publichealth research&practice

March 2018; Vol. 28(1):e2811803
https://doi.org/10.17061/phrp2811803
www.phrp.com.au

Perspective

Canada's response to refugees at the primary health care level

Kevin Pottie[a,b,c,e], Doug Gruner[b] and Olivia Magwood[d]

[a] Bruyère Research Institute, Ottawa, Ontario, Canada
[b] Department of Family Medicine, University of Ottawa, Ontario, Canada
[c] Department of Epidemiology and Community Medicine, University of Ottawa, Ontario, Canada
[d] Department of Population Medicine, University of Guelph, Ontario, Canada
[e] Corresponding author: kpottie@uottawa.ca

Article history

Publication date: March 2018
Citation: Pottie K, Gruner D, Magwood O. Canada's response to refugees at the primary health care level. Public Health Res Pract. 2018;28(1):e2811803. https://doi.org/10.17061/phrp2811803

Key points

- Responsive health systems emerge through collaboration by government, the private sector, advocacy groups and primary health care
- The influx of Syrian refugees provided an opportunity to test the responsiveness of existing primary health care, health practitioner and interpreter training, and evidence based approaches
- Despite Canada's network of refugee health clinics, services such as medical interpretation, drug and dental benefits, and counselling services remain susceptible to political perspectives

Abstract

Responsive primary health care systems and services must be at once complex and nimble. Policy makers may wish to believe that existing health systems effectively care for all populations equally, including refugees. However, we know that refugees may require a health equity approach: an approach where all levels of government, all types of health practitioners, and even the public sector, participate to ensure access to effective primary health care.

This article outlines some of Canada's healthcare responses for refugee populations. We provide field examples and guidelines that demonstrate responses, as well as ongoing inconsistencies and limitations. Refugee-receiving countries such as Australia, the US and Canada all have stories of success in resettlement and health systems. This article will focus on Canada.

Introduction

The global refugee crisis presents an opportunity for countries to come forward as leaders in resettlement of the more than 65 million refugees, asylum seekers and internally displaced persons worldwide. In 2016, Canada resettled 55 800 government-assisted and privately sponsored refugees, comprising 33 200 Syrian refugees and 22 600 refugees from other countries. The most common countries of origin for refugees being resettled in Canada include Syria, Iraq, Eritrea, Iran, Somalia, Afghanistan, Pakistan, China, Haiti and Colombia. In addition to government and privately sponsored refugees, Canada also accepted approximately 15 000 additional refugees from its population of asylum seekers.[1]

Government-sponsored resettlement programs in Canada aim to address many of the documented social determinants of health such as ensuring shelter and housing, employment, education, and training.[2] Global health education in medical schools across Canada now includes refugee community service learning, with competency-based e-learning and interpreter, shelter and mental health initiatives.[3] As these students become leaders and advocates, health settlement[4] has emerged to improve health

system navigation, access to evidence based clinical prevention guidelines[5] and integration into community primary health care. Refugees value a relationship with community-based primary care practitioners, and with students[5], and most refugee care takes place in communities and not hospitals.[6] Encouraging and training community family physicians to accept refugees has been an ongoing challenge[7]; this has also been documented in systematic reviews in Australia.[8]

Box 1. Case study of Syrian refugees

The Syrian humanitarian crisis, combined with a Canadian federal government policy to resettle tens of thousands of Syrian refugees, led to Canada resettling the largest wave of refugees since the Vietnamese boat people in 1978–79. In December 2015, the newly elected Canadian Liberal government promised to resettle 25 000 refugees, a target that was met by March 2016. The Canadian primary health care system had to respond to this sudden influx of refugees.

Limited resources led to certain innovative approaches: multiclinic research screening protocols, video and web conference training of large numbers of physicians and public health practitioners across Canada, and unprecedented public engagement to assist with community settlement. Existing networks of practitioners and settlement workers collaborated, took action and iteratively reported statistics and qualitative findings to the government. These reports advocated for additional strategic resources for the mass resettlement of refugees. Many academic family medicine centres, for example, joined with community health centres and public health workers to develop evidence based health assessment programs.

In one city, 5000 members of civil society volunteered to help settle Syrians in the city. In most cases, existing settlement and mentorship programs with student outreach, clinical prevention, interpretation and settlement were scaled up and improved access to primary health care. In Ottawa, for example, 2000 Syrian refugees received preventive vaccination and care, and were integrated into primary health care centres within 2–4 months of arrival. Arabic-speaking interpreters emerged thanks to relationships between the academic sites, the medical school and settlement agencies. Many international medical graduates with Arabic language interpretation capability volunteered to fill early gaps and ensure timely medical assessments. Cities with existing refugee health networks, immigrant-friendly clinics and program expertise were more successful than cities that were less prepared.

Pre-existing primary health care

To understand Canada's response to Syrian refugees, it is important to appreciate that Canada has a long history of resettling refugees. Canada was recognised by the United Nations for its outstanding humanitarian tradition of settling refugees in 1986, receiving the Nansen Refugee Award, the only time the medal has been awarded to a whole country. Historical examples of mass resettlement include 37 000 Hungarians escaping Soviet tyranny in 1956 and more than 60 000 boat people after the communist victory in the Vietnam War. More recently, 6600 Bhutanese and 23 000 Iraqi refugees arrived in Canada in 2015[9], in addition to the commitment to resettle 25 000 Syrian refugees in 2016. The national government has also consistently funded resettlement programs for shelter, orientation, and language and employment training across the country.

Advocacy has emerged as a unique strength in Canada. In 2012, Canadian Doctors for Refugee Care (CDRC) emerged as a national advocacy group to fight previous government cuts to healthcare for asylum seekers and refugees. This advocacy group led 'white coat' protests demanding the government change this inequitable policy that was not informed by evidence and lacked any consultation with health and settlement stakeholders. The CDRC engaged with federal ministers, held rallies on Parliament Hill in Ottowa and, in collaboration with the Canadian Association of Refugee Lawyers, took the government to court. The federal court ruled the cuts to refugee health services unconstitutional, thus forcing the government to reinstate Interim Federal Health (IFH) – basic health coverage for all refugees.[10]

Another valuable health system component was public health collaboration. Building on past refugee vaccination, tuberculosis screening and mental health programs, partnerships with primary care clinics are now well established. In addition, a public health focus on health equity in policy and programs contributes to the foundation of a responsive health system.[11]

Despite well-intentioned government policy, a universal health system does not always ensure access and quality for all. Government exhortations are not always backed up with political will and robust programs. A universal healthcare system without a universal pharmaceutical benefits program creates barriers to treatment and management of conditions. Additional barriers, such as fee-for-service payment plans for physicians, prevent access to care for refugees.[12] There are also barriers to high-quality care at the level of medical practitioners, because many physicians do not feel equipped to deal with the often unique challenges that refugees may bring.[7]

Evidence based guidelines can support both public health and primary health care in the detection and care of infectious diseases and chronic diseases. Interpreters play a supportive role in the delivery of care and were, for example, in high demand to provide care to Arabic-speaking Syrian refugees. Responsive primary health care systems include interpreter services, evidence based guidelines, specialist physicians, cultural and political profiles, and interdisciplinary collaboration. Ensuring all migrants receive a health card soon after arrival is at the forefront of access to health services.[11] The Syrian refugee response in Canada revealed some notable bright spots: well-prepared cities, young health practitioner and community leaders, intersectoral collaboration, and an ability to scale up existing programs. However, regionally coordinated programs existed in only a minority of cities. Some regions were slow to prepare for the Syrian refugees, had minimal programs to scale up, and lacked primary health care capacity. The recent influx of Syrian refugees showed the importance of well-prepared refugee-responsive programs.

The newly elected government made true on an election promise to bring in 25 000 Syrian refugees in 2016. However, even now, certain claimants still are without IFH support for weeks to months. This is often a crucial time when they need chronic disease management most. Without IFH, many refugees hold off on seeking healthcare until late in their disease, aggravating their condition and leading to more expensive care later on. This is especially concerning when delays in care affect children, which is in breach of the United Nations Convention on the Rights of the Child.[13]

Conclusions

The Canadian primary health care system response to refugees demonstrates the importance of working with settlement programs and of open dialogue between policy and decision makers and clinicians, as well as researchers. An environment open to best practice, evidence based approaches and lessons learnt was key to the successful health settlement of refugees that continues today.

Advocacy is fundamental to an effective interplay between policy, research and high-quality care. As was learnt during a time when the system experienced significant stress because of ill-informed policy, advocacy efforts can result in real change. Of course, even when the system is working well and is supported by positive policy, it remains as fragile as the population it serves. Constant monitoring to ensure efficacy and equity is essential. Finally, based on our experience, sustainability is made possible by supporting primary care, building a more shared care mental health model, and having a focus on social accountability training in medical school.

Competing interests

None declared

Author contributions

All authors contributed equally.

References

1. Government of Canada. Ottawa: Government of Canada; 2018. Statistics and open data; 2017 [cited 2017 May 2]; [about 3 screens]. Available from: www.cic.gc.ca/english/resources/statistics/
2. Beiser M. The health of immigrants and refugees in Canada. Can J Public Health. 2005;96:S2.
3. Gruner D, Pottie K, Archibald D, Allison J, Sabourin V, Belcaid I, et al. Introducing global health into the undergraduate medical school curriculum using an e-learning program: a mixed method pilot study. BMC Med Educ. 2015;15:142.
4. Pottie K, Hostland S. Health advocacy for refugees: a medical student primer for cultural competency and global health. Can Fam Physician. 2007;53(11):1923–6.
5. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrant and refugees. CMAJ. 2011;183(12):E824–925.
6. Pottie K, Greenaway C, Hassan G, Hui C, Kirmayer LJ. Caring for a newly arrived Syrian refugee family. CMAJ. 2016;188(3):207–11.
7. Mota L, Mayhew M, Grant K, Batista R, Pottie K. Rejecting and accepting international migrant patients into primary care practices – a mixed method study. Int J Migr Health Soc Care. 2015;11(2).
8. Joshi C, Russell G, Cheng H, Kay M, Pottie K, Alston M, et al. A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. Int J Equity Health. 2013;12:88
9. Government of Canada. Ottawa: Government of Canada; 2018. Canada: a history of refuge; 2017 [cited 2017 May 2]; [about 3 screens]. Available from: www.canada.ca/en/immigration-refugees-citizenship/services/refugees/canada-role/timeline.html
10. Gruner D, Cleveland J, Pottie K, Demirdache L. Barriers to accessing health care for refugees, government policy and the healthcare community response. In: Pashang S, Gruner S, editors. Roots and routes of displacement and trauma. Oakville: Rock's Mills Press; 2015.
11. Pottie K, Hui, C, Rhaman P, Ingleby D, Akl EA, Russell G, et al. Building responsive health systems to help communities affected by migration: an international Delphi consensus. Int J Environ Res Public Health. 2017;14(2):144.

12. Batista R, Pottie K, Dahrouge S, Manuel D, Tanuseputro P, Mark AE, et al. Enrollment of immigrants into primary care practices in Ontario. Fam Pract. Forthcoming 2018.

13. United Nations General Assembly. UN Convention on the Rights of the Child: General Assembly resolution 44/25, article 24. New York: UNGA; 1989 [cited 2018 Jan 17]. Available from: www.ohchr.org/Documents/ProfessionalInterest/crc.pdf