

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

A Review of Current Findings and Opportunities for Change

Summary: Immigrant Population

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Summary: Immigrant Population

Immigration is an increasingly important component of new population growth in British Columbia. As of 2006, over one-quarter of the provincial population were immigrants, the vast majority of whom had settled in the Lower Mainland region of the province. Although overall the immigrant population in Canada appears to be healthy in terms of total disease risk, some subgroups may be at higher risk of adverse health outcomes, particularly relating to chronic conditions. Canadian and British Columbian immigrants are remarkably diverse in terms of personal characteristics, place and culture of origin, migration experience, length of residence in Canada, and predispositions to disease. Immigrants' experiences of the socioeconomic and community-level determinants of post-migration health also vary widely. The overall picture of health for immigrants hides important health disparities existing among some subgroups. Those subgroups presenting higher health service needs and poorer health outcomes include immigrants who have been in the country for many years, groups with lower socioeconomic status, and certain demographic and ethnic groups (e.g., South Asians have increased risk for developing insulin resistance and therefore diabetes; immigrant women have a higher prevalence of mental illness than male immigrants; South Asian women's risk of heart disease increases with length of stay in Canada, etc.).

In general, immigrants often have higher health status upon arrival in Canada than the general Canadian population, but tend to lose their health advantage over time. This *healthy immigrant effect* may occur within five to ten years after arrival, and has important implications for health care systems, particularly if the superior health with which immigrants arrive in the province is to be preserved.

While overall utilization of physician services and hospitals appears to be lower among newly arrived immigrants than among the general population of BC, for various specific conditions and procedures immigrants do have higher rates. Utilization of medical services has been found to vary substantially according to demographic and socioeconomic characteristics and existing medical conditions, as seen in the case of immigrants on a Refugee or Family visa utilizing physicians and hospitals the most, and those on an Economic-Business visa using them the least. Disparities in utilization rates raise concern that there may be inequities in access to health services for immigrants in BC, occurring through several channels (i.e., geographic, sociocultural, and economic barriers to access).

Key Findings

Mortality and Health Status

- *Healthy Immigrant Effect.* In general, immigrants often have higher health status on arrival in Canada than the general Canadian population, but tend to lose their health advantage over time. Known as the “healthy immigrant effect,” the superior health status seemingly enjoyed by new immigrants appears to deteriorate and converge toward the native-born population’s health status with increasing duration of residency in the host country, and may occur within five to ten years after arrival.
- *Length of Residence.* More recent arrivals generally conform to the healthy immigrant profile—reporting better health than Canadian-born residents—but the health of those who have lived in Canada for at least five years declines to the same level as non-immigrants. Thus, over time, immigrants report higher prevalence of some chronic conditions, including diabetes, heart disease, and arthritis.
- *Mortality.* Current research suggests that age-adjusted mortality rates among immigrants are lower than the general population, but rates appear to increase with increasing length of time in Canada for all immigrant subgroups. There are some notable exceptions to this trend, wherein mortality rates are higher among immigrants than the broader Canadian population. These include mortality related to nasopharyngeal cancer and liver cancer among immigrant males, AIDS and liver cancer among immigrant females, and stomach cancer for all immigrants.

Specific Chronic Disease Concerns

- *Prevalence of Chronic Conditions.* In general, immigrants have been found to report fewer chronic conditions than do the Canadian-born, and this advantage appears to be greatest for most recent immigrants. In fact, among both men and women, after adjusting for age, education, and income, the odds ratios for reporting a chronic condition appear to climb steadily across groups. Thus, those immigrants who have resided in Canada the longest—30 years or more—become indistinguishable from their Canadian-born counterparts.
- *Cancer.* When adjusted for age, education, and income, the overall prevalence of cancer among immigrants is comparable to the broader Canadian population, but mortality associated with specific cancers is higher for some subgroups, as noted above. The disparities observed according to cancer site and regions of origin may be attributable to delayed detection resulting from reduced utilization that may occur as a result of limited access to screening and other preventive services.
- *Heart Disease.* Rates of heart disease appear to be lower among recent immigrants, and there is little evidence to suggest that rates of hypertension or heart disease increase over time. One exception to this pattern has been observed among South Asians in Canada, and

especially South Asian women, who have an increased risk of heart disease and hypertension with increasing length of stay.

- *Diabetes.* Although relatively limited, the available literature on diabetes prevalence among Canadian immigrants suggests three themes:
 - rates of diabetes among non-recent immigrants may be surpassing those of the Canadian-born population;
 - there are distinct ethnic disparities in the prevalence of diabetes;
 - rates of obesity are increasing among Canadian immigrants.
- *Disability.* There has been very little research performed on immigration and disability in the Canadian context. Much of the focus in this area has been on ethnicity, rather than immigrant status. For example, some studies find that Asian girls may be at a disadvantage for bone health compared to Caucasian girls, and that the prevalence of arthritis is lower for Asians compared to Europeans and all other ethnic groups.
- *Mental Health.* Findings from the available literature on immigrant mental health are complex and sometimes inconclusive. While some suggest that, after an initial risk period, mental health of new arrivals to Canada improves over time, others suggest that certain subgroups experience an increased mental health risk following migration. These subgroups include refugees, seniors, and women. Variations in rates, trends, symptoms and responses have led to speculation that common risk factors are not universal across ethnic groups and that more research is needed on how cultural factors such as ethnic identity, discrimination, and coping mechanisms may affect stress-reactivity.
 - In general, immigrants are observed to have lower rates of both depression and alcohol dependence than the Canadian-born population, and this is particularly true among recently arrived individuals and immigrants from Africa and Asia.
 - Multiple studies focus specifically on the mental health of Chinese seniors and demonstrate concern that this group reports lower overall well-being and more depression than seniors in the general population. There is also documented concern over risk of under-diagnosis or misdiagnosis of depression among foreign-born seniors in Canada due to substantial cultural differences in perceptions of aging, depression, and emotional distress.
 - Little research has been conducted on the mental health of immigrant children in Canada, although it is generally conceded that immigrant and refugee children are more likely to live in poverty and to suffer the adverse effect poverty may have on the mental health and well-being of their parents.

- Immigrant and refugee women have been found to have more mental health needs than male immigrants, with such disparities being attributed to various factors in the pre-migration and post-migration periods.
- *HIV/AIDS.* HIV-positive individuals from endemic countries represent a disproportionate segment of Canada's HIV epidemic. The proportion of positive tests attributed to the endemic category has risen significantly over the past decade, and may be due to increased testing, better provincial reporting, or an actual increase in cases within this category.
 - Young people (under the age of 40) and women account for a substantial proportion of positive HIV test among immigrants in Canada.
 - Post-migration, vulnerability to HIV may be augmented among immigrants due to poor working and living conditions and reduced access to health care shortly after arrival.

Health Service Utilization

- *Utilization Rate Patterns.* During their first year of residence in Canada, immigrants in British Columbia appear to have lower utilization rates of health services than the general population, although rates vary by sex and condition for which treatment is sought. The use of services is observed to rise with increasing length of residence for male and female immigrants of all ages.
- *Use of Services Varies for Women.* The utilization of medical services by immigrant women in BC has been found to be particularly high for pregnancy-related conditions, and rates of use peak in the second six months of residence.
- *Other Variations in Utilization Rates.* In their first year of residence in British Columbia, large variations in immigrants' physician and hospital utilization have been noted according to region of birth, immigrant class, and medical condition upon landing in Canada.
 - Immigrants on a Refugee visa have the highest number of physician visits and hospitalization rates per person, followed by those on a Family visa. Male and female immigrants on an Economic-Business visa utilize physicians the least and have lower hospitalization discharge rates.
 - Immigrants born in Northeast Asia have the lower number of physician contacts per person, while immigrants from Central and West Africa and females from North Africa and North America have higher rates in their first year of residence than the general population.
- *Hospital Procedures.* Recent immigrants tend to have lower overall rates of procedures performed in hospital than the rest of the population in BC, with some exceptions. All immigrants have higher rates of eye operations than the general population. Among males, procedures relating to the endocrine system are more common for immigrants, and

- *Triphasic Pattern of Use over Time.* Over time, immigrants' utilization of health care services has been found to evolve from the ad hoc use of walk-in services to the adoption of regular sources of care. In addition, as immigrants settle in to their new lives and surroundings in Canada, they tend to progress through three phases of help-seeking behaviour: making contact, selections of specific services, and ultimately, consolidation of choices.
 - During the first phase—making contact—and particularly in the first years following arrival in Canada, immigrants learn about services essentially by accident. The vast majority of consultations initiated by immigrants tend to be visits to emergency rooms or walk-in clinics and are motivated by isolated health problems. Physical proximity to facilities, temporal availability of services, and decisions made by health professionals and immigrant settlement services are all key influences during this phase.
 - The second phase—selection of specific services—includes evaluation of alternatives and retrospective evaluation of services received previously. Geographic accessibility is most frequently cited as being crucial during this second phase, as are temporal accessibility, relational quality of care, and health professionals' ethnic affiliation and language of service.
 - The final phase—consolidation and adoption—results from the knowledge acquisition, utilization, and evaluation occurring in the two preceding phases. Geographic and temporal accessibility remain important, and are generally followed in importance by technical and interpersonal skills of the provider, and language spoken by health professionals and staff.
- *Unmet Needs.* Certain barriers and health system factors may lead to unmet needs among the immigrant population, understood as either insufficient or untimely treatment of a medical problem. Data from the 2000/01 cycle of the Canadian Community Health Survey (CCHS) show that, while immigrants have lower levels of unmet needs than non-immigrants in Canada, there are considerable differences in reason for unmet needs. This suggests that some immigrant-specific health care access barriers may exist. In the survey, immigrants reported a higher occurrence of unmet needs due to perceptions that the care would be inadequate, not knowing where to access health care, transportation barriers, and language barriers
- *Accessibility.* Three categories of accessibility pertinent to immigrants can be defined: geographic, sociocultural, and economic.

- *Geographic Accessibility.* Geographic access refers to the physical location of a health care service as well as a person's ability to receive care at that location. Thus, this category also includes factors such as hours of operation and wait times. Qualitative studies have observed that Canadian immigrants often report geographic and temporal availability as insurmountable barriers to receiving care.
- *Sociocultural Accessibility.* The language in which health services are provided and the ethnic origin of health care professionals are considered to be particularly important determinants of immigrants' initial selection of, and long-term fidelity to, services. Language and cultural barriers can have adverse effects on the accessibility of care, the quality of care received, patient satisfaction, and health outcomes. While there will always be a need for language interpretation services for some patients, it is generally agreed that the best communication is achieved where health care providers and patients speak the same language. In addition to language and cultural differences, some immigrants have identified the lack of female family physicians and specialists as a barrier to receiving appropriate care.
- *Economic Accessibility.* Although the intent of the accessibility principle of the Canada Health Act is to remove the direct costs associated with receiving health care, several studies reveal that direct costs remain a significant barrier for immigrants seeking health care. Immigrants must complete a three-month waiting period before they are covered by the provincial health plan in BC, and so do not benefit from any health care insurance during their first three months in the province. While private insurance is available, many newly arrived immigrants do not have the resources available to purchase such plans or to afford direct payment for care. Finally, the costs of prescription medications, eye and dental care as well as other extended health services may remain out of reach for those immigrants with limited resources and who lack full-time employment.

Population-Specific Opportunities

System and Policy

- *Modification of existing services to respond to accessibility barriers for immigrants:* The primary attributes identified as essential to the evaluation, selection, and adoption of health services were related to geographical and temporal accessibility, interpersonal and technical quality of services, and language spoken by health professionals and staff. Thus, health services could be improved by considering the particular concerns of the populations they primarily serve and making appropriate modifications.
- *Increased translation and interpretation services:* Existing interpretation and translation services within all clinical settings should be enhanced and improved in accordance with the latest findings and recommendations on best practices from the literature. Enhancement of these services may require future assessment of regions where additional services may

need to be implemented. The utilization of interpretation services would be further enriched by the following:

- *Initiatives to promote awareness of the importance and appropriate use of interpretation services within the health professions:* Such initiatives should cover the importance of provider-patient communication and training on working with interpreters should become a required component of pre-service professional preparation.
- *Strategy for health interpreter training, accreditation, and standards of service provision:* Provincial and national strategies should include standards of practice and appropriate models of service for the Canadian and British Columbian context. Also, strategies should include official, Aboriginal, visual, and immigrant languages.
- *Improved information support:* All immigrants and Canadians in general would benefit from better information support. In this respect, health care establishments could be more attentive to immigrants' information needs. This could include information tools tailored for immigrant populations, as well as improved sharing of health care strategies and clear explanations of the organization of health services.
- *Enhanced assistance from community agencies:* At the local level, research findings suggest a need for community agencies to assist further in making physicians more accessible to immigrants. This may include providing a means of transportation, thereby reducing geographic barriers to care. Alternatively, bringing physicians to the patients via community health centres or community agencies could also help eliminate geographic barriers.
- *Re-examination of waiting periods:* Those provinces that impose a waiting period before newcomers can access the publicly funded health care system may need to re-examine such policies, as they appear to contradict the accessibility principle of the CHA.
- *Measures to address physician shortages:* Provincial regulatory bodies could play a role in reducing the current shortage of physicians in Canada. This could be accomplished through enhanced physician recruitment and training programs, as well as streamlining the process of assessing the qualifications of foreign-trained doctors. At the federal level, the overall shortage of physicians, and culturally and linguistically appropriate physicians in particular, could be re-examined. Some researchers have suggested that the *Skilled Worker Program* could be an effective means of increasing the number of internationally trained health care providers in Canada.¹⁴
- *Reassessment of the Canada Health Act:* Some of the findings explored in this report suggest that the effects and reach of the Canada Health Act and its guiding principles ought to be reassessed and possibly modified so that it better reflects the barriers that have arisen since its implementation, particularly as they relate to immigrants.

Research

- *Qualitative studies of health service utilization:* Future research should aim to elucidate some of the factors affecting immigrants' utilization of health care services. This could include qualitative studies examining the perceived need for care, health beliefs, and engagement with alternative resources, as well as immigrant perceptions and experiences of the Canadian health care system. Additionally, immigrants' views on gaps in the system as well as existing successes that they see as positive in terms of health services would contribute positively to the organization and implementation of health care services across the province.
- *Quantitative studies of health status indicators:* Further quantitative understandings of various chronic conditions among immigrants are needed. Little longitudinal data is available, which would help in elucidating trends in immigrant health status and service utilization over time. This is significant because much of the currently available data is cross-sectional in nature, thus comparing disparate groups of immigrants who have arrived in Canada in differing time periods and circumstances. Additionally, many studies consider immigrants as one group therefore little is known about the prevalence of chronic health problems among subpopulations of Canadian and British Columbian immigrants.
- *Consideration of the influence of culture and ethnicity in relation to systemic barriers to access:* Within the Canadian context, research has tended to focus on the effects of socioeconomic factors on health status and service utilization, and to a lesser extent on regional differences. Studies considering the influence of culture and ethnicity are limited to differences attributed to cultural beliefs and practices, and not on the effect of systemic barriers to access. Future research could contribute to understandings of cultural and ethnic differences in how the health care system exacerbates or ameliorates health inequities through the expansion of qualitative and quantitative studies to include immigrant subgroups.
- *Inclusion of immigrant subgroups:* Many of the studies reviewed considered the prevalence of health conditions and health care service utilization among immigrants as a whole. For example, the studies on utilization highlighted here were limited to newly-arrived immigrants. Further studies comparing utilization rates of immigrants over time and considering specific subgroups are certainly warranted. Such comparative studies would allow for a more thorough and nuanced understanding of what happens to immigrants' health as they settle in the province, and would allow for separation of the effects of length of residence and migration circumstances from actual worsening or improvement of health.