, the vulnerabilities that participants experience in their lives (identified as social determinants of health in Appendix A2) contribute to the precarity of their healthcare, and

thus contribute to the precarity of their employment and wellbeing. While all of the participants mentioned not having the time to waste on long wait times in walk-in clinics or to struggle to get an appointment due to crowded wait lists, Karelle delved deeper into these topics. Her experiences with financial difficulties and struggles in obtaining proper care highlight how difficult situations with medical care can negatively impact other aspects of a person's life. Such aspects as their employment contribute to financial strain that can further prevent access to care. These ongoing cycles can negatively impact a person's mental wellbeing, and thus negatively impact their physical health. Studies such as the one published by Ohrnberger, Fichera & Sutton (2017) discuss this link. Through a mediation analysis in populations in the UK, this study found "that past mental [or physical] health has a significant direct and indirect impact on physical [or mental] health" (p. 48). Overall, there is room for more research to be done on the impact of the stressors of navigating the Ontarian healthcare system on physical well being.

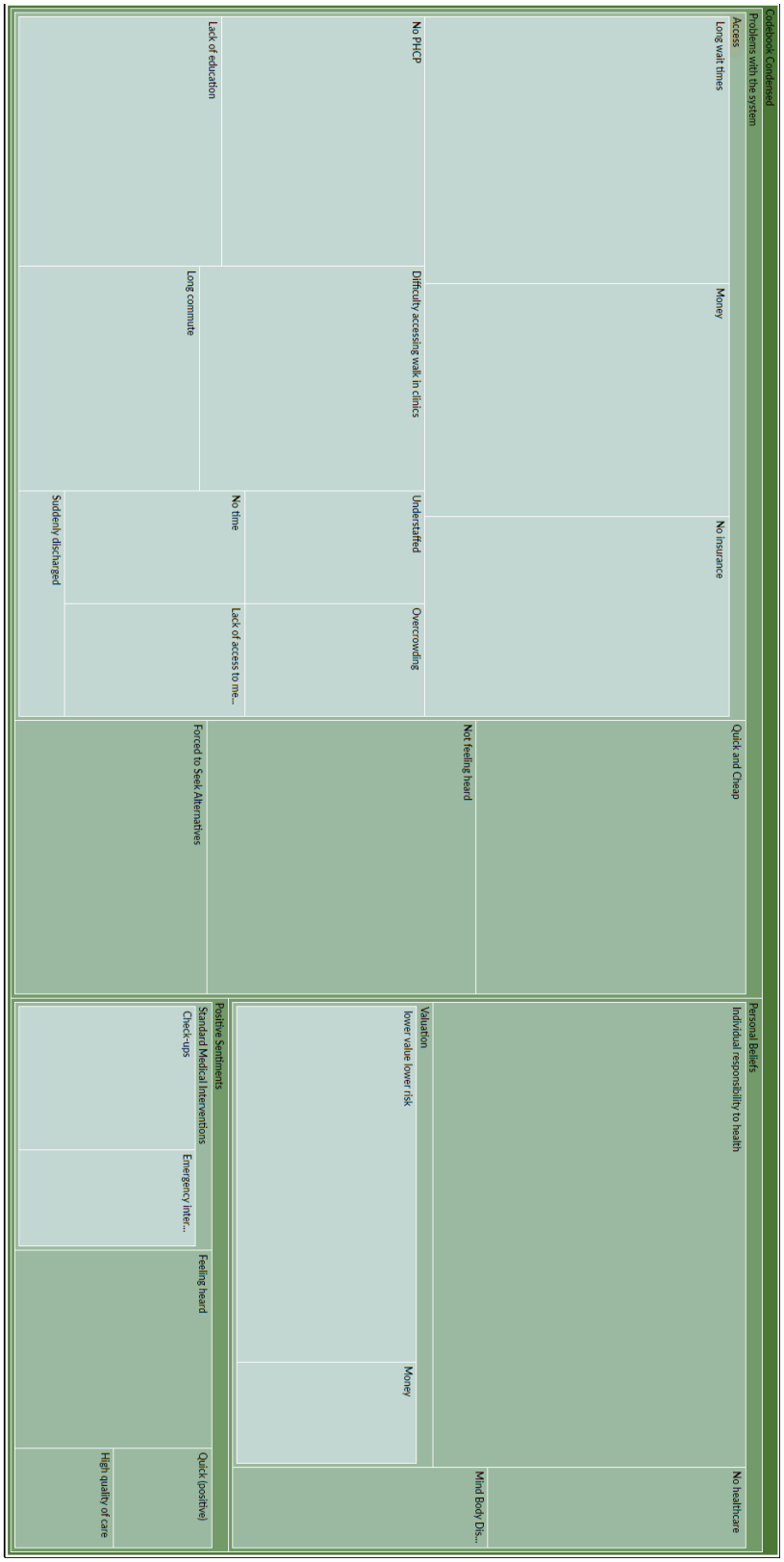
The intersections of race and quality of care have been touched on in the results of this study as well. There is some existing literature on this topic, such as a study conducted in Toronto by Mahabir et al. (2021), discussing the experiences of racism in certain populations. It was noted that "negligent communication" was one form of racism experienced by participants (p. 6), substantiating the experiences Karelle and Yannis have had in their own healthcare.

As has been mentioned in social research about precarity, the "precariat" as discussed by Guy Standing (Han, 2018, pp. 331-333), is a newly constructed social class that can perpetuate itself if not addressed. The participants in this study have experienced this perpetuation in the form of ongoing barriers and continual strain on their minds, bodies, and finances. In looking at class, it can thus be argued that the state of the healthcare system in Ontario contributes to

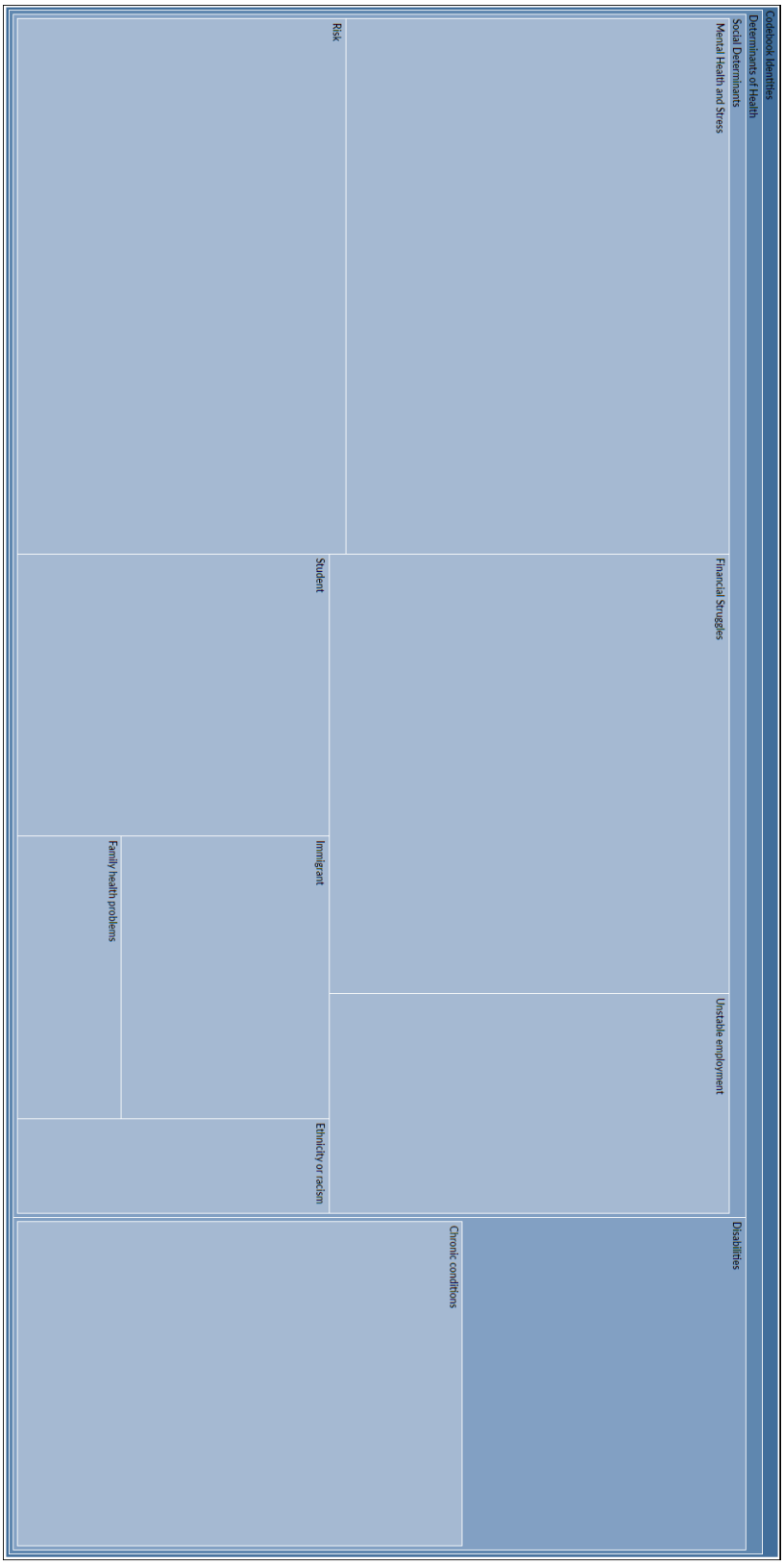
creation of the precariat in vulnerable populations within the province, as has been seen in the lives of the participants.

Moving forward, discussions on the intersections of vulnerability must be addressed in the realm of healthcare in Ontario and within the social research conducted in the sphere. These vulnerabilities are perpetuated within the system and translate into multiple aspects of publicly funded healthcare in Ontario no longer being "free", even for those with OHIP coverage. An understanding of this issue can help to lay the foundation for structural changes in the future. Thus, this study has only scratched the surface so far.

Appendix A1


Codebook Condensed
Problems with the system
Access
Long wait times
No PHCP
Lack of education
Long commute
Sudden discharged
No time
Lack of access to me...
Difficulty accessing walk in clinics
Understaffed
Overcrowding
Money
No insurance
Quick and Cheap
Not feeling heard
Forced to Seek Alternatives
Personal Beliefs
Individual responsibility to health
No healthcare
Mind Body Dis...
Valuation
lower value lower risk
Money
Positive Sentiments
Standard Medical Interventions
Check-ups
Emergency inter...
Feeling heard
Quick (positive)
High quality of care

Appendix A2


Codebook Identities
Determinants of Health
Social Determinants
Mental Health and Stress
Risk
Financial Struggles
Student
Unstable employment
Immigrant
Family health problems
Ethnicity or racism
Disabilities
Chronic conditions

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