

Improving Health Care System Responses to Chronic Disease among British Columbia's Immigrant, Refugee, and Corrections Population:

A Review of Current Findings and Opportunities for Change

Summary: Refugee Population

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Summary: Refugee Population

In many ways, the health status of refugees in Canada is similar to that of the broader population of newly arrived and more established immigrants across the country. However, refugee health concerns and experiences with the health care system do vary in crucial and significant ways, and this variation has important repercussions on chronic conditions and long-term well-being. Forced migration has increased worldwide, and in recent years Canada has received the second largest proportion of refugees resettled in industrialized countries. In British Columbia, refugees comprise 4.8% of all newcomers to the province.

The healthy immigrant effect is not as evident among refugees as among the broader immigrant population. Indeed, refugees often arrive with health problems due to pre-migration circumstances, such as refugee camp living conditions and endemic infectious diseases and may require special care and protections, particularly in the early stages of resettlement. Moreover, ethnic, religious, socioeconomic, and cultural differences between and within groups of refugees arriving from distinct regions can result in community fragmentation. In order to adequately and appropriately serve this population with unique needs, health care and social support systems must take the particular health needs, social circumstances (i.e., isolation and exclusion), and community fragmentation of refugees into account in the development and implementation of programming.

Among refugees in Canada, there are significant variations in chronic disease prevalence and trends according to gender, region of origin, length of residency, migration experience, and sociocultural and socioeconomic characteristics. Pre- and post-migration, refugees frequently encounter trauma that may directly undermine their physical and psychological health. Such traumatic experiences may also act indirectly to diminish individuals' and communities' capacity to cope with acculturation stressors, thereby rendering refugees more susceptible to stress-related disorders and psychological disturbances. Additionally, refugee morbidity and mortality attributable to infectious diseases and parasites is elevated, particularly in comparison with rates seen among non-refugee immigrants and the broader Canadian population. HIV/AIDS and chronic hepatitis infection are considered chronic conditions and prevalence has been found to be elevated among refugee populations throughout the country.

Upon arrival in the province, refugees initially have low health care utilization patterns, for primary and tertiary care services alike. Rates of physician visits increase shortly after the

three-month waiting period for provincial insurance coverage passes, and until regular care is established refugees tend to rely on walk-in clinics and emergency room services.

Key Findings

Mortality and Health Status

- *Mortality.* Mortality rates among refugees tend to be higher than among non-refugee immigrants, and significant differences can be observed by region of origin. Compared to the general Canadian population, however, mortality is markedly lower among refugees in for all causes except infectious and parasitic diseases.

Specific Chronic Disease Concerns

Many of the same chronic health conditions experienced by all immigrants also affect refugees, but there are a few conditions unique to refugees, as outlined below.

- *Mental Health.* Refugees have often experienced trauma pre- and post-migration that may directly undermine their physical and psychological health. Such traumas may also act indirectly to diminish individuals' and communities' capacity to cope with acculturation stressors, thereby rendering refugees more vulnerable to stress-related disorders and psychological disturbances. Though few Canadian studies have explicitly examined refugee mental health, refugees of all ages who have experienced traumatic events are thought to suffer from elevated levels of mental health problems, including PTSD, chronic depression, and suicide.
- *Long-term Communicable Diseases.* Mortality attributable to infectious diseases and parasites is elevated, particularly in comparison with rates seen among non-refugee immigrants and the broader Canadian population. HIV/AIDS and chronic hepatitis infection represent an important portion of infectious disease prevalence and associated morbidity and mortality for refugees.
- *Cancer.* Overall, mortality attributable to cancer is lower among refugees than the Canadian-born population, but higher than among non-refugee immigrants. As an exception, mortality rates for non-Hodgkin's lymphoma are not significantly different from the general population

Health Service Utilization

- *Utilization Rates.* Upon arrival, refugees initially have low health care utilization patterns, for primary and tertiary health care services alike. In BC, the number of family physician visits generally increases shortly after the three-month waiting period for provincial insurance coverage expires. Until they are able to acquire family physicians, newly arrived refugees

tend to use walk-on clinics and emergency room services. Overall, refugees have fewer physician visits than non-immigrants.

- *Variations in Utilization.* Refugees' utilization of medical services has been found to vary substantially according to demographic and socioeconomic factors, as well as medical conditions predating migration.
 - Of all immigrants to British Columbia, those individuals arriving on a Refugee or Family visa tend to utilize physicians and hospitals the most, while those on an Economic visa utilize them the least. Only male refugees in BC utilize physicians more than all residents.
- *Accessibility.* Challenges common to immigrants and refugees in the process of adaptation and settlement in Canadian society include the existence of language barriers, changes in familial and generational roles and relations, shifts in socioeconomic status (often resulting from underemployment), lack of familiarity and understanding of the educational and health systems, and coping with the loss of a support system.
 - *Geographic Accessibility.* Refugees settling in British Columbia experience many of the same issues around geographic access that are cited as barriers to care by all immigrants to the province. In effect, refugees are often forced to rely on walk-in clinics and hospitals for primary and chronic care due to a lack of conveniently located family physicians and extended wait times for new patients.
 - *Sociocultural Barriers.* Shortages of linguistically and culturally appropriate services for refugees often lead to underutilization and worsened health outcomes for refugees, as is seen among the broader immigrant population. There are some challenges for refugees that are often much greater than those experienced by other immigrants to the province, including the following:
 - The population of refugees changes very quickly, and health professional and systems may not be prepared to serve persons with unique and unexpected language and cultural backgrounds.
 - Refugees are much less likely to speak either English or French when they arrive in BC than are immigrants arriving through other classes.
 - Health professionals who share the language and culture of their patients are an extremely valuable resource for refugees. They are often in short supply, however.
 - On the other hand, many refugees may be understandably reluctant to use a physician from their home country until they can be certain of the doctor's politics, social position, and possible association with groups responsible for torture, persecution, and eventual displacement.

- *Economic Accessibility.* In British Columbia, the three-month waiting period for provincial health insurance coverage leaves newly arrived refugees without coverage upon arrival. The Interim Federal Health Program (IFHP) provides emergency and essential coverage for convention refugees until they are accepted into the provincial insurance plan. Asylum seekers applying for refuge from within Canada are not covered under the IFHP policy, however. Additionally, IFHP coverage may not be sufficient, as research has revealed that IFH certificates are often not recognized or accepted by health service providers. Consequently, refugee patients are left to seek care in emergency rooms and urgent care centres for non-acute conditions, or may delay seeking care until the problem has compounded. Furthermore, the IFHP does not consistently cover specialist care.

Population-Specific Opportunities

Many of the opportunities covered in the section on immigrants to BC are also relevant for refugees, therefore the following suggests some additional areas for systematic change and future lines of research that are unique to refugees.

System and Policy

- *Interventions to enhance coping skills:* Many refugees have experienced traumatic events before arriving in the province, and continue to confront stressful situations associated with adaptation to life in a new country. Intervention efforts that facilitate refugees' abilities to cope with ongoing acculturation stressors may be beneficial in promoting overall mental health. Such interventions may enhance both individual and community resilience.
- *Disease surveillance and follow up on IME results:* Refugees and all other immigrants have been found to have elevated rates of infectious diseases. Although all immigrants to Canada must undergo an Immigrant Medical Examination (IME), follow up on positive test results for conditions such as HIV, chronic hepatitis, and tuberculosis are often complicated by the mobility of refugees after arrival. This highlights the importance of effective and comprehensive disease surveillance systems at the federal and provincial levels, which may help to ensure timely and appropriate care for newcomers once they have settled into communities and have established regular health care providers.
- *Increased acceptance and ease of use of IFHP coverage:* Several studies have documented refugees' difficulties in utilizing IFHP coverage to the fullest extent. Modifications to the plan should be considered in order to ensure complete coverage of refugees' health needs, particular as they relate to specialized care. Furthermore, structural changes and policies may need to be implemented to guarantee that providers are familiar with the program and are able to easily process all required paperwork for reimbursement.

- *Education and training of health care professionals:* Health professionals working with refugees are challenged by the limited information readily available about refugees, and their diverse cultures and experiences. The population of refugees changes very quickly, and health professionals may not be prepared for persons with unexpected languages and cultural backgrounds. Moreover, the few professionals experienced in working with refugees have difficulty meeting their varied and pressing needs. Thus, education and training of health care professionals ought to include information regarding the particular needs of refugee patients and best practices for appropriate and effective care.
- *Expanded services at the community level:* Refugees, particularly asylum seekers who do not receive as many government services as convention refugees, could benefit from enhanced orientation to the health care system in BC. This should include tips on how to navigate the system and information on system procedures and policies. Furthermore, community level services to help refugees better access available care could be designed to address the barriers unique to this population (e.g., transportation, targeted health promotion, IFHP assistance, etc.).

Research

- *Chronic conditions:* In this review, information on the prevalence of heart disease, diabetes, disabilities and other major chronic diseases among refugees was not found. This represents a significant gap in our understanding of refugee health, and ought to be addressed through quantitative and qualitative research and analysis of existing databases.
- *Other categories of refugees:* Many studies of health status and health care utilization consider the broader immigrant population, and are unable to contribute reliable data or analysis on the specific needs of refugees. Furthermore, what little is known about refugees tends to only include those individuals granted protected status and permanent residency. Future research should attempt to include other categories of refugees, including Asylum Seekers, whose needs and interaction with the health care system remain largely invisible, as they are not captured by existing studies.