

Innovations to Champion Access to Primary Care for Immigrants and Refugees

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Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health.

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Introduction

Connecting with the health care system is an important part of the settlement process when moving to Canada from another country. For those who grew up in Canada, we don't always realize how complex navigating the system for the first time can be. Canada has a large immigrant population and in 2015 over 300,000 newcomers came to Canada (Statistics Canada, 2016a). However, many immigrants and refugees face barriers in accessing the health care services they need. There is considerable evidence that immigrants in particular arrive in Canada in good health but their health deteriorates over time. Part of this may be due to challenges accessing health care. Often it is a combination of economic, geographic, cultural and language barriers that negatively impact access to health care for newcomers.¹ (Ahmad et al., 2015). To promote good health and address their health care needs we need to ensure immigrants and refugees to Canada have the best possible access to primary care and preventative care services so health conditions do not get worse. A one-size-fits-all approach to program and service delivery is not sufficient to respond to the growing and diverse needs of immigrants and refugees who arrive from different countries with unique languages, cultures, norms and migration histories.

The majority of immigrants and refugees to Ontario settle in the Greater Toronto Area (GTA). The GTA is characterized by a large proportion of newcomers, high linguistic diversity and an increasing number of second and third generation immigrants (City of Toronto, 2016). In 2011, an estimated 44 percent of the GTA population was born outside of Canada and the immigrant population continues to grow (National Household Survey, 2011). In Ontario, Community Health Centres (CHCs) provide comprehensive care to newcomers but only 4 percent of all Ontarians have access to CHCs (Association of Ontario Health Centres, 2016). The lack of comprehensive support has the potential to leave behind many immigrants and refugees who struggle with accessing timely and high-quality care.

Immigrants and refugees in the GTA require access to care when they need it to ensure their ongoing good health and well-being (McDonald & Kennedy, 2004; Newbold, 2009). With this requirement in mind, there is a growing need in the GTA for targeted interventions that facilitate better access to care for immigrants and refugees. Three key promising practices are described below that take an integrated approach to addressing access barriers including: mobile clinics, workplace outreach models for care and, language and cultural brokers.

1 Newcomer refers to recently arrived immigrants and/or refugees. All terms are used in this paper.

The diverse health care needs of immigrants and refugees

Immigrants and refugees have health care needs distinct from the general population. The majority of existing research still treats immigrants and refugees as a homogenous group despite the diversity between populations. The process of migration and settlement interacts with other social determinants of health (such as gender, race, sexual orientation, housing, income, social inclusion, employment or working conditions, healthy child development) to shape the health of immigrants (WHO, 2008). Recently arrived immigrants and refugees can experience a loss of social status, unemployment, poor working conditions, difficulty learning a new language and social isolation, all of which negatively affect their quality of life and well-being (Beiser, 2005). On top of these factors, experiences of racism and discrimination can also negatively impact mental health and well-being over time (De Maio, & Kemp, 2010).

Refugees are particularly vulnerable and contrary to the general population trends evident in the Healthy Immigrant Effect,² some may arrive in worse health condition than the general Canadian population (McKreary & Newbold, 2010). For example, a study of Somali and Rwandese refugees living in resettlement camps showed high rates of post-traumatic stress disorder (Onyut et al., 2009). A Canadian study also found refugees had higher mortality rates than other immigrants (Des Meules et al., 2001). Refugees flee from countries where they may have faced absolute poverty, forced migration, war or repressive policies that lead to persecution based on race, religion, sexual orientation, political beliefs or ethnic community (UNHCR, 2016). Consequently, the political and economic context of their country of origin greatly impacts the health status of refugees. Pre-migration factors such as the experience of trauma, violence and the loss of family members can lead to poor mental health and physical health (Burnett & Peel, 2001). Refugees living in countries with prolonged wars and/or in refugee camps are also impacted by poor living conditions, poor access to health care, and malnutrition (Burnett & Peel, 2001). Refugees living in these conditions may have limited access to health care prior to migration with many untreated symptoms (Kirmayer et al. 2011, Tiong et al., 2006).

Even within immigrant admission classes (such as economic class, family class, government-assisted refugees, privately-sponsored refugees and refugees landed in Canada) there are significant demographic and socioeconomic differences that can influence health care needs. For example, economic class immigrants are more likely to be highly educated, refugees arrive at younger ages compared to other immigrants, and family class immigrants are more likely to be women (Statistics Canada, 2016b).

² The Healthy Immigrant Effect refers to the phenomenon where immigrants to Canada arrive healthier than the Canadian-born population but within 10 years their health significantly declines. (McDonald & Kennedy, 2004)

Health care utilization and barriers to accessing primary care

Despite Ontario's universal health care system marginalized groups still face barriers in accessing high-quality care. Facing barriers to accessing timely and appropriate primary care and screening may lead to poorer health outcomes and illnesses that require acute care. In general, recent immigrants have lower rates of primary care and mental health care use compared to the Canadian-born population (Gushulak et al., 2011). Research has shown that South Asian women have lower breast cancer screening rates in Ontario and that newcomers from East Asian and Pacific regions have lower rates of mental health service utilization (Durbin et al., 2015; Vahabi et al. 2016). For newcomers, a lack of awareness of available health services and a lack of knowledge and experience with the health care system can lead to delays in accessing health care (Beiser, 2005). In Ontario, only 78 percent of recent immigrants reported having a family doctor or other primary care provider compared to 88.1 percent of Canadian-born individuals (HQO, 2016). Even individuals with primary care providers may face barriers accessing care when they need it. We must focus on underlying causes of disparities to effectively support immigrant and refugee populations attain the highest quality of care.

There are ethnic and cultural differences that influence individual health behaviours and health service use. Some ethnic groups have increased genetic risk for particular diseases like cardiovascular disease, diabetes and prostate cancer (Bunker et al., 2002; Gujral et al., 2013; Whitty et al., 1999). In addition, cultural or religious beliefs around illness influence health care-seeking behavior (Scheppers et al., 2006). A conception of health as more holistic and less bio-medical can also lead to delays in seeking health care or looking for alternative medicine (Garces, Scarinci & Harrison, 2006). Preconceived notions about cultural beliefs and stigma can influence both providers and patients during health care encounters. For instance, some immigrant women are less likely to get Pap tests or discuss sexual health openly with providers due to cultural norms and religious beliefs but educating women on Pap tests in a culturally sensitive manner and offering self-examination options can increase uptake (Vahabi, Lofters, Kumar & Glazier, 2016). In fact when providers do not let patients know about different preventative care measures patients may feel it is not necessary and, with limited health literacy, would not bring it up on their own (Vahabi et al., 2006).

However, we can not overlook structural and systemic barriers that affect access to care. Many Ontarians have difficulties booking an immediate appointment or accessing care after hours. This may lead to using a walk-in clinic for many health concerns where individuals don't always receive care from the same provider, and there is little continuity of care.

Immigration policies restrict access to health care services depending on immigration status. Refugees receive basic health care coverage under the Interim Federal Health Program

(IFHP) at arrival and immigrants have a three-month waiting period before receiving OHIP coverage (MOHLTC, 2015). Many refugees settle in the GTA but in the past few years changes to the IFHP have made it difficult for providers to stay up-to-date on what is covered. Refugees seeking primary care from providers who lack familiarity with IFHP and what is covered may result in being turned away from care (Ruiz-Casares et al, 2016). Additionally, many immigrants and refugees are unemployed or precariously employed and do not have employer-provided benefits (Block & Galabuzi, 2011; Worker's Action Centre, 2007). In the GTA additional barriers may limit access to quality care including speaking a language other than English, living far away from health services, and having financial difficulties or the lack of culturally appropriate care (Ahmed et al., 2015; Higginbottom & Safipour, 2015; MHCC, 2016). To address these barriers the health care system needs to invest in targeted interventions that build on existing promising practices to serve immigrants and refugees.

Promising practices and strategies to improve health care access

1. Mobile Clinics: Providing care where patients live

Many immigrant and refugee populations are considered “hard-to-reach” but rethinking how and where services are delivered and how to best serve people where they live can address this gap in access to care. In Toronto, the Immigrant Women’s Health Centre has a mobile sexual health clinic that provides free clinic services including birth control and testing, counselling, and treatment for STIs, Hepatitis B and HPV (IWHC Toronto, 2016). An evaluation of this mobile clinic found most women were satisfied with their care and found receiving care in a mobile clinic acceptable (Guruge et al., 2010). This evaluation also found that women had an increased understanding of sexual and reproductive health after using the clinic services (Guruge et al., 2010). A similar initiative for primary care services is the Sherbourne Health Bus (Sherbourne Health Centre, 2014) that serves many homeless and under-housed clients at different stops in the city. Many recent immigrants live in low-income neighbourhoods where health and social services are less accessible (Asanin & Wilson, 2008; TPH & Access Alliance, 2011). By offering outreach services through mobile clinics people who live in less well-serviced areas can have enhanced access to primary care.

2. Workplace Outreach: Providing care where patients work

Many immigrants and refugees are precariously employed and this impacts their ability to access care (Worker’s Action Centre, 2007). Precariously employed workers often lack the flexibility to take time off work to make medical appointments and lack access to paid sick leave and health benefits (Wilson et al., 2011). Different work schedules make it difficult to

access care during regular business hours and many after hours care options are unavailable. Primary care and screening interventions based in workplaces may be a potential solution to alleviate this barrier and support workers in accessing health care. In the U.S., the Latino Health Connector pilot program provided health care navigation and screening services to Latino workers and their families in Columbus, Ohio (RWJF, 2011). This program included an orientation on how the health care system worked and screening for cholesterol and blood sugar levels. Of the 198 workers and family members who participated in the screening, 22 percent were diagnosed with diabetes and 29 percent had high cholesterol (RWJF, 2011). The health connector program was well supported by employers and led to improved education on occupational health and safety alongside preventative health care.

Outreach models for delivering care are a way to connect individuals with primary care providers and orient them to available health care services. As well, outreach models allow organizations to develop an understanding of the need for primary care services in a particular neighbourhood and an opportunity to receive input from community members before opening more permanent services at new locations.

3. Language and Cultural Brokers: Providing care that patients understand

In Edmonton, Alberta the Multicultural Health Brokers Cooperative (MHCB) works with newcomers to navigate the health care system, provide interpretation and play a cultural brokering role so newcomers can access services in a culturally safe³ environment (MCHB, 2016). Providers can also receive intercultural competency training to enhance their patient-provider relationship. What started as a small volunteer-run service has expanded to a large co-operative with 24 brokers and collaborations with federal, provincial and municipal agencies (MCHB, 2016). MHCB primarily works with immigrant and refugee women and their families on perinatal outreach but has expanded to include seniors' programming, culturally responsive home visitation programs, parenting programs and support to families navigating childcare services (Torres et al., 2013). The organization has a holistic approach to health promotion and supports the training and development of their Health Brokers. As an independent organization MHCB acts as a bridge between institutional health care settings and other sectors such as child care services (Torres et al, 2013).

Cultural beliefs and norms can influence how immigrants and refugees perceive health care and their preferences for the health care system. Recently arrived immigrants and refugees may commonly only visit a primary care provider when they are sick, have a reliance on seeing specialists over primary care providers and seek providers who speak their mother tongue (Ahmed et al., 2015; Wang, Rosenberg & Lo, 2008). Refugees may not have seen a primary

³ Cultural safety "includes cultural awareness, cultural sensitivity and cultural competence and involves the recognition of unequal power relations to address inequities in health care" (RNAO, p. 70., 2007)

care provider for many years prior to arriving in Canada so as they become settled underlying physical health symptoms and emotional problems may come to the surface (Spiegel et al., 2010). Some immigrant and refugee women may prefer a female provider particularly for gynecological examinations or emotional problems (Ahmad et al., 2002; Asanin & Dean, 2008). At Multicultural Health Brokers Cooperative they are breaking barriers to access by centring their work on the needs of immigrant and refugee women and educating providers on how cultural background influences health care experiences. Language and cultural barriers need to be addressed so providers are well equipped to communicate with their patients and understand their concerns. For most individuals, primary care is often the first point of contact with the health care system. Embedding health care workers in the system who have both linguistic and culturally brokering skills can enhance efforts to improve access to high quality health care.

Reflecting on diverse patient populations

These barriers in health care are not new and yet we continue with the status quo in delivering care. Different cultural beliefs and norms alone do not drive the disparities in health care among different ethnic groups (Nazroo, 1998) and more responsive models of care are needed to serve marginalized populations. We need to consider how race, country of origin, immigration status, socioeconomic status and other intersecting identities can influence health or we risk missing the real story. Primary care providers need to know where to access resources to support their patients. These resources can include language interpretation, care navigation or culturally tailored disease prevention programs targeting recently arrived immigrants and refugees who are unfamiliar with the health care and social service systems. Since most newcomers are receiving less comprehensive primary care services (Glazier, Zagorski & Rayner, 2012; Muggah, Dahrouge & Hogg, 2012) the use of targeted interventions in the GTA could enable improved access to primary care services.

Understanding diverse patient needs among immigrants and refugees is more than just a matter of culture. It is also important for primary care providers to know their patients and ask themselves questions like: what language does this person prefer to speak? Are they low-income? Do they have a low literacy level? Do they have prescription drug coverage? Do they have difficulty coming in for appointments due to shift work? Primary care providers are being encouraged to screen for the social determinants of health and incorporate this knowledge in their practice (DeVoe et al., 2016; Pinto et al., 2016). Additionally, poverty screening tools have been developed for Canadian provinces to aid providers in asking relevant questions and taking action (Centre for Effective Practice, 2016).

Conclusion

We need to prioritize a health equity lens in health systems planning to develop policies and programs that meet the needs of vulnerable populations, including immigrants and refugees. There are considerable access barriers faced by immigrants and refugees including geographic access, economic barriers, limited after-hours options and language and cultural barriers that have been well-documented in the literature (Ahmad et al., 2015). Moreover, it is challenging for immigrants and refugees to be advocates for their health when living in a new country with many competing priorities. Innovations in delivering care should be responsive to patient needs from diverse immigrant and refugee communities. Targeted interventions can offer more flexibility, be closer to where immigrants and refugees live and work and provide a culturally safe environment.

Further research is needed to identify what interventions can facilitate access to the health care system for vulnerable groups. Before we develop innovative models for care we need to understand what best practices exist, test out other solutions and understand which groups really need them. An intersectional approach that considers these connected factors can inform the development and application of promising practices and advocate for health care reforms that drive health equity.

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