INCLUSIVE OR TARGETED HEALTH SERVICES FOR NEWCOMERS

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Although there has been much research on the barriers and supports that impact newcomer access to healthcare, there is not agreement on whether the optimal healthcare services model for newcomers should be targeted specialized healthcare services for specific populations or an inclusive model where extra navigation or language supports are embedded in regular healthcare. This paper describes the health partnership model in Regina and presents some learnings from their experience. Overall it would be ideal to enhance the capacity of the healthcare system to provide responsive, culturally competent healthcare through the addition of mobile healthcare navigators.

The vast majority of the 260,000 plus newcomers who arrive annually in Canada (Citizenship and Immigration Canada, 2015) are in fairly good health, somewhat better than that of the average Canadian, but they commonly experience health declines shortly after their arrival (Newbold, 2009). Given the large annual influx of newcomers and the additional Syrian refugees in 2015-2016, it is important to understand the potential health and nutritional concerns of newcomers and how healthcare services can be optimally designed to meet those needs. This will support the development of effective healthcare policies and programming that support the health-care needs of newcomers and ensure the development of an overall healthy, productive Canadian population.

ACCESS TO HEALTHCARE

Access to healthcare plays a vital role in preventing diseases and promoting the health and well-being of newcomers to Canada. Some Canadian research suggests that newcomers access primary healthcare less frequently than the Canadian-born. A Canadian study focused on healthcare use found that newcomers with less than 15 years in Canada had 5-24 percent fewer physician visits than longer-term immigrants and the Canadian-born (McDermott *et al.*, 2010). Newcomer health-care service use decreased over the first few years in Canada and then increased in later years. The study also identified several sub-groups, including refugees and female family class immigrants who visit physicians more often than the Canadian-born. It is possible that newcomers make frequent physicians visits shortly after their arrival to address older health

problems (McDermott *et al.*, 2010) and/or that settlement agencies are actively supporting newcomers to access health services soon after arrival. Over the next few years of residency decreased use of physician services may indicate that newcomers are preoccupied with engaging in the labour market and/or taking English classes; while increased use of medical services may occur among longer-term newcomers as they develop chronic disease conditions similar to the Canadian-born.

A key component of primary healthcare is preventive care, such as immunizations and screening for chronic disease development. McDermott *et al.* (2010) did not observe any difference in the rates of immunizations or annual check-ups among recent newcomers, longer-term newcomers and the Canadian born, so newcomer children appear to be accessing preventive care on an equitable basis. However, at least one study noted that children of refugees are less likely to have up-to-date immunizations compared to other immigrant classes (Guttmann et al., 2008). Another group at high risk for poor access to preventive care are newcomers with undocumented status (Access Alliance, 2011), likely due to ineligibility for provincial healthcare coverage. This research indicates that refugees and undocumented immigrants are at increased risk of not accessing recommended preventive care.

BARRIERS

As described above, all newcomers do not necessarily experience equitable access to healthcare to support their health and well-being. A Canadian study found that 43 percent of recent immigrants experience difficulties with accessing immediate healthcare, while only 15 percent of the Canadian-born had the same difficulties (Sanmartin & Ross, 2006). Research has identified several barriers that impact newcomer access to healthcare services, including lack of familiarity with the healthcare system (Wu *et al.*, 2005), cost (Access Alliance, 2011), cultural competency (Hansson et al. 2009), traditional beliefs (Council of Agencies Serving South Asians, 2008), and lack of transportation (Kilbride, 2010), or childcare (O'Mahony & Donnelly, 2007).

Unfamiliarity with the healthcare system being noted as a barrier in some studies suggests the need to ensure that newcomers are systematically provided with information on how to access healthcare and healthcare benefit programs and a healthcare contact to address any questions related to navigating the healthcare system. Lack of cultural sensitivity or competency suggests the need to critically examine the capacity of healthcare services to appropriately serve newcomers. In addition, healthcare services need to consider how to make their services more responsive to newcomer needs, which may include offering extended hours and decentralized services to address practical service access barriers. The documented existence of ongoing barriers to healthcare highlights service gaps and points to the need for advice on optimal models of healthcare to ensure equitable access for newcomers.

SUPPORTS

Given the many barriers that impact newcomer access to healthcare, healthcare systems should be designed to better accommodate newcomers. The World Health Organization (2010) advocates that healthcare systems should be designed to accommodate cultural, religious, linguistic, and health status differences common to newcomers that can impact their ability to access healthcare. The use of basic English words in healthcare material or translated resources; engagement of immigrant communities in a program advisory capacity; provision of culturally competent health services, including the use of interpreters; and collaboration between traditional and biomedical practitioners can support enhanced newcomer access to healthcare (Young *et al.*, 1999; Anderson *et al.*, 2003). At the heart of all the inter-related initiatives that support newcomers' health is the provision of culturally competent health services. It is evident that we need to progress from research to the implementation and evaluation of model programs that comprehensively address the recognized barriers.

Current research suggests the need to review healthcare services to ensure that they are responsive to the health needs of newcomers; and to redesign services and/or offer staff training to ensure that services are culturally competent. Although there has been much research on the barriers and supports that impact newcomer access to healthcare, there is not agreement on whether the optimal healthcare services model for newcomers should be targeted specialized healthcare services for specific populations or an inclusive model where extra navigation or language supports are embedded in regular healthcare services that can be accessed by anyone.

HEALTHCARE SERVICES FOR REFUGEES IN REGINA

The Regina Open Door Society (RODS), Regina Qu'Appelle Health Region (RQHR) and Regina Community Clinic (RCC) have partnered to offer targeted health services to government assisted refugees (GAR) in the Regina area since 2004. The partnership has established a coordinated healthcare protocol to guide the provision of comprehensive services to GARs during their first six months in Canada. All GARs receive an initial health assessment from the public health nurse at the Regina Open Door office and are then referred to the RCC for their complete physical examination, which can be done urgently if required; otherwise it may be completed within a couple of weeks. The RCC is a comprehensive primary care centre that includes a lab, x-ray department, nurses, nurse

practitioners, nutritionist, exercise therapist, counselor, and salaried physicians. These physicians have time to spend with people who do not speak English and might need interpretation, which can take additional time that fee-for-service physicians may not have. The RCC has also developed a health guide, available in seven languages, to tell refugees what to expect when they come to the facility. The health guide includes a range of useful health resources, including crisis response resources, when to go to emergency, how to read medication labels and an explanation of the Saskatchewan health card. The RCC provides supportive interpretation services in the client's first language, either with a contracted interpreter, or through a staff member who can speak their language. These supportive services facilitate GARs' access to healthcare.

SUCCESSES

Overall, RODS perceives that the Regina partnership has been highly successful in terms of healthcare access measures and client satisfaction. The partnership has been working very effectively as it has resulted in coordinated healthcare for all individuals with high medical needs, and reports a 99 to 100 percent success rate of up-to-date immunizations. RODS estimates that about 98 to 99 percent of clients continue to access a family physician at the RCC. In addition, they estimate that the partnership approach has prevented 95 to 96 percent of clients from accessing emergency services when that level of care was not required. Before the partnership started, RODS reported that many refugees used Emergency Department services as their default healthcare service because there was no systematic approach to facilitate access to healthcare.

Many recent refugees have indicated their satisfaction with healthcare services provided by RQHR and RCC shortly after their arrival. When they first arrive they usually have no idea of where to go to see a physician or access healthcare so they appreciate that their RODS case managers guide them through the process and that interpretation is provided when necessary. In some instances quick access to the targeted healthcare service has been beneficial for those with existing health issues. As part of the Healthy Immigrant Children study we conducted in-depth interviews with families to understand their experiences with the healthcare system. A refugee shared her husband's experience of accessing care for his depression. When the family first arrived the public health nurse identified them as needing urgent referral to RCC so the father could access medication for depression. He continued to see a physician there for about one year. After he got a job and started working he no longer required the medication. The family credits the good care he received at RCC with supporting his recovery. This refugee, who had a potentially stigmatizing mental health issue, had facilitated access to proper treatment that assisted him to recover and successfully integrate into Canadian society.

CHALLENGES

The Regina Community Clinic is committed to meeting the healthcare needs of GARS, although they are currently experiencing increased service demands that they are stretched to accommodate with existing resources. When the partnership started, there were about 20 or 30 new GAR patients per year and the number continues to increase annually to about 200 to 250 patients per year in 2014-2015. This figure will be even larger once the Syrian GARs are added. RCC estimates that they have over 1000 GAR patients, since over 90 percent of them continue to seek their primary care at the clinic on an ongoing basis. GARs are part of the official health partnership during their first six months of residency, but GARs are not forced to leave the care of RCC physicians at the end of that term. GARs appear to be comfortable at the clinic because even though they are advised that they can find another physician in the community, perhaps more conveniently located near their residence, they don't leave. Perhaps the good service they get from their RODS case manager who provides transportation to the clinic or the interpretation provided at the clinic creates such a welcoming environment that there is no motivation to transfer to another healthcare provider. Since RCC accepts all new GARS in the Regina area as patients and many of them do not transition to other physicians in the community, it can become difficult to continue the same level of service without the addition of new resources. Even demand for the public health services provided by RQHR at the RODS location is growing. RODS notes that the annual flu clinic they host at their office has grown exponentially in recent years to close to 700 clients in 2014-2015, which is becoming difficult to accommodate within existing space.

Although the RQHR Public Health Services and RCC are providing high quality targeted service to GARs, immigrants and privately sponsored refugees do not have access to the same dedicated service. Given this lack of targeted services for new immigrants and the increasing demand for supportive healthcare services by refugees, RODS suggests the need for a primary healthcare clinic that focuses on newcomer health. Presently, immigrants are not getting any interpretive services to access healthcare in Regina, while GARs are only getting in-person interpretation services for the first six months while they are going through the health partnership.

CONCLUSION

The experience of the Regina GAR health partnership provides some guidance to inform the development of an optimal newcomer healthcare services model. It would be ideal to enhance the capacity of the overall healthcare system to provide responsive, culturally competent healthcare so that one specific site would not be burdened with an ever-increasing patient load. This could be accomplished by expanding

healthcare system navigator programs that currently exist to serve Aboriginal populations to also include a broader target group of new Canadians from various ethno-cultural backgrounds. Cultural navigators would proactively contact all new refugees and immigrants to help arrange access to appropriate healthcare services with the support of a pool of trained interpreters available on an as-needed basis. Co-location of the navigators within selected health region or clinic sites in areas with high newcomer populations would likely support convenient access to healthcare services over the long-term. However, the navigator should not be confined to supporting newcomers in specific locations. In a truly patient-centered approach, navigators should be able to assist newcomers to access healthcare that is convenient for the patient.

In Canada we do not currently have a unified evidence-based approach to providing healthcare to newcomers. Thus, there is an opportunity to thoughtfully consider policy and practices options by moving forward with a cohesive national review of current practices, challenges and opportunities, and the formation of a stakeholder group to review available information and make recommendations.

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