# Climbing the walls

## *Structural barriers to accessing primary care for refugee newcomers in Canada*

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For newcomers to Canada, health care delivery varies from province to province. In New Brunswick, Ontario, Quebec, and British Columbia, newcomers are required to wait 3 months before they can enrol in a provincial health insurance program. Many newcomers purchase private health insurance to ensure health care coverage; however, those in one group of newcomers—refugees—are often unable to purchase such insurance.

Newcomers initially have low health care utilization patterns, be it for primary or tertiary health care services. In those provinces that have a 3-month waiting period, the number of family physician visits increases shortly after the 3 months have expired. Where possible, newcomers tend to use walk-in clinics and emergency room services until they acquire family physicians.[1] Overall, physician visits for newcomers are fewer than those of non-newcomers.[2-5]

### Refugee newcomers to Canada

In general, newcomers are healthier than the nonimmigrant population. The phenomenon is referred to as the *healthy immigrant effect*.[5] The healthy immigrant effect has been attributed to the self-selecting nature of the immigration process. This process favours newcomers who are healthy and well educated.[4] The healthy immigrant effect, however, is negated by time. After 10 years of residency in Canada, newcomers report poorer health outcomes than nonimmigrants.[6] The healthy immigrant effect is not evident among refugees[7]; in fact, refugees can often arrive with health deficits due to refugee camp living conditions and might need "special care and protections in a new country, particularly in their early stages of resettlement."[4,8]

### Interim Federal Health Program

Refugee newcomers to Canada can apply to the Interim Federal Health (IFH) Program for "emergency and essential" coverage until they are accepted into a provincial medical insurance plan in their province of residence. The IFH Program was introduced in 1957 to assist refugees "who are unable to pay for essential and emergency healthcare and who are not covered by a public or private health insurance plan."[9] The IFH Program also covers some essential services, which are not covered under the provincial health insurance programs, for a set period of time.

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### Barriers

A refugee settlement agency in New Brunswick approached the Fredericton-based Dalhousie University Family Medicine Teaching Unit to explore the difficulties they experience with refugee clients and the IFH Program. Although the information provided in this commentary is based on the experiences in New Brunswick, refugees in other provinces, particularly the provinces that observe the 3-month waiting period for health coverage, likely have similar concerns.

In order to examine the issue in detail, we discussed the topic with 3 of the 6 Resettlement Assistant Program (RAP) workers in New Brunswick. These workers were located in 3 different cities in New Brunswick that have an RAP in place to assist government-sponsored refugees.

The stories of these front-line settlement workers drew a disturbing picture of the barriers to accessing primary care for refugees. According to the RAP settlement workers, family physicians—often as solo, fee-for-service practitioners—frequently do not recognize the IFH Program certificate owing to their unfamiliarity with the program. If they are familiar with the program, they find the reimbursement requirements too cumbersome. Physicians must complete a great deal of paperwork in order to be reimbursed for services provided. One settlement worker summed it up as follows: "The [after-hours] clinics will not accept the IFH papers any more because IFH is so difficult to work with that the accounting staff of all these doctors hate doing IFH. Because it's time-consuming to fill out the forms and it's months and months before they get their payment."

### Chain reaction

Because many family physicians refuse to accept the IFH Program coverage, refugees tend to go to emergency rooms for nonurgent conditions. As one RAP worker stated, "So if someone just has a flu or they just want to get a birth control pill and they don't have the money to pay to go to the after-hours clinic, they end up sitting in the emergency room." Hospital authorities tend to accept IFH certificates more readily because direct income payment for the attending physician does not depend on whether or not the hospital authority

can recover the cost from the IFH Program. In addition, hospital authorities have entire departments dealing with billing issues, instead of lone practitioners and their bookkeepers.

If a refugee is being assessed in an emergency room and it is deemed necessary to pursue follow-up investigations with a specialist, further problems are created by the rules of the IFH Program coverage. As one settlement worker stated: "I am experiencing problems with clients who are coming into the country and they're extremely ill ... so what's been happening is we go to the emergency room. Well, I've had several people who [were referred] to specialists ... [but] the doctors don't recognize the IFH form. So it's difficult to get in."

A further complication of the IFH Program is that it only covers "essential and emergency health services for the treatment and prevention of serious medical conditions."[9] However, who makes the assessment of what is "essential and emergency" care? The refugee? The settlement worker? Settlement workers feel that they are sometimes forced to assess medical conditions. As one settlement worker said, "I am not a doctor; if somebody tells me 'I have malaria' or something, I can't make the diagnosis if the client really has the illness or not. So I have to take them to the hospital, to the emergency room."

Finally, it is not uncommon for family physicians to approach their refugee patients for payment for services when the IFH Program is slow with reimbursements or requires yet another form before reimbursement can take place. This billing can add considerable stress to the lives of the refugee newcomers. One of the settlement workers said, "Six months later my client gets a bill because IFH hasn't paid it. And they are like, 'What's going on?' ... My clients are freaking out; they can't afford these bills."

## Paradox

Refugee newcomers to New Brunswick experience substantial barriers to accessing health care, particularly in the first 3 months of their stay, even though they are covered by a health insurance program specifically designed to facilitate access. The barriers to accessing health care for refugees can be traced back to the limited parameters and administrative bureaucracy of the IFH Program, which creates obstacles for physicians to be reimbursed for their services. A study published 15 years ago raised this issue of cumbersome physician reimbursement; however, not much has changed.[7,10]

## Taking action

We urge the federal government to revise the IFH Program in order to make its reimbursement procedures for primary health care physicians and other service providers transparent, smooth, and accessible. It seems bizarre that a program developed to facilitate access to health care for a vulnerable group of newcomers has such complicated reimbursement procedures that primary care physicians prefer not to treat such patients. These patients are forced to use tertiary health care services that are far more costly, reduce continuity of care, increase emergency room waiting times, and reduce patient satisfaction.

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**Competing interests**
*None declared*

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## References

1. Leduc N, Proulx M. Patterns of health services utilization by recent immigrants. *J Immigr Health* 2004;6(1):15-27.
2. DesMeules M, Gold J, Kazanjian A, Manuel D, Payne J, Vissandée B, et al. New approaches to immigrant health assessment. *Can J Public Health* 2004;95(3):I22-6.
3. Ali JS, McDermott S, Gravel RG. Recent research on immigrant health from Statistics Canada's population surveys. *Can J Public Health* 2004;95(3):I9-13.
4. Hyman I. *Immigration and health.* Health Policy Working Paper Series 02-05. Ottawa, ON: Health Canada; 2001. Available from: **www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/wp-dt/2001-0105-immigration/index_e.html.** Accessed 2008 Jan 16.
5. McDonald JT, Kennedy S. Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada. *Soc Sci Med* 2004;59(8):1613-27.
6. Newbold KB, Danforth J. Health status and Canada's immigrant population. *Soc Sci Med* 2003;57(10):1981-95.
7. Caulford P, Vali Y. Providing health care to medically uninsured immigrants and refugees. *CMAJ* 2006;174(9):1253-4.
8. Dilmann E, Pablo R, Wilson A. Resettlement and integration of immigrants. In: Masi R, Mensah LL, editors. *Health and cultures: programs, services and care.* Oakville, ON: Mosaic Press; 1993. p. 293-306.
9. Citizenship and Immigration Canada. *Application for IFH coverage.* Ottawa, ON: Citizenship and Immigration Canada; 2005.
10. Gagnon AJ. *Responsiveness of the Canadian health care system towards newcomers.* Discussion Paper No. 40. Ottawa, ON: Commission on the Future of Health Care in Canada; 2002. Available from: **www.hc-sc.gc.ca/english/care/romanow/hcc0426.html.** Accessed 2008 Jan 16.