Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers

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Much of the existing research literature on the health of immigrant populations does not address the health care experiences of refugees, even though they likely experience unique and different health care needs relative to economic or family class immigrants. The objective of this paper is to explore the systemic barriers to health care access experienced by Canada’s refugee populations. The paper focuses on understanding these challenges as expressed by health and social service providers at the local level in Hamilton, Ontario. Data from interviews illustrate the impact of these systemic barriers for both refugees and providers. The paper examines issues of interpretation/language, cultural competency, health care coverage, isolation, poverty, and transportation in terms of health care and availability of services.

Keywords: Canada, refugees, health care, systemic barriers

Introduction

It is well established that Canada’s immigrant population experiences important health disparities, both relative to other immigrant groups as well as to the native-born population (Ali 2002; Newbold 2005; Newbold and Danforth 2003; Ng et al. 2005; Perez 2002). However, much of this literature does not address the potentially unique health experiences of refugees, with this group remaining an under-researched population (Gagnon 2002; Hyman 2001). At the same time, it is generally acknowledged that refugees have greater health needs than most immigrant arrivals, with needs that are partly shaped by the refugee experience and the resettlement process (Drennan
and Joseph 2005; Lawrence and Kearns 2005; Proctor 2005; Wynaden et al. 2005). In addition to concerns related to accessing health care, refugees may also require access to employment services, shelter, and specialized health services including mental health and counselling. As such, refugees may be a particularly vulnerable population with multiple health risks (Hyman 1996; Nolin 2002).

Despite the significance of Canada’s refugee programme and the seeming awareness of the health needs of its refugee population, detailed information on the refugee experience within the Canadian health care system is notably missing in the literature and broader reports such as the Romanow Commission (Romanow 2002). The majority of Canadian research focusing on refugees is related to settlement issues such as housing, income, and access to employment (Frisken and Wallace 2002; Picot and Hou 2003). The limited body of research examining health-related issues has primarily focused on mental health issues (see, for example, Beiser et al. 1999, 2002; Rios et al. 2000; Yuan et al. 2000) or the health status of preschoolers and mothers (Wahoush 2007). The lack of information regarding systemic barriers to health care access within the refugee community is problematic for developing effective public policies, potentially resulting in the inappropriate allocation of resources. At the level of provider/patient interaction it can also lead to misdiagnosis and misuse of interventions, under-diagnosis, and the under-utilization of treatment and services (Brach and Fraser 2000; Koehn 2005; Smedley et al. 2003; Van Ryn and Burke 2001).

The purpose of this paper is to identify and explore some of the major systemic barriers faced by both health care providers and refugees as they attempt to improve health status within Canada. It accomplishes this by considering the local level, based on a discursive analysis of qualitative data collected during interviews with key service providers working with newcomer populations (refugee and immigrant) in Hamilton, Ontario. All of these providers were chosen both for their long term experience and for their expertise within the field. As such, the analysis provides insight into health care barriers faced by Canada’s refugees. The analysis also allows us to begin to address a critical gap in the research literature and formulate a more comprehensive picture of the refugee population and the systemic barriers they encounter when attempting to access health care.

Background

Since 2000, Canada has resettled approximately 11,000 refugees per year, representing approximately 10 to 15 per cent of all foreign-born entering the country each year. While fewer than the yearly average of 18,000 in the 1980s and 1990s, Canada has broadened its protection to those who face returning to torture or a risk to life, and has recognized that individuals can be persecuted on the basis of gender and sexual orientation. Recent
arrivals have included refugees from Mexico, Haiti, Columbia, Iraq, Burma, and Iran.

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). A significantly greater proportion of refugees report physical, emotional, or dental problems than the immigrant population in general (Statistics Canada 2005). Research in New Zealand, for example, noted that that the rate of TB infection amongst refugees was significantly higher than within the broader population (Harrison et al. 1999). Other studies have noted mental health issues among refugee arrivals (Hyman 1996; Whittaker et al. 2005), including undiagnosed psychiatric problems (Blakely 1996), and higher proportions of psychological illness (Hobbs et al. 2002).

In addition to pre-arrival experiences, the comparatively poor health of refugees and the observed declines in their health post-arrival may represent a lack of access to health care resulting from systemic barriers, despite correspondingly high health needs (Burnett and Peel 2001). Lawrence and Kearns (2005), for example, noted challenges for the refugee population included not only access to care, but also that many refugees were unfamiliar with the health care system, uncomfortable with the lack of culturally competent care, and were unable to navigate the system in order to meet their needs. Calls for more culturally competent care have been on the rise, showing awareness of the need to educate professionals and help them reflect on their own and others’ cultural attitudes, beliefs, behaviour and communication strategies, and to modify practice skills that enable quality, non-discriminatory care (Guilfoyle et al. 2008). Currently, many health services are not culturally competent in their practice and therefore are often dysfunctional for individuals who hold non-Western values (Vissandjee 2001). Several researchers (Bottorff et al. 1998; Choudhry 1998; Vissandjee 2001) have investigated the role of culture with respect to health services and have argued that increased cultural diversification challenges the public health care system in multiple ways. A major obstacle may be both the organization of, and lack of access to health care insurance (Sylvain 2005), making for precarious health status. Other barriers to care, including language and interpretation, cultural differences and social roles may limit use of the health care system, despite need for care (Gagnon 2002; Lawrence and Kearns 2005). Even those aware of services may be reluctant to utilize the system due to cultural or social unease, or fear of deportation (Wahoush 2007).

While many of these concerns and barriers to care may be shared among the broader foreign-born population, the impact is magnified within the
refugee population given their history (Rummens 2007). Providers too must attend to these challenges with respect to extending appropriate services to their clients while simultaneously dealing with issues of programme funding, resource shortages, relationship building, providing appropriate cultural interpretation, and becoming skilled in culturally competent health care delivery (Burnett and Peel 2001; Drennan and Joseph 2005; Koehn 2005; Lawrence and Kearns 2005; Ramsey and Turner 1993; Wynaden et al. 2005). Providers, for instance, require training in culturally competent methods but are often constrained by time pressures, as well as access to training curriculum and opportunities. Cultural interpretation is particularly important, covering not only health care communications, but an awareness and understanding of diverse health beliefs and expectations within provider and client interactions. Since many refugees have left behind civil unrest, there may also be issues in terms of the country of origin or ethnic identity of chosen interpreters, and the complexity of establishing trust between providers and clients can be exacerbated by the existence of a third party (Drennan and Joseph 2005; Lawrence and Kearns 2005). Shared ethnic backgrounds with interpreters may also lead to privacy and confidentiality issues, especially within small refugee communities.

A review of national level data based on Statistics Canada’s Longitudinal Survey of Immigrants to Canada (LSIC, see Statistics Canada 2005, 2007a; Schellenberg and Maheux 2007) that tracked Convention refugees after arriving in Canada reinforces many of these results. Survey results (see Table 1) highlighted a declining proportion of refugees who reported trying to gain health care over the four years after arrival, dropping from 80 per cent trying to access health care within their first six months of arrival in Canada, to 66 per cent approximately four years after arrival, a proportion which tends to be much lower than that typically observed in the broader Canadian

| Table 1 |
|---|---|---|
| **Refugee Health Care Use and Problems with Health Care Access (%)** | Six months Post-arrival | Two years Post-arrival | Three years Post-arrival |
| Have tried to get health care | 80.4 | 71.4 | 66.0 |
| Problems getting health care | | | |
| Language | 20.5 | 10.3 | 12.4 |
| Don’t know where | 37.5 | 18.2 | 16.7 |
| Costs too much | 12.5 | – | – |
| Waiting lists/lineups | 50.0 | 40.0 | 41.7 |
| No card/insurance | 31.3 | 40.0 | 66.7 |
| Unable to get GP | 6.3 | 18.2 | 16.7 |
| Other | 6.3 | – | – |
population (Birch et al. 1993), and also significantly less than that observed in the broader immigrant population (Newbold 2009a). Importantly, their reduced attempts to seek health care are counter to their increased health needs (Newbold 2009b). At the same time however, the proportion of refugees that indicated they had experienced a problem with receiving health care also declined, dropping from 20.5 per cent to 12.4 per cent, suggesting that individuals were having less trouble accessing health care, or had given up.

Amongst those who had problems receiving health care, one interpretation may be that refugees were still learning and understanding the system post-arrival. For instance, 12.5 per cent of respondents noted a lack of knowledge (‘don’t know where to go’), a barrier which disappeared in subsequent interviews. A lack of insurance coverage also created a barrier to care (6.3 per cent) six months after arrival, although this too disappeared with increasing residency, with most respondents holding a provincial health card which entitles them to a range of services equivalent to the broader population two years after arrival (Newbold 2009b). A combination of waiting lists/lineups remained a significant barrier to care over the duration of the survey (up to four years after arrival), and appeared to grow in importance. Waiting lists/lineups may work in concert with the costs of health care: despite Canada’s universal health care system, cost of care was a significant barrier to care, a reason which most likely includes costs of daycare, transportation, and income forgone. Finally, language represents a significant barrier to care, concurrent with Pottie et al.’s (2008) finding that poor English or French proficiency was associated with poor health outcomes.

It is important to acknowledge that refugees are not a homogeneous group and differences including origin, journey, health status before and after flight, culture, and refugee status, will have differential impacts on both their health status and their access to health care. For example, a major difference between refugee claimants and Government Assisted Refugees (GARs, defined as convention refugees and whose resettlement is completely supported by the Government of Canada or Quebec) is the latter’s greater access to services, including partnering with agencies that can assist and advocate for them within the health care system.

To begin to have their ‘voices’ recognized, the research presented in this paper will analyse the major barriers faced by refugees as expressed by health care providers working with the refugee population. Do we, for example, see similar barriers to care at the local level? What additional detail can be uncovered at the small scale? Barriers to care are uncovered through a series of semi-structured, in-depth interviews with health care professionals based in Hamilton, Ontario.

Methods

We conducted a series of semi-structured, in-depth interviews of key professionals in the social service and health fields in Hamilton, Ontario during late
2007 and early 2008. With approximately 25 per cent of its 2006 population defined as foreign-born (Statistics Canada 2007b), Hamilton is home to a substantial foreign-born population. Importantly, up to one-third of all foreign-born within the city entered Canada as refugees, representing a greater proportion of all immigrants than observed for all Ontario or all Canada (CIC 2004, 2005). Hamilton’s refugees arrive from a diverse set of origins representing over 65 different languages. Due to its proximity to Toronto (Canada’s primary immigrant reception centre, approximately 60km east of Hamilton) and its lower cost of living, Hamilton is also an important centre for ‘secondary’ settlement (i.e., settling in Hamilton after an initial settlement elsewhere). Given a long history of refugee resettlement in the city, Hamilton has not only developed an expertise but can offer a comprehensive array of services to the refugee population. Available organizations include public health, settlement, employment agencies and community health clinics.

Since the authors adopted a holistic view of health needs, we included both providers involved directly in health care and those in social services focused on meeting health needs. One of the authors has spent many years working within and in collaboration with Hamilton’s refugee community, and was therefore able to recommend and recruit key personnel via letters of invitation. Interviewees were selected on the basis of long term experience and expertise collaborating with newcomers and refugees in particular, and all had a strong interest in the unique health needs of refugees. All key providers identified by the researchers accepted our invitation to participate in the project, including Executive Directors, Program Managers, Nurses, Physicians, Health Educators, Settlement Workers and Community Health Centre employees. Respondents were offered anonymity and quotes are identified by coded number only to ensure confidentiality, given the comparatively small pool of potential respondents in the city. The recruitment letter explained the premise of the study, outlined the interview process, explained confidentiality guidelines, and provided the investigators’ contact information. A total of 14 interviews were conducted with the health care professionals, resulting in approximately 25 hours of transcription. The interviews represent over 20 years of Hamilton ‘reception’ history. In accordance with the agreed ethics protocols, and with the participants’ consent, interviews were recorded. The standard university ethics guidelines were followed and approved by the University Research Ethics Board.

Interviews were primarily conducted by the first author. Although flexible, the interviewer worked from a pre-arranged script that addressed the major health and health care issues of the refugee population but from the provider perspective, with the script based on both a literature review and the investigators’ experience working within the community. Open-ended questions were favoured so as to maximize discovery and description (Reinharz 1992). Participants were asked to describe their role in the refugee community via their employer and their position within the organization, as well as
length of time working with newcomers. Further questions inquired about client demographics, barriers to care, priority health needs, cross cultural health beliefs and definitions, use of alternative and preventative care, and the challenges of working with scarce resources within the refugee population.

Conversations were recorded, transcribed, and thematically analysed using discourse analysis (Cope 2005; Wright 1995). Following Foucault (1973), we understood the discourse concept to refer to the meanings found within language, but also the application of language effects, which ultimately sustains specific relations of power and constructs and re-constructs particular social practices. Thus, transcripts were viewed as representing ‘cultural texts’, ultimately allowing us to examine health and health care needs within the ‘lived’ social and material conditions of refugees’ lives (Walters et al. 1995). Both authors independently reviewed the data and accompanying emergent themes for relevance and significance.

**Results**

Based on the interviews, barriers include issues of interpretation/language, cultural competency, health care coverage, availability of services, isolation, poverty, and transportation, issues that were observed regardless of refugee classification. Consequently, we do not distinguish between GARs or other refugee groups in the discussion below. Although we explore these barriers in greater detail below, it is important to note that respondents consistently stressed that refugees faced more and greater barriers than those who enter the country as economic class or family class immigrants. As one respondent stated:

\[...\] there is a huge difference between immigrants and refugees. To me an immigrant is somebody who by choice immigrates or moves to Canada. While a refugee is somebody who leaves her or his country because there is a need… While an immigrant has more [resources], it’s predetermined and so they are more eligible for resources. The barriers or the accessibility to services is quite different for both groups… in terms of barriers to services for refugees, there are different barriers. (#502)

**Interpretation and Language Issues**

Although not unique to refugees, language difficulties and the need for interpretation services are consistently noted in the literature as key systemic barriers to health care, and have been noted to be one of the most significant barriers to accessing care (e.g. Harper and McCourt 2002). Clinical appointments with clients who speak English as a second language may require additional time due to accommodation of cultural interpretation, as well as making sure information is accessible and understandable. The alternative can be errors in translation or understanding with subsequent health impacts.
Even they get…finally they find a specialist, they have no way to communicate with the specialist, which I had…I have two cases who really make big mess. Because uh…the women were seeing a gynecologist…and they talk about some…some problem pre-cancer. So they…they talk about the cutting of the cervix…and some parts of the cervix…And the women told me uh…the specialist had a note saying he’s going to remove…remove…removal of uterus. But…but the patient didn’t get that far. Patient thought it was only cervix, but on the specialist note…that was an accident because they couldn’t communicate uh. They phone me and I found out oh my goodness that is a big misunderstanding. Because specialist told me such things, and talk to me. But I didn’t get that message. I didn’t know that part. So finally the patient decided not…not going to see the specialist. But if there wasn’t any communication between [them]. I don’t know what is going to happen. (#509)

Language issues also extend beyond the initial consultation and impact on such things as subsequent appointments and instructions associated with follow-up or prescriptions, all of which would typically be conducted in English. Although there is a great demand for interpretation services and Community Health Centres provide such services, many of the mainstream health care institutions do not believe it is their responsibility to be ‘accessible’ to clients through provision of interpretation services. As respondents observed:

So the service providers…do not feel they have a responsibility to make their services accessible to everyone…Not bothering to even know what you should be knowing. Making the appropriate arrangements so that you could communicate with the people that you’re delivering services to. (#505)

While translation is available through an expensive call-line, the provincial health care plan typically does not cover translation costs, placing the expense on the individual or back on community health centres. This lack of interpretation services means that many social service/community health care agencies must stretch internal budgets and re-assign already limited resources to arrange for the availability of an interpreter to accompany their clients into the mainstream medical system. From a systems perspective, the solution must be addressed at the policy/governmental level by acknowledging that accepting refugees (and immigrants) must be simultaneously recognized within health care budgets.

Funding issues remain probably a major barrier for that. Just the lack of a funded interpreter service for priority services, healthcare. There’ve been sort of halted attempts. There’ve been these projects that have been funded and then the funding’s been removed. We’ve been on the brink of having this for a while, but it still doesn’t exist. (#507)

Some of the funding issues are created by the tripartite government structure (federal, provincial and municipal), differing responsibilities across the levels,
and the lack of co-ordination as to which government agency/level is ‘responsible’ for the health and welfare of refugees:

\[\text{... Health is a provincial issue... Refugees and language and settlement services is a federal issue. And so even through they’re connected there’s no way the two will fund each other. ... It’s a lot of bureaucracy... And then you have[a] commitment from the government to bring in newcomers but there isn’t actually a commitment to do translation. (#508)}\]

The lack of translation services may delay appropriate care when the need for care is acute. When interpreters are available, the presence of another person in the examination room may further stress trust relationships, as medical histories are no longer shared with just the health professional but also with a third party. While professionally trained interpreters are preferred and community health organizations are committed to finding the resources in their budget (unlike the mainstream health care system), small refugee communities, and particularly ‘new’ refugee communities, may mean that the pool of interpreters is small (or non-existent) and client confidentiality compromised. Likewise, the lack of a consistent professional interpreter that follows a client through the system may mean that refugees need to re-tell their story via multiple interpreters, further increasing the potential to compromise confidentiality and using valuable time in a provider’s office.

In the absence of professionals, family or friends may be used as interpreters or participate in the consultation. The use of family and friends as interpreters can be problematic, as they have been known to unintentionally omit, add, condense or wrongly translate medical terms, potentially leading to misunderstanding and misdiagnoses (Tang 1999). There are also issues of power dynamics within families, such as role-reversal of children and adults, with children becoming the teachers.

[Its] assumed if you didn’t want your child in the room talking about your breast, then you should speak English. That’s basically the sentiment that happens now. It’s so inappropriate to place that responsibility on a family member or a child. Or putting women who are in abusive situations in the terrible situation of saying [they’re being abused] and their husband will be there. (#505)

In short, there is not only a shortage of professional interpretation but there is very little acknowledgement of the importance as well as the expertise required to perform the task correctly.

Language barriers are, however, more complex than simply issues of interpretation and include recognition of literacy levels. Although this typically depends on country of origin, refugees may have greater issues with literacy than other immigrants (e.g. Brown et al. 2006; Dewitt and Adelson 2007; Folinsbee et al. 2007), are more likely to have a more limited command of the English language, or do not have sufficient vocabulary to describe their conditions, all of which complicate diagnoses, follow-up care and instructions. Health care providers themselves may not understand what the patient is
expressing, particularly if statements are wrapped within cultural norms and desires of the client (Lawrence and Kearns 2005). As such, health care providers may be faced with a reduced ability to communicate with their patients, leading to unmet needs on the part of the patient.

I have a client who went to the specialist who refused to give him service because he couldn’t understand him. And the client spoke English, with an accent, but he said that he couldn’t understand him. And I could understand him...I have no problem,...but he refused him, because he couldn’t understand,... To me, he [the specialist] didn’t want to...Ok. But that’s the way. Yeah, of course people are going to treat you different if you have an accent. (#500)

...clients can be as oppressive as anybody else... I’ve had a client say to me, ‘oh no, I don’t like that doctor, he has very heavy accent.’ I’m sorry, if you don’t like it, you will have to go to somebody else. (#500)

Culturally Competent Care

Accessing health care services is not only about finding a provider, but also about finding an environment that is comfortable and understanding (Dyck 1995; Naish et al. 1994; Zanchetta and Poureislami 2006). Western health care institutions and the medical system are premised on the ‘universal’ patient body, with very little recognition of the social context/identity of that body. There are many issues involved with ‘offering’ culturally competent care. Culturally competent care exists when 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. However, many medical institutions do not offer this specialized knowledge as part of the curriculum, and the dominance of biomedicine fails to acknowledge the social and cultural basis of health.

While the need for cultural competency clearly extends to the larger immigrant and ethnic communities, it is in critical demand in order to address and care for the special needs that refugees bring to the health care system. Refugees often require physicians and health professionals that are knowledgeable of their experiences, a problem compounded by waiting lists and general service shortages:

A shortage of providers that are experienced, knowledgeable, open to understand[ing] that refugee populations have a different health experience. That victims of war and torture, that the symptoms present and the outcomes present differently. (#505)

For providers engaged with the refugee community, the importance of culturally competent care is even greater, with cultural competence including the need for providers to know who they are caring for, the history of their clients, and awareness of difference(s) between refugee clients and others.
However, culturally competent care in a refugee situation is difficult for many providers, and reflects the time commitment to know the client, (re)construct the medical history, communicate, and build trust, comments that are elaborated upon elsewhere in this paper. Moreover, studies on caregiver attitudes and resulting differences in care for different ethnic groups remain rare (Guilfoyle et al. 2008). In effect, the story or history of clients is vital, meaning that providers must (conceptually) travel a similar road to that of their refugee clients to understand their health needs.

In addition, cultural modes of privacy, discomfort with the gender of the provider, or the lack of language skills may create barriers and reduce disclosure:

Or people who are new and are not quite comfortable, after their experience, particularly as a refugee, that I’m going to show anybody, anything. Because I’m not sure where I’m going to end up, how that’s going to impact, are you government or not. The last time I showed someone my papers this is what happened to me. So sometimes there’s that concern. (#505)

They, sometimes, they are afraid that you, as a worker, might influence the outcome, if they make you unhappy. And if you come from a country that is very corrupt, that is something that happens from the top,... So they think that here is the same,... (#500)

While we further evaluate disclosure and medical histories below, the quotes raise issues of trust and concerns with confidentiality—issues that the provider may be comfortable with, but are new or foreign to the client.

Shortage of Health Care Services

Systemic barriers also include the (un)availability of services. Similar to elsewhere in Ontario, Hamilton has a shortage of primary care providers. Clients frequently encounter waiting lists and the situation is exacerbated when providers are reluctant to accept new clients who not only bring complex health needs, but linguistic challenges and complex insurance coverage. While services catering to refugees have been created ‘by demand’ within the city, a lack of appropriate services remains and was often cited by respondents, leaving many refugees under-serviced and lacking access to individual family physicians. Newcomers are often forced to utilize ‘walk-in clinics’ or remain attached to Community Health Centres (CHCs), which burdens this resource and makes it difficult for the CHCs to accept new clients.

We actually, very sadly, have a wait list for people to access our primary health care services, our clinical services. And, most of the community health centres in this province, there are 55 of us, so far, and soon to be over 70, have wait lists. (#505)

When I came to the centre [CHC], in 1998, January 1st, there was 215 clients on the register, and that was it. And, from 215 to over 10,000 it’s just consistently experienced growth. And, if we had more resources I know without a doubt
that we would double that again. You know, there’s such, a tremendous need in the city. (#505)

Walk-in clinics are, for that reason, getting quite popular with these immigrants who do not find doctors for an x number of months or even years. (#509)

This shortage of resources is exacerbated when individuals restrict their search for a physician or health care provider to those that share the same gender, or ethnic, linguistic, or cultural background, since such providers are often scarce, a problem that is frequently encountered amongst women seeking care but where culture and religion limit options. The result is that newcomers are much more limited in their choices:

Limitation of services … limitation of choices for them … for example, if a Somali woman is assigned a Somali worker and there is a conflict there, this woman has no place to go and they end up alone. Or, if she’s assigned to a Latin American, I would say the Latin American people have more choices, they have more workers out there that people have access to. But there are some cultures … [where] people don’t have … as much access. (#500)

The lack of primary care providers is also a reflection of the unwillingness of providers to accept new patients, particularly when language and insurance are issues. The added time and expense of working with such clients becomes an additional drain on physician resources (Newbold and Willinsky 2009). As such, physicians, even if seeking new clients, may decline refugees, including those with pressing health needs:

Even family physician, that … are accepting new patient. But when you call them they say: ‘No, they will accept them if they speak English.’ The meaning is ‘no’. You know? This is barrier. Big, big challenge. [Especially] if we have a person who really need to have a family physician … a woman with a pregnancy or some other issue. (#503)

… there’s times when there’s nobody receiving new clients in the inner city at all and so it’s just a challenge. (#505)

These quotes also hint at institutional and systemic discrimination, and also reflect results by Ramsey and Turner (1993) who noted that GPs expressed concerns over language difficulties leading to extended consultations when dealing with refugees with limited English abilities. While not overt discrimination (as compared to, for example, verbal or physical abuse), the results are counter to the expectation of the equitable delivery of health care, and the refusal of patients impacts the quality and effectiveness of care received across various settings and points of delivery (e.g. hospitals, community health centres), leading to inferior or inadequate care (Johnson et al. 2004; Magoon 2005; Access Alliance 2005; Stewart et al. 2008; Wahoush 2007).
Health Insurance Coverage for Refugees

Health care access is affected by the complexities and challenges of health insurance for refugees, which reflects a bureaucracy that impacts on health access as various levels of government are responsible for different components. While some refugees may be eligible for provincial health insurance plans (such as Ontario’s ‘OHIP’ plan), this is typically based on refugee status and a minimum residency period in the province of up to 90 days. Refugee claimants, including GARs, may also be eligible for health care coverage under the Interim Federal Health (IFH) insurance programme. IFH is a temporary health insurance programme (typically for a period of 12 months, but renewable under certain circumstances) that covers urgent and essential health needs. Local governments are responsible for social welfare provision and public health issues, while various agencies, including resettlement agencies, will provide other assistance related to resettlement. The mix of government levels, eligibility requirements, and programmes means that insurance coverage and service delivery is frequently confusing, and new refugees may fall through the gaps.

Depending on the category that they [are assigned] [it will determine] their access to health services. If they are refugee claimants they are eligible for receiving the Interim Federal Health assistance. They may be eligible to receive essential medical services. Government sponsored refugees have IFH however, they are immediately eligible to apply for OHIP. They have to wait three months to receive their OHIP. However, if they are refugee claimants, that mean that sometimes these refugees are not eligible for IFH. They are not eligible and they have to wait three months without any health coverage to get their OHIP. Their access to health care depends on those eligibilities to have health coverage. Some doctors, some pharmacies, some dentists, may not accept clients who have IFH. So that it becomes very important if they want to go to a particular doctor, a family doctor ... So there are different systemic barriers that are happening in terms of accessing the health care system based on the refugee status, and within that category, as a refugee. (#502)

The above quotation highlights the fact that IFH is a complex system that is often misunderstood or unknown to clients and providers alike. Many general practitioners and dentists do not wish to deal with the bureaucracy, payment delays, pre-approval process for some procedures, and lower financial compensation, and will turn clients away. Once again, this could be seen as an institutionally reinforced discrimination, as health care providers are compelled to avoid patients that may be problematic or costly in terms of time (Spitzer 2004).

The other thing is that not everybody knows, even within...health care professionals, what an IFH is, and even if they do,...there are some systemic barriers. IFH, you may be eligible for IFH, but for certain medical procedures, for certain medical services they are approved automatically. [Others], I mean if there are particular procedures that need to be pre-approved, meaning...the IFH or the OHIP office, you need to submit the requisition. (#502)
Even with the IFH...we do have to speak with those folks [IFH providers] to let them know, you're supposed to be covering this, it says so on the latest document. We also do try to let providers know, the challenges...the federal government, pays very, very late. So as much as people might understand it's covered, they don't get paid for long periods of time. It could be six months before they get paid for a service that was delivered...And, they're not paid at the level which necessarily OHIP has decided the charges should be, right? [So many providers] are not interested because of the late payment and under-payment system that's associated with it. (#505)

If they are GARs, they may be lucky to have an agency or resettlement worker who can advocate and explain the system. For non-convention and non-claimant refugees, IFH may not be accessible, depending upon determination by the Federal Government. Even for those refugees that are eligible for coverage under IFH, they may not be aware of it, may not understand they have coverage, and/or may be unaware of the services they are entitled to. Individuals are often overwhelmed by the amount of paperwork their arrival and settlement requires. For example, one respondent described a situation where an individual had coverage but neither the individual nor the health care provider utilized the coverage:

The other reason [is] you may be eligible for IFH, you may have the IFH document with you, but the other reason [is that the provider] may not be aware that they [the refugee] have the IFH. I had a case, one of my clients was a refugee and he needed to go to the doctor. He didn’t present the IFH document when he went to the doctor’s office. So he was paying the doctor for medical services and he was getting behind in his rent. Then he wasn’t buying food because he needed to cover his rent. He was paying the doctor and all this time he had his IFH... He wasn’t aware. Maybe they didn’t ask the right questions. (#502)

Participation and enrolment in IFH is not automatic, with refugees required to apply to the programme for coverage, a difficulty when language barriers are present and there is a lack of formal assistance from sponsors or resettlement agencies. A lack of coverage can lead to poor outcomes:

I can think of one [case] in the past, one boy in a wheelchair that came in. They were seeking status and they were still pending refugee claimants and he had a major bedsore that was infected. [We] didn’t get any service for him because he didn’t have any type of funding. But when I saw him he was running a 102 fever. So it was a matter of getting angry and saying, ‘Hey, look! You know, this boy is going to die if you don’t do something.’ (#501)

While care was ultimately provided in this situation, the quote highlights the health risks of being uninsured—one case of a client falling through the cracks. Refugees must also re-apply for IFH every year if they remain eligible, although this too can be a confusing and time intensive process.
Client Medical Background

Health care providers are challenged by the lack of continuity of care amongst refugees who may have moved from their birthplace through refugee camps and ultimately to their final destination, with different levels, types, and availability of health care in each case. Even though some refugees, in particular GARs, will arrive with files following a Pre-Departure Medical Screening (PDMS), the files are often incomplete and fail to capture the full medical history of the client. Settlement does not necessarily improve the situation. The lack of physicians who are willing to accept new clients, for example, means they may visit a number of providers including CHCs, emergency departments, or walk-in clinics, requiring each provider to individually reconstruct health histories in the short consultation window and resulting in disjointed care as the individual moves from one provider to another. These issues, combined with language barriers, time constraints, and lack of cultural competency on the part of the provider, result in a reluctance to ‘share’ one’s personal history for fear of the impact on a refugee claim.

The other barriers are just an absence of continuity around health information from previous experiences. And not having that understanding of what actually has happened. You have to construct, sometimes, many times reconstruct and, in most cases we listen to families and to the people. Moms know what’s happened with their kids. They may not know, the proper name for it but when you talk to them… they know. (#505)

Part of the cultural differences are that a typical North American presentation of dealing with issues is everybody gets in a group in a room, sit down and talk about how you’re feeling. What’s going on with ‘you’. Just open [up] and right out in front [discuss things]. That’s a huge barrier because many cultures do not sit down in a room and disclose. (#505)

The need for trust between client and provider in a clinical setting is a major barrier for many refugees, due to past experience and the belief their current residence is ‘tenuous’. This barrier exists at all levels: personal, institutional and societal (Hynes 2003). Trust requires time and consistency to develop, both of which are difficult to achieve within an already stressed system, while it is eroded or damaged by experiences before entering the country as well as afterward. Trust will be further compromised in situations of power or when refugees are excluded from decisions (Hynes 2003), particularly if the individual is fearful that too much information could result in denial of claims and deportation. Clearly, issues of trust need to be taken seriously by agencies and the staff assisting refugees. As noted by Hynes (2003), making space for trust should be a priority, with trust between provider and refugee serving to reinforce health.

Economic Barriers

Many respondents commented on the particular effect of poverty and scarce economic resources on broader health concerns, or the fact that health per se
was not an immediate priority for new refugee arrivals.

I guess from our perspective, if I were looking at the priority health needs. I would say addressing poverty is the number one priority health need. There is no other need greater than addressing the issue of poverty. Because it is pervasive and it impacts on every area of health and wellbeing. (#505)

The other thing is that in terms of preventative approaches. For newcomers in Canada it [health care] isn’t a priority for two reasons. One, I need to concentrate, if I am a newcomer, on securing income for my family. I need to secure food for my family. So preventative measures are going to be at the bottom of your priority list because there are other things. ‘Ok, I need to learn English, if I don’t learn English I won’t be able to work, if I don’t work, I don’t have food for my family. So for me having a pap smear, having a mammogram, that wouldn’t be a priority.’ I mean I think it is for everybody. (#502)

It’s hard. It’s hard because when they come as new immigrants, in the beginning they’re, as mentioned, it’s on their mind to get a place to stay. That’s very important priority. Understand the culture, get a job, get going and to basically find their way around where they have…[found] themselves. So health is put sort of on the backburner, if you will. And uh…and the main problem that arises for them is that they…first they don’t find a doctor. (#509)

Resettlement in the new country can offer safety but may also result in a loss of economic and social status. Refugees are often dealing with employment deskilling and credentialism issues, both of which have implications far beyond immediate socio-economic status by mediating physical and mental health, as well as contributing to poverty or low income status:

But it doesn’t mean that these refugees who are coming to Canada don’t have a professional background. Yes, they are doctors, nurses, engineers, any kind of professional who suddenly because of the situation in their country, where they are living, [there is a] break down of stability and they become refugees. They come to Canada and there is a long road for them to practise within their own profession…all of a sudden they lose that position [and] that status. So it affects the person’s life, the person’s health (mental, emotional, social). They don’t have the social supports and so on. (#502)

Isolation

Social and cultural isolation also emerge as significant barriers to health care by restricting interaction within the community and constraining individuals within their homes.

Because of other cultural barrier, you know, she is stuck in their houses. [The] same thing [is] happening with other refugees… (#503)

While there are many successful programmes that encourage social interaction through religious groups, settlement agencies, and community centres,
isolation is further complicated by transportation availability, gender, and age. Some refugees, including women and certain ethnic groups, are especially vulnerable. Recent refugee arrivals may find themselves without any established community, leading to feelings of fear, discomfort and isolation, while established communities assist new individuals by sharing knowledge of available services, facilities and processes, as well as advocating and explaining complex access or eligibility rules. An example of a refugee group faced with these barriers would be the recent influx of GARs from Sudan:

Many of the communities that are new and are coming don’t have a host community group that’s here. So, like for example you have the Sudanese people. There isn’t a large, supportive host community organization of Sudanese people who can be there to welcome and facilitate. (#505)

So try to walk in those shores, try to think, how would you feel, if you were forced to leave your country one day, and be put in a new place and not have those supports that you need to, to be able to swim those waters, but you have to learn to swim before you’re thrown in the water, you know? Otherwise you drown, and you can drown in so many ways in this...country. And there are people that I know are, they are out there and they don’t have resources. The resources might be there but they don’t have the knowledge, especially refugee claimants, who don’t know they have access to doctors...people who think if they go and ask for help, they are going to be refused, because they are already a burden to society. (#500)

Although it is often assumed that women are less willing to talk of their experiences, respondents also noted that men find social isolation difficult and that for ‘men to talk about their experience is harder than women’ (#503), perhaps reflecting the adjustment process that is shifting societal and family roles, along with their own cultural roles and perceptions of ‘strength’, which increases their reluctance to talk to relative strangers about health needs.

Social isolation and access to health care facilities is frequently complicated by transportation challenges. Being new to the country, 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 (Newbold et al. 2008), or they simply don’t know 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 means of transportation, but requires not only economic resources—the ability to afford the fare—but knowledge of the system, the ability to ‘ask questions’, and assistance from drivers or others if lucky. Often appointments are missed because of the lack of transportation or other complicating factors:

But they didn’t show up because they didn’t know how to get there. Or there wasn’t anybody to take them. Or the children, one of the kids was sick and the others were at school. Or you know they just didn’t have—guess what it’s the
end of the month and there’s no money. They couldn’t even get to where they could get a bus ticket. (#505)

Cost is clearly an issue, and costs include time and money for both the actual transportation along with care for children and other dependents, both of which may be in short supply in the refugee community.

Discussion and Conclusion: Linking National and Local Barriers

This paper has examined the barriers to health care faced by refugees in Canada. By doing so, it has begun to unpack and differentiate the unique health barriers faced by this group, as opposed to a more broadly defined ‘immigrant’ or ‘foreign-born’ population. While community groups have responded to the needs of the refugee population, community providers have been stressed by the limitations or absence of the current service field. Decreased access ultimately leads to decreased health status and increased suffering among an already traumatized population.

Results echo those observed from national studies, but with additional detail. Major systemic barriers can be broadly differentiated into 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 federal plan (IFH) that impose waiting periods, status requirements, or limits to health care provision and that ultimately create additional work for health care providers seeking to claim compensation from IFH. Additional issues of poverty, isolation and lack of 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 telephone communications. In short, cross cultural language competency on the part of both provider and client affects relationships all the way through consultation.

Most barriers to health care that are observed in this paper are not necessarily unique to refugee populations (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 1996). 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. Similarly, language is not just a refugee issue. But, refugees are more likely to be illiterate, to have a limited command of the English language, or to lack the vocabulary to describe their conditions, complicating diagnoses, follow-up care and instructions. Both issues highlight the difficulties associated with determination of the client’s medical background. Small community size also complicates provision of care within the refugee community. By limiting the availability of interpreter services and opportunities for interaction, small communities may promote isolation. Consequently, prioritizing basic needs while attempting to overcome systemic barriers becomes a ‘double jeopardy’ for clients and providers alike.

Surprisingly, public and institutional representations of refugees, overt forms of discrimination and marginalization of this group did not appear in the discussions. However, instances where providers did not accept new patients based on language ability or insurance suggests that other, institutionalized forms of discrimination exist within the system, which may lead to marginalization and poor health outcomes as providers avoid more problematic or time consuming patients. Despite widespread acceptance that discrimination is a key determinant of health, and recent arguments for measures to counter racism being incorporated into Canada’s Population Health framework (Oxman-Martinez et al. 2001; Hyman 2009), these issues were not directly raised. Moreover, there is relatively little literature, at least in the Canadian context, to strengthen these linkages from the perspective of newcomer, immigrant and refugee populations. Instead, much of the evidence base demonstrating racism’s detrimental effects upon health focuses on the experiences of visible minorities such as African Americans in the US, Maori in New Zealand, or Caribbean and South Asian populations in the UK (see Krieger and Sidney 1998; Taylor and Turner 2002; Karlsen et al. 2005; Harris et al. 2006). Nevertheless, further exploration of such representations, including the perspectives of individual refugees and their outcomes, is warranted.

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. This lack of acknowledgment leads to refugee health needs being rendered invisible within the policy and academic literatures. It is important to recognize the extent of systemic barriers in order to effectively shape public policy. Equally, refugees are not a homogeneous group: GARs, asylum seekers, and others may have differential experiences and needs, and further research is required. Researchers and policy analysts, as well as health care providers, must acknowledge that the differential impact of country of origin, language, culture, and refugee status leads to diverse health needs. That is, health is not ‘one size fits all’, and must respond to the unique needs of this group. Second, it is important to recognize that the health status and need for health services within refugee populations cannot be
considered as only ‘current’. That is, the health of the refugee population must be contextualized around their post-arrival experiences within the host country, as discussed in this paper. However, their health status is also a reflection of their pre-arrival health and health care experiences, their care while in transit, and their immediate post-arrival health status. Finally, culturally competent care on the part of providers, along with interpretation services, is vital for successfully working with this group. Strategies to promote cultural competencies include sensitivity training and evaluation, hiring professionals who share clients’ ethnicity or language, and developing interpretation services (Fowler 1998; Adams and Assefi 2002). Successfully recognizing these issues and working to minimize barriers will improve the health outlooks of future arrivals.


