



## **Immigrant and Refugee Health Needs and Service Provision in Hamilton**

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## 1.0 Introduction

### Immigration to Hamilton

With successive waves of new arrivals, including Italians and Portuguese in the 1950s and 1960s, and Vietnamese in the 1970s, along with an increasingly diverse set of origins today, Hamilton has a long history of immigration. As a mid-sized Canadian city, Hamilton is home to a substantial foreign-born population, with approximately 25% of its 2006 population defined as foreign-born (Wayland, 2010).<sup>1</sup> On average, Hamilton attracts in excess of 3,500 new arrivals per year, placing it amongst the top five immigrant receiving metropolitan areas in Canada. Amongst those identified as foreign-born and residing in the City of Hamilton, 16,565 immigrated to Canada between 2001 and 2006.

Beginning with the Vietnamese 'boat people' of the 1970s, Hamilton is also home to a large refugee population. In fact, up to one third of all the foreign-born in the City entered Canada as refugees, representing a greater proportion of all immigrants than observed for all Ontario or all Canada (Citizenship and Immigration Canada, 2004, 2005). Due to its proximity to Toronto and its lower cost of living, Hamilton is also an important center for 'secondary' settlement (i.e., settling in Hamilton after an initial settlement elsewhere in Canada). Recent refugees to Hamilton source from a diverse set of origins including Kosovo, Burma, Vietnam, China, Pakistan, India, Turkey, Afghanistan, Iraq, El Salvador, Columbia, Honduras, and Somalia.

### Evolving Health Needs

There is strong evidence within the existing literature that the health of immigrants at the time of arrival in Canada is significantly better than the Canadian-born population (Newbold and Danforth, 2003). This good health partially reflects medical screening during the application process, a process that is meant to ensure satisfactory health levels for those entering the country (Laroche, 2001). Known as the 'healthy immigrant effect', the health advantage seemingly enjoyed by new immigrants appears to deteriorate and converge toward the Canadian-born with increasing length of residency in Canada (Newbold and Danforth, 2003). Moreover, the literature suggests this transition occurs rapidly, and within as few as five years after arrival in Canada. Some research suggests this decline in health is noticeable within as little as two years (Newbold, 2009a).

Clearly, new immigrants are faced with multiple challenges – finding employment and housing, education and training, language barriers, in addition to accessing and using health care. Often, local service providers or agencies fill the needs for new arrivals. It is important to note, however, that health is not an entity unto

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<sup>1</sup> For a complete review of the demographic profile of Hamilton's foreign-born population, see: Wayland SV. 2010. *A Demographic Profile of Immigrants in Hamilton*. Report prepared for the City of Hamilton Immigration Strategy.

itself, but one that is explicitly connected to related concepts as employment, housing, social position, social contact, and food security. This 'determinants of health' (Evans and Stoddart, 1990) viewpoint underscores the fact that such effects influence health, but that health also influences such effects as employment opportunities.

Refugees may present different health profiles from the broader immigrant population related to existing mental and physical health conditions as well as the trauma of resettlement and being a refugee (Lawrence and Kearns, 2005). Mental health needs amongst refugees are likely to be particularly acute, given their history. Refugees may also have more tenuous contact with the health care system, either in the host country or in previous locations.

The following review evaluates and comments on immigrant and refugee health needs within Hamilton. In particular, the paradox of the 'healthy immigrant effect', and the particular health needs of some of the most vulnerable foreign-born, notably women and refugees, underlies the discussion. The structure of the paper is as follows: Following a general review of the health of Canada's immigrant and refugee population, the paper considers access to health care, and then challenges to health care provision to the immigrant and refugee population. Throughout, the discussion highlights Hamilton-centered research, along with vulnerable populations and their particular health needs.

## **2.0 Context: The Health of Canada's Immigrant Population**

We begin by setting the overall context by evaluating the health of Canada's immigrant and refugee population, before discussing the needs of immigrants and the challenges of providing health care to this group. On average, immigrants are healthy at the time of arrival, reflecting Canadian immigration policy that favours immigrants who are young and well-educated through Canada's 'Points System'. In addition, immigrants (principal applicants and their dependents<sup>2</sup>) are required to pass a medical exam before coming to Canada, with applications for permanent residence denied if an applicant's health is a danger to public health or safety or would cause excessive demand on health and social services in Canada (Laroche, 2001). Refugees are somewhat different, in that those with chronic conditions (implying potentially greater demand on health services) may be granted admission to the country under the Immigrant and Refugee Protection Act, provided they are not a health risk to the broader population.

### **The Healthy Immigrant?**

While medical screening is meant to ensure satisfactory health levels for those entering the country, it does not guarantee that health levels will be maintained over time. Indeed, significant post-arrival changes in the health status of

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<sup>2</sup> Dependents, even if not planning on coming to Canada, must also pass the health exam.

immigrants and refugees are observed. The health of Canada's immigrant population can be assessed using a variety of scales and indicators, including self-assessed health, mental health, obesity, and the presence of diagnosed chronic conditions. Regardless of the measure used, there is strong evidence that the health of immigrants at the time of arrival is significantly better than that of the Canadian-born population. Recent immigrants typically rank their health higher than the Canadian-born via a standard question that typically asks: 'In general, how would you rate your health?', and answered on a five-point Likert-type scale (excellent, very good, good, fair, or poor).

Although there is some debate over the validity and reliability of the self-reported health measure, including its equality of applicability and interpretation between and across different cultural groups, it remains a commonly used measure of health. Moreover, the health advantage noted amongst new arrivals is seen in other, more 'objective' measures of health including chronic conditions such as heart disease, cancers, or arthritis. These more objective measures note that new immigrants are less likely to report chronic conditions or disabilities. This 'healthy immigrant effect' is also observed in Canada (e.g., Chen et al., 1996; Dunn and Dyck, 1998; Gee et al., 2003; Globerman, 1998; McDonald and Kennedy, 2004; Newbold, 2005a; Newbold and Danforth, 2003; Ng et al., 2005; Pérez, 2002), the United States (Jasso et al., 2003; Marmot and Syme, 1976), and Europe (e.g., Doetvall et al., 2000; Gadd et al., 2003; Razum and Rohrmann, 2002; 2001; Silman et al., 1985).

### **Declining Health**

However, the health advantage enjoyed by immigrants appears to deteriorate and converge toward the Canadian-born with increasing duration of residency in Canada. Moreover, this decline in health – measured across the same health measures as noted above – occurs within five to ten years of arrival. Refugees are the most likely to transition to poor health (Newbold, 2009a) given their greater vulnerability and potential exposure to trauma or violence while in refugee camps or during transit, and poor living conditions and food opportunities while living in camps (McKeary and Newbold, 2010). Additionally, low income immigrants, individuals with poor English or French language abilities, and non-European arrivals are more likely to transition to poor health (Ng et al. 2005; Pottie et al., 2010).

While Canada's health screening of potential immigrants (and some refugee classes) usually leads to the selection of healthier individuals, this does not provide a reason why health status declines after arrival. The question is, therefore, why health status declines, and why it occurs over such a short period of time. Researchers have, for example, suggested that changes to Canada's health care programs over the past two decades have resulted in an increasing proportion of care that is non-insured, with unequal impacts across the population (Eyles et al., 1995). In particular, low-income groups and the poorly educated are associated with poor health outcomes even within the publicly financed system (Birch and Gafni, 2005), and the immigrant population may be

particularly disadvantaged. Consequently, deterioration of health status is also closely associated with the sociodemographic and socioeconomic profile of new arrivals. Although income barriers seemingly have been removed by the Canada Health Act (CHA), lower-income immigrants, for example, are two times more likely to report unmet health needs than those with higher incomes (Chen et al., 1996).

The uptake of unhealthy lifestyles post-arrival has also been suggested as a reason for the observed decline in health status. Frisbie et al. (2001), for example, argue that while some cultures engage in health promoting behavior, including healthier diets and prohibitions against smoking or drinking, these advantages may be lost with immigration to a new host country. There, the potential uptake of unhealthy lifestyles and poor dietary habits, particularly if individuals and families are unable to find (or afford) traditional food, forces reliance on less healthy or convenience foods. Consequently, the health advantage may be eroded, contributing to declines in health. Contributions to poor health stemming from unhealthy lifestyle choices are, however, likely to manifest themselves over decades, and not the years observed within the literature.

### **Differing Health Needs**

Given Canada's (and Hamilton's) increasingly diverse population, significant differences arise in terms of health needs, demands, and priorities on the health care system can be expected. The health needs of new arrivals often differ from Canadian-born, with the prevalence of disease differing based on exposure, migration trajectories (i.e., where individuals came from and how they arrived in Canada), previous living conditions (i.e., refugee camps, locations with limited primary health care), and genetic predispositions (Pottie et al., 2010). Language, cultural differences, and a lack of familiarity with the health care system and preventative care accentuate health differences.

Compared with the Canadian-born population, particular immigrant subgroups are at increased risk of disease specific mortality. For example, Southeast Asians are nearly 1.5 times more likely to experience a stroke, and individuals from the Caribbean are nearly 1.7 times more likely to report diabetes and 4.2 times at risk for HIV/AIDS (DesMeules et al., 2005; Pottie et al., 2010; Wilkins et al., 2008). Global and regional differences in disease prevalence, exposure and genetic differences means that the health needs of new Canadians often differ from the Canadian-born population. Given the diversity of immigrant origins and their experiences, individual patients might present with conditions or concerns, particularly tropical diseases, which are less familiar to local practitioners.

Vulnerable groups within society, including women, children, the aged, and refugees are particularly likely to experience poor and declining health. As a whole, refugees tend to be a vulnerable population, in that they have not voluntarily chosen to leave their country of origin, they often arrive at short notice and via other countries or from refugee camps. Refugees may also be separated

from family members at the time of resettlement, be survivors of torture and have lost most of their material possessions, wealth, and status (Dillmann et al., 1993). Not surprisingly, therefore, refugees tend to have poorer health status than other immigrant classes (i.e., family class entrants or economic immigrants), and a greater proportion of refugees report physical, emotional, mental, or dental problems than the immigrant population in general (Statistics Canada, 2005).

### **3.0 Primary Access to Health Care: Where are the Providers?**

Given observed declines in health status amongst new arrivals and the variety of health needs within the diverse immigrant population, it is reasonable to question whether the health needs of immigrants are being met. Indeed, we can argue that if health status is declining, then there must be unmet needs for health care. In part, this may reflect general physician shortages, such that individuals do not have a regular or 'family' physician. Such shortages may be due to the lack of physicians (common even in Hamilton), or individual preferences for a physician with similar gender, linguistic, or ethnic background (someone that can 'speak the language'). Similarly, 'geographic mismatch', whereby client and physician are geographically separated, also means that many do not have easy access to a primary care physician.

#### **Health Care Utilization**

Physician shortages and wait-lists are a fact of the Canadian health care landscape. Yet, even if the availability of physicians was not an issue, there is conflicting evidence regarding immigrant health care utilization within the literature (Elliott and Gillie, 1998; Newbold, 2005b). Research suggests that even amongst individuals with a primary care provider, difficulties in scheduling appointments are common (Bierman et al., 2010). Additionally, adults from particular groups (South and West Asian or Arab, East and Southeast Asian) are more likely to report difficulties with access to primary care, as are more recent immigrants and women and men who do not often speak English or French (Bierman et al., 2010). Recent immigrants are also more likely to report problems in accessing a specialist (Bierman et al., 2010) as compared to longer-term residents or the Canadian-born.

Beyond access to health care providers, immigrants as a whole are typically considered to be under-users of the health care system (Bentham et al., 1995; Cook, 1994; Deinard and Dunnigan, 1987; Raja-Jones, 1999). While Newbold (2009b), for instance, noted that general practitioner use increased as health status declined, there was no difference in the use of hospital services between the foreign- and Canadian-born populations. Similarly, the foreign-born were neither more nor less likely to experience a hospitalization relative to the Canadian-born. Consequently, only limited support for increasing utilization of health care facilities over time was found, despite concomitant declines in health, particularly the increasing number and prevalence of chronic conditions. As such,

the need for care amongst the foreign-born may not be met, and/or immigrants may receive poorer quality care than the Canadian-born (Chappel et al., 1997; Chen et al., 1996; Elliott and Gillie, 1994).

Research also notes that immigrants have different utilization rates and/or that they tend to receive poorer quality health services than non-immigrants (Chen et al., 1996; Elliott and Gillie, 1995), with some studies suggesting that there is actually little difference in health care utilization between immigrants and the Canadian-born (i.e., Chappel et al., 1997; Globerman, 1998; Laroche, 2000). However, equality of use does not mean that the need for care is adequately met, findings echoed by Newbold (2009b) who concluded that near equal levels of health service use between immigrants and the Canadian-born did not reflect the greater need for health care amongst immigrants (given their lower health status). The implication is that immigrants are characterized by unmet needs, a finding echoed by Pomerleau and Ostbye (1997) who found poor health and unmet needs to be pervasive within the immigrant population in a study based upon the Ontario Health Survey (OHS).

### **Geographical Mismatch**

Geographical disparities in service provision and uptake may, in part, also contribute to observed differentials in the ability to access health care services. With the decentralization of immigrants outside of the traditional urban core and into new suburban areas comes the need for adequate service provision. These suburban places that have not traditionally received large volumes of immigrants will likely have fewer service opportunities and/or experience 'geographic mismatch' between the location of immigrants and service providers. Existing locations may not adequately serve new arrivals, and the dispersion of some new immigrant groups to more suburban locations creates further challenges for service provision. Work by Lo et al. (2007), for example, noted a general mismatch between immigrant settlement patterns and the provision of settlement services in the Toronto Census Metropolitan Area (CMA), with the authors finding that most services remained in the core city, while immigrants were increasingly located in suburban areas.

Similarly, work by Newbold et al. (2008) found evidence of geographical mismatch between immigrant populations and health care providers within Hamilton. Overall, the distribution of conventional health services within Hamilton is not geographically even, with the majority of immigrant-oriented health services located in the old City of Hamilton boundaries, and specifically within the downtown core, along with an eastward extension into the former town of Stoney Creek. In part, this geographical mismatch between service need and providers represents historical placement of hospitals and health clinics across the City.

Concurrently, it reflects new trends in immigrant settlement patterns that have emerged in recent years, including the by-passing of the downtown as a traditional immigrant reception area in favour of settlement in suburban locations (i.e., Hiebert and Ley, 2001), as has been observed in Hamilton. While the

downtown core is still home to a large immigrant population, many new immigrant arrivals are locating outside of the downtown core, particularly in Stoney Creek or Hamilton's suburban developments on the mountain. These newer locations may place services out of reach, even when public transportation options are available, given the cost (dollar and time) associated with the use of public transport. Consequently, service providers must follow clients by relocating to suburban locations. Limited funding dollars hampers service response and locations.

#### **4.0 Secondary Access: Barriers to Care**

New Canadians may not be aware of the range of health services, where services are located, or how to access them (transportation). Consequently, a series of barriers to health and health care, such as language (Pottie et al., 2008), gender, and cultural roles (Pottie et al., 2010) are also responsible for the observed declines in health, reducing the likelihood of health care use or engagement in health protecting activities. Deinard and Dunnigan's (1987) analysis of health care use and perceptions among Hmong refugees in the U.S. demonstrated that different cultural beliefs and practices made some reluctant to follow the advice of health care professionals. Instead, traditional forms of health care were preferred, even when individuals were knowledgeable of health care facilities and options.

#### **Precarious Health Status**

A major obstacle to health is both the organization and lack of access to health care insurance (Sylvain, 2005), making for precarious health status. Despite Canada's universal health care insurance program, new Canadians arriving in Ontario (and other provinces) must wait for three months before they are eligible to apply for provincial health care insurance (i.e., OHIP). While private insurance is available, it is expensive and typically cost-prohibitive. As a result, many do not have any form of health insurance.

Government Assisted Refugees (GARs) are only allowed limited access to health care services under the Interim Federal Health Program (IFHP). The IFHP provides only essential and emergency health services for the treatment and prevention of serious medical conditions and the treatment of emergency dental conditions; contraception, prenatal and obstetrical care; essential prescription medications; and costs related to the Immigration Medical Examination by a Designated Medical Practitioner. The IFHP is not designed to replace provincial health plans and does not provide the same extent of coverage allowed to permanent residents. Many health providers also complain of its cumbersome paperwork, delays in reimbursement, and lower rates of reimbursement for services provided, leading some local providers to potentially dissuade or refuse service to newly arrived refugees (McKeary and Newbold, 2010).

## **Economic, Linguistic and Other Barriers**

Despite Canada's universal health care system, cost of care has also been noted as a significant barrier to care. It is important to note, however, that cost most likely includes daycare expenses, transportation to the service provider, and income foregone if the person had to take time from work. Social isolation and access to health care facilities is frequently complicated by transportation challenges. Being new to the country, immigrants and refugees often lack the ability to get around, particularly when distances are large, connections are complicated, there is 'spatial mismatch' between client and provider locations, or they simply are not familiar with the city or how to ask directions.

While some may be able to rely on friends or other members from the community for transportation, availability may be unreliable. Public transportation is often the likely source of transportation, but requires not only economic resources – the ability to afford the fare – but knowledge of the system, the ability to ask questions (how to I get from the Mountain to downtown?), and directional assistance from bus drivers or others, all the while factoring in language issues. Not surprisingly, appointments are often missed because of the lack of transportation or other complicating factors including the need for childcare (McKeary and Newbold, 2010).

## **Differing Perceptions of Preventive Health Care**

Immigrants are also less likely to participate in preventative health care programs, especially those that are not necessarily considered 'essential' by the individual. For example, research in Hamilton-Wentworth noted that approximately 25 percent of immigrant women had never had a Pap test, compared to just 9 percent of non-immigrant women (Black and Zsoldos, 2003). Consequently, recent immigrant women may be at a higher risk for cervical cancer (McDonald and Kennedy, 2005), particularly amongst more recent arrivals (Duarte-Franco and Franco, 2003).

Reasons for the lack of preventive care include lack of awareness of the service, lack of awareness of the importance of preventive care, and cultural roles. For example, the relatively low uptake of cervical screening among Asian women has been associated with cultural reasons, including gender roles and preference for female providers, trust of western medicine, and attitudes and beliefs about reproductive health practices, exemplifies a lack of culturally sensitive health care (Bentham et al., 1995). Immigrants may also embody different perceptions of health relative to health professionals, whereby particular complaints or health concerns are not defined as such, hindering understanding of health and illness (i.e., Cook, 1994; Health Canada, 1999). Indo-Canadian women, for example, perceive loneliness and depression as matters that do not warrant medical attention, but instead view them as personal problems (Anderson, 1987).

## **Gender, Faith and Cultural Barriers**

The challenges of access to health services, and ultimately to overall health, are also greater among immigrant women whose family, job, or cultural expectations and roles may make it difficult to access and use resources (Anderson et al., 1993; Dyck, 1995; MacKinnon and Howard, 2000; Oxman-Martinez et al., 2000; Weerasinghe et al., 2000). Individuals may also prefer health care providers with the same culture, language, and gender (Black and Zsoldos, 2003). For example, some immigrants, especially those with a Muslim background, prefer a female provider (Bhagat et al., 2002; Tsianakas and Liamputtong, 2002). Muslim women expect this cultural practice to be respected, but the structure of Ontario's health care system makes this extremely difficult. Individuals must request a different physician, assuming one is available. If the patient cannot be guaranteed a female care provider, some Muslim women will refuse care (Brar et al., 2009). Consequently, while health care is available, cultural and religious expectations prevent use of care, forcing them to either seek care from informal care providers in their community (Bhagat et al., 2002), or only when emergency care is needed.

## **5.0 Tertiary Access: Provider Care, Physician Competency, and Discrimination**

### **Inaccessible Health Services**

In addition to the barriers to care noted above, a common barrier to health care amongst racial minority groups is inadequate cultural competency and respect for alternative health values, definitions, and practices on the part of the provider (i.e., Fenta et al., 2006; Kafele, 2007; Oxman-Martinez et al., 2001). Cultural differences can inhibit meaningful or therapeutic client/practitioner relationships, prevent individuals from seeking care or following advice, and undermine service utilization. Deteriorating health status for some racialised groups and individuals can result from health problems that are not addressed, either because clients do not raise them with the physician, owing to such things as language ability. Likewise, physicians may not ask the right questions or probe responses, again potentially due to language. Likewise, services that do not address particular cultural needs (i.e., preference for female providers, same language, respect and knowledge of cultural traditions) become inaccessible.

### **Discrimination by Health Care Providers**

Although the Canadian literature has not fully addressed the relationship(s) between racism, discrimination, and health outcomes, existing work suggests that discrimination reinforces disparities in health status and inequitable access to health services, while inhibiting educational and occupational achievement (Access Alliance, 2005; Fenta et al. 2006; Hyman, 2009; Kafele, 2007). Instead, much of the evidence-base research demonstrating racism's detrimental effects

upon health focuses on the experiences of visible minorities such as African Americans in the U.S, Maori in New Zealand, or Caribbean and South Asian populations in the UK (see Krieger and Sidney, 1998; Taylor & Turner, 2002; Karlsen, Nazroo and McKenzie et al., 2005; Harris, Tobias and Jeffreys et al., 2006). However, instances where providers did not accept new patients based on language ability or insurance (IFHP) suggests that other, institutionalized forms of discrimination exist within the system, which may lead to marginalization and poor health outcomes as providers avoid the more problematic or time consuming patients. Nevertheless, further exploration of such representations, including the perspectives of individual refugees, and their outcome is warranted. further exploration of such representations, including the perspectives of individual refugees, and their outcome is warranted.

### **Impact of Discrimination on Health Outcomes**

Discrimination has been linked to a range of poor health outcomes and behaviours, including poor self-rated health, hypertension, cardiovascular disease, respiratory conditions, psychological distress, depression, and anxiety (De Maio and Kemp, 2009; Hyman, 2009; Williams et al., 2003). In addition, studies examining racial disparities in health outcomes suggest that discrimination is an important factor underlying such disparities (Guilfoyle et al., 2008; Kobayashi et al., 2008) and that disparities based on immigrant status and race persist after adjusting for age, gender, education, income and other variables (Dunn and Dyck, 1998; Karlson and Nazroo, 2002). Discrimination may also result in avoidance of health care (Beiser et al., 2001; Magoon, 2005; Wang, 1997). For instance, Chinese immigrant women in Halifax reported feelings of being disregarded or dehumanized by their physicians who they felt dismissed their health concerns while treating them like young children and expecting them to merely follow orders (Wang, 1997). Consequently, many of the women subsequently avoided care.

Similar sentiments were echoed in a study of refugee mothers living in Hamilton, Ontario that perceived racial discrimination as a barrier to accessing health care for their young children (Wahoush, 2009). Mothers referred to negative attitudes and experiences of being ignored by health care practitioners. Prolonged periods of waiting in emergency rooms were also perceived as evidence of racism. Interestingly, if the simple explanation that such delays are normal had been provided, it is much less likely that such instances would have been perceived as discriminatory (Wahoush, 2009).

Other work has explored discriminatory encounters experienced by newcomer women accessing maternity care in hospital settings. An analysis of immigrant Muslim women living in St. John's Newfoundland found health care professionals' lack of knowledge and discriminatory attitudes resulted in insensitive and inappropriate care (Reitmanova and Gustafson, 2008). In this case, women reported instances of health care providers becoming frustrated or angry when asked to acknowledge or respect religious or cultural beliefs and needs (e.g., having a strong preference for female oriented care, a need for

privacy, extreme discomfort with male attendants and being unclothed) (Reitmanova and Gustafson, 2008). Regardless of whether discrimination is 'real' or 'perceived', negative experiences can discourage individuals from seeking health care and contribute to feelings of isolation and despair.

Together, these provide examples of how the current health care system is not prepared for the changing health needs as a result of immigration, and consequently producing perhaps unintentional, but nevertheless differential impacts which appear as discriminatory and inequitable. In response to concerns with discrimination and provider competency, calls for more 'culturally competent care', whereby health care providers are aware of the potential and actual factors that affect their interaction with patients and have specialized training in order to address the cultural divide, have been on the rise. That is, there is a need to educate and help health professionals reflect on their own and others' cultural attitudes, beliefs, behavior and communication strategies, and to modify practice skills that enable quality, non-discriminatory care (Guilfoyle et al., 2008).

### **Barriers to Health Care**

Barriers to health experienced by the immigrant and refugee population include transportation, language (Pottie et al., 2008), familiarity with the system, and poverty. In an analysis of barriers to health care faced by refugees within Hamilton, McKeary and Newbold (2010) noted the presence of systemic barriers to care, which can be broadly differentiated by social/cultural barriers and legal frameworks. The former includes language/interpretation issues, isolation, poverty, and cultural competence, while the latter includes health insurance issues and refugee status. Although insurance is included as a systemic barrier, it is not necessarily the absolute absence of insurance. It is more the complexity, cost, burdensome paperwork and unclear eligibility rules between provincial plans and the refugee specific Interim Federal Health Plan (IFHP) that impose waiting periods, status requirements, or limits to health care provision and that ultimately creates additional work for health care providers seeking to claim compensation from IFHP. Additional issues of poverty, isolation and access to transportation either lead to, or exacerbate these systemic barriers. Results also revealed the difficulties of language, both from a provider as well as client perspective, with language barriers impacting service provision on the part of health care professionals, client understanding, prescriptions and follow-up telephone communications. In short, cross cultural language competency on the part of both provider and client affects relationships all the way through the consultation process.

Most of these barriers are not necessarily unique to the refugee population (with perhaps the exception of insurance coverage) when compared to the broader immigrant population. However, barriers assume an added urgency given the greater vulnerability of refugees, as they also deal with complex and inter-related issues of food, poverty, shelter, legal needs, transportation and employment priorities, have often experienced physical and sexual violence, have acute mental health needs owing to stress and violence, and carry the impact of

diverse social and gender roles (Beiser et al., 1999, 2000; Harrison et al., 1999; Hyman et al., 1996).

## **6.0 Conclusions**

It is well established that Canada's immigrant population experiences important health disparities. These have been measured by reductions in overall health, an increase in the number and severity of chronic conditions, and lower than expected (relative to need for care) health care use relative to the Canadian-born population. These disparities reflect barriers to health care, including language, transportation, lack of GPs, cultural roles and knowledge which serve to limit access and use of health care and result in increased health needs.

Although these issues also apply to the refugee population, refugees also exhibit unique and different health needs shaped by the refugee experience and resettlement process. Beyond direct health needs, refugees may also require access to employment services, shelter, and specialized health services including mental health and counseling. As such, refugees are a particularly vulnerable population with multiple health risks.

Research to date, including work done in Hamilton, points to the existence of significant barriers to health, including language, insurance, cultural competency, isolation, knowledge of services, and transportation issues. All serve to restrict or limit access to health care, and ultimately impact health within the foreign-born population. Together, these strongly suggest the existence of the need for health care within the foreign-born population. That is, their needs for care are not being met within the current system.

Caught between declining health status and greater need for care but a seemingly limited increase in the uptake of health care services, Canada's foreign-born may find their poor health further entrenched, with the potential for long-term consequences including poorer individual and societal health and marginalization within Canada. Poor health outcomes may be particularly troublesome for marginalized or vulnerable groups.

## **7.0 Recommendations**

Although most immigrants arrive in Canada in good health, women, refugees, individuals with language barriers, and low-income individuals are at greater risk of rapidly declining health. Given disparities in health and the diversity of the immigrant population, there is a broad need for services to respond to these needs. The local community is urged to create an inclusive community that is aware of the particular health concerns and histories of new arrivals by enhancing the capacity of health providers to address immigrant health and to ensure that health services are delivered in a comprehensive and coordinated fashion. Given the observed health disparities, lesser use of health care, and

known barriers to care within the immigrant and refugee populations, are there solutions or best practices that can be put in place to address these concerns and facilitate better health amongst New Canadians? The following seven recommendations tackle this question.

- ***Increase service provision:*** While community groups and service providers have responded to the needs of immigrants and refugees within the City, new arrivals stress already over-loaded organizations. Additional resources must be committed to service provision for newcomers to the City, while ensuring that all individuals have equitable access when needed. The implementation of clinical guidelines (i.e., Pottie et al., 2010) for newly arriving immigrants would further assist service provision by targeting responses to those who need assistance.
- ***Locate health services near new arrivals:*** Following the first recommendation, one of the challenges of ensuring health care to Hamilton's diverse population is linking providers and clients, with distance and cost of transportation. In the absence of new physical health clinics in under-served areas, Hamilton's Community Health Bus could be used to ensure basic health services, including dental care and Public Health services, reach immigrant communities, provided translation support is available and outreach material is also available in various languages.
- ***Emphasize resources for refugees, women's health, and mental health:*** Despite more pronounced barriers to health within the refugee community, the health care system has been largely silent and unresponsive to the unique health needs of refugees and other highly vulnerable groups, including women. This lack of acknowledgment leads to refugee health needs being rendered invisible within the policy and academic literatures. As such, it is important to recognize the scope and extent of systemic barriers to effectively shape public policy. For example, while culturally competent care is required with both immigrant and refugee clients, providers working with refugees must better understand the refugee experience and the case history of that client, a difficult task in the relatively short consultation window. Service providers in Hamilton must recognize the importance of these needs, and there needs to be greater integration across federal, provincial, and local governments.
- ***Ensure translation services are available:*** Too often, professionally trained translators are not available, or are costly, forcing individuals to rely on family and friends, raising issues of confidentiality, trust and understanding. Translation services must be widely accessible, and would benefit both client and provider. In addition, flyers and related health messaging should be available in various languages and in all health settings.

- **Ensure other health-related needs are met:** While there remains a strong need for addressing disparities in immigrant and refugee health, as well as an on-going tracking of immigrant and refugee needs and services available to them, attention to the broader determinants of health are needed. Beyond health care *per se*, for example, other services such as employment counseling, housing, mental health, or other social assistance programs are also limited within the City, with new arrivals relying on already over-burdened providers. In as much as health care is important, need for and access to related resources, including food, shelter, transportation, and employment may be ranked as high or higher than access to health care services. Likewise, programs and policies to reduce poverty (such as the Hamilton Roundtable on Poverty Reduction) and remove discriminatory barriers or racial biases will also contribute to improved health within the immigrant and refugee communities.
- **Educate providers in culturally competent care:** Issues of culturally competent care and an increased awareness of the needs of vulnerable populations including refugees, women, and youth must be addressed within the health care profession. Currently, many health services are not culturally competent in their practice and therefore are often dysfunctional for individuals who hold non-Western values, conclusions that have been reinforced based on work in Hamilton (McKeary and Newbold, 2010).

Consequently, there is immediate need for cultural competence training amongst service providers, particularly amongst front-line workers (physicians, nurses, etc.) who are most likely to have contact with new arrivals. In part, this must require the attention of organizations such as the Ontario Medical Association and by building culturally competent care into the medical school curriculum. Local opportunities are also available given the presence of McMaster's medical school and related local resources. Current students and individuals already practicing could be trained through workshops linking health care providers and agencies such as SISO. Topics should include diversity training, listening skills, anti-discrimination training, and understanding of different cultures and needs, amongst others.

- **Need for on-going research:** Finally, knowledge of the role of discrimination and racism would be enhanced by more distinct and comparative analyses of the experiences facing a wider range of minority ethno-cultural groups, particularly refugee populations as their diverse experiences are inadequately accounted for within the literature. In particular, further research is required in the following areas:
  - a. What is the impact of disability within the immigrant population? How does this affect their integration into Canadian society, workplace experiences, etc.?
  - b. Use of traditional (i.e., non-Western) forms of health care by immigrants and refugees. Most analyses focus on the use of

western health care services. In large part, this reflects a relative shortage of information or data on the use of alternate forms of health care by immigrants, and an area where further research is needed.

- c. On-going and comparative work within the City of Hamilton by the author will address issues such as youth health and the impact of discrimination in health care settings, with discrimination potentially leading to marginalization and poor health outcomes.
- d. Mental health needs within Hamilton's foreign-born population remain to be examined, a particularly important point given Hamilton's comparatively large refugee community and the known increased prevalence of mental health needs within this group.

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