

**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

Executive Summary

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*Reducing Health Inequities:
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Executive Summary

The purpose of this report is to provide an overview of current research and available reports describing the health status and health care service utilization of three underserved populations of interest in British Columbia—immigrants, refugees, and the corrections population—particularly as they relate to chronic conditions. An exploration of some of the ways in which the health care system responds to the health needs of these populations is also included. This literature review is intended to serve as the starting point for further dialogue and collaboration, and to inform the process of developing a strategy for the equitable prevention and management of chronic diseases within the provincial health service delivery system.

The body of this report examines research related to the health status and chronic conditions particular to each population of interest and highlights opportunities where the health system could improve delivery of health care. Unfortunately, there is a general paucity of studies examining the specific health concerns and status of immigrant, refugee, and corrections populations in British Columbia. Therefore, the findings highlighted in this report are based largely upon literature that covers the three populations across Canada and in other provinces, although studies specific to the province are included whenever they are available.

Key Findings

Immigrants

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).

Refugees

In many ways, the health status of refugees in Canada is similar to that of the broader population of newly arrived and more established immigrants across the country. However, refugee health concerns and experiences with the health care system do vary in crucial and significant ways, and this variation has important repercussions on chronic conditions and long-term well-being. Forced migration has increased worldwide, and in recent years Canada has received the second largest proportion of refugees resettled in industrialized countries. In British Columbia, refugees comprise 4.8% of all newcomers to the province.

The healthy immigrant effect is not as evident among refugees as among the broader immigrant population. Indeed, refugees often arrive with health problems due to pre-migration circumstances, such as refugee camp living conditions and endemic infectious diseases and

may require special care and protections, particularly in the early stages of resettlement. Moreover, ethnic, religious, socioeconomic, and cultural differences between and within groups of refugees arriving from distinct regions can result in community fragmentation. In order to adequately and appropriately serve this population with unique needs, health care and social support systems must take the particular health needs, social circumstances (i.e., isolation and exclusion), and community fragmentation of refugees into account in the development and implementation of programming.

Among refugees in Canada, there are significant variations in chronic disease prevalence and trends according to gender, region of origin, length of residency, migration experience, and sociocultural and socioeconomic characteristics. Pre- and post-migration, refugees frequently encounter trauma that may directly undermine their physical and psychological health. Such traumatic experiences may also act indirectly to diminish individuals' and communities' capacity to cope with acculturation stressors, thereby rendering refugees more susceptible to stress-related disorders and psychological disturbances. Additionally, refugee morbidity and mortality attributable to infectious diseases and parasites is elevated, particularly in comparison with rates seen among non-refugee immigrants and the broader Canadian population. HIV/AIDS and chronic hepatitis infection are considered chronic conditions and prevalence has been found to be elevated among refugee populations throughout the country.

Upon arrival in the province, refugees initially have low health care utilization patterns, for primary and tertiary care services alike. Rates of physician visits increase shortly after the three-month waiting period for provincial insurance coverage passes, and until regular care is established refugees tend to rely on walk-in clinics and emergency room services.

Corrections Population

Prison and penitentiary inmates experience disproportionately high levels of chronic and acute physical and mental health problems, resulting in increased utilization of health services within correctional institutions and once released from custody. The provision of health care in correctional facilities differs from care for the non-prison population in community settings in numerous ways. These include the need for greater control of medications, heightened security and escort services necessary when inmates require health services beyond what is offered within the correctional facility, and some tension between the goals of inmates seeking care and the staff providing health services.

There are several demographic features of the inmate population that distinguish it from the Canadian population. On average, inmates are much younger, they are predominantly male, and Aboriginal people are substantially overrepresented. In recent years the demographic profile of the incarcerated population has been shifting, as the number and proportion of female, Aboriginal, and older prisoners entering custody has increased. Such shifts have important implications for correctional services in terms of the types of rehabilitative and health programming needed and the infrastructure required to house this changing population.

From a health determinants perspective, several critical factors influence the health of inmates, including: low rates of education completion and literacy; poor employment histories and financial instability; unstable accommodation; poor social networks and attachments; and extensive criminal histories. Additionally, the three subgroups seen in higher numbers and proportions of the corrections population in recent years—Aboriginals, women, and older offenders—have a higher risk of poor health outcomes, when compared with the general inmate population.

Mental health and infectious diseases are of particular concern among the corrections population. Substantial proportions of offenders are identified as having mental and substance abuse disorders at intake and concurrent disorders are extremely common. The correctional environment can challenge mental health, and may lead to the development of new disorders as well as the exacerbation of those that are pre-existing. Offenders are at increased risk of having acquired several types of infectious diseases prior to incarceration, including HIV and hepatitis. Furthermore, transmission of communicable diseases within corrections facilities is considerable, and is influenced by the extent of risky behaviour initiated and continued throughout incarceration. Inmates in custody have substantially higher mortality rates than comparably aged members of the general population. Violent deaths, cardiovascular disease, cancer, liver disease, and HIV/AIDS are among the most significant causes of death for this population, and reflect the diseases and risk behaviours that are highly prevalent (e.g., hepatitis infection and lung cancer, smoking and injection drug use).

Institutionalized offenders have substantially higher utilization rates of health care services than similarly aged individuals in the community. Penitentiary and prison health services make extensive use of nurses, which reflects the institutional setting of correctional facilities as well as specific inmate health issues.

Opportunities for Health Systems Change

Based on this review of the literature, the following opportunities for change have been identified. All suggestions are intended to stimulate and inform further dialogue and development of a strategy that could be adopted by the health care system in British Columbia, aimed at ensuring equal access to health services, reducing health inequities observed, and maximizing the health of the three underserved populations considered. Many different actions could be taken within each of these areas, and some are explained in depth within the sections of the report specific to each population. Directions for future research, though not listed here, are highlighted in the population sections.

Common Themes

- Improved information support, to include:
 - Tailored information tools
 - Clear explanations of health system organization
 - Sharing of health care strategies with patients
 - Assurance of continuity of care through communication between health care delivery systems and among health care providers
- Enhanced assistance from community agencies and expansion of services at the community level
- Implementation and expansion of interventions to enhance coping skills
- Enhancement of prevention efforts

Immigrants and Refugees

- Modification of existing services to respond to accessibility barriers
- Increased translation and interpretation services
 - Initiatives to promote awareness of the importance and appropriate use of interpretation services within the health professions
 - Strategies for health interpreter training, accreditation, and standards of service provision

- Re-examination of waiting periods for provincial health coverage
- Measures to address physician shortages
- Disease surveillance and follow up on Immigrant Medical Examination results
- Increased acceptance and ease of use of Interim Federal Health Program
- Expanded and enriched education and training of health care professionals

Corrections Population

- Adaptation of health care services to reflect shifting population demographics
- Improvement of continuity of care between correctional health facilities and health authorities
- Modification of existing services to respond to specific mental health concerns of inmates
- Expansion and enhancement of harm reduction interventions
- Expansion of culturally appropriate services
- Revision of policies on smoking within corrections institutions