The Future of Healthcare in Canada: Diagnosing the Needs of Immigrants

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Abstract
Canada has a publicly funded healthcare system, mandated at a federal level and administered individually through each of its provinces and territories. The Canada Health Act of 1984 serves as the foundation for the healthcare system and promises universal and accessible health services to all Canadians. Nonetheless, over the past two decades Canada has experienced a significant rise in immigrants entering its borders, and consequently several deficiencies in healthcare delivery to this emerging population. The recent release of the government-mandated Romanow report briefly addresses some of these issues, but does not propose specific remedies concerning immigrant health. We briefly discuss our experiences in a largely South Asian neighbourhood of East Toronto and explore some of the issues that require careful consideration if Canada is to fulfill its obligations to recently landed immigrants.

The Present Situation
Canada has experienced a significant boom in immigration, welcoming over two million new arrivals over the past twenty years.1 Originating mostly from South Asia and the Far East, these immigrants have little understanding of the Canadian health system and the services available to them, thus creating new obstacles for providers throughout the country. Although providers are becoming increasingly aware of the need for “culturally sensitive access,” several shortcomings exist in the delivery of services and in the debate regarding these issues.

Recently immigrant health issues have received much needed attention by the government. The recent federally mandated report2 by Commissioner Roy Romanow presented several recommendations concerning how to improve the Canadian health system in the years to come, including some areas of immigrant healthcare. Specifically, Romanow stated “health care professionals should reflect the diversity of Canadian society and understand the ethnic and cultural backgrounds of the populations they serve.”2

According to Romanow the federal government should:
• Revise licensing requirements for international medical graduates and, when necessary, provide additional training.
• Encourage regional health organizations to undertake language training for their staff and to promote relationships between the healthcare providers and minority language associations and communities.
• Undertake health promotion and prevention efforts that are designed to take into account differences in gender, ethnicity and language.
• Promote the undertaking of medical research that is sensitive to issues of gender and ethnicity.

Romanow provides the government with several constructive, albeit broad, guidelines for Medicare improvement specific to immigrants. However, without a clear plan of action, Canada will be left with a theoretical framework for improving immigrant healthcare with a high risk of falling short in implementing these goals.

East Toronto: Indicative of a much Larger Dilemma in Canada
Our experiences in the Riverdale neighborhood of east central Toronto, where a large portion of the population is South Asian, indicate a dire need for providers to address the unique health concerns of community residents, for instance the lack of familiarity with routine Western practices such as gynecological examinations. Of 104 recently-landed South Asian women (residing <5 years in Canada) surveyed in 2003 in this neighborhood as part of a pilot data project, a chief complaint among them (68% of respondents) is that there is a shortage of health providers who share the same cultural background. Western perceptions of health and illness are quite different from those of many immigrants,3 and women in this community (72%) report unease in discussing their concerns with a caregiver of a different cultural orientation. Moreover, largely due to their cultural regard for physicians as confidants, these

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women frequently assert (53%) that they would be more comfortable discussing problems such as domestic violence with a physician rather than a social worker. Our findings in Toronto, although limited to a subset of the immigrant population, demonstrate the need for continued evaluation of immigrant health services on a national level.

Specific Needs Require Immediate Attention
Culturally sensitive access is not a new topic - several studies have closely examined cultural barriers, linguistic differences, and strategies for health promotion in immigrant populations, both in Canada and in the West. Nevertheless, future recommendations to the government must convey specific solutions to bridging the cultural gap that exists between patients and providers in Canada. In order to ensure that immigrants receive proper and efficient healthcare, a few fundamental strategies must be implemented immediately:

• In a 1997 report by the Canadian Medical Association, 27.8% of physicians in the province of Ontario were international medical graduates (IMG), although many were unable to provide services because of the current procedures required for licensing. In the past year, the Canadian Taskforce on Licensure of International Medical Graduates has made a series of recommendations to the federal and provincial governments to standardize IMG licensing procedures. For this purpose, the Canadian government has earmarked over $4 million. We additionally propose that, after careful consideration, those who are unable to obtain a medical license in Canada be evaluated for other healthcare positions in which their skills and talents can be utilized, such as nursing or health counseling. The large number of foreign medical graduates represents a sizable resource in terms of medical experience, knowledge, language, and culture, and hence should be given priority in filling health provider shortages in high-density immigrant locales.

• Health professionals in areas where immigrants largely reside should be provided basic foreign language instruction to best serve patients in their community. Although interpreter services are widely available in many localities, issues such as medical confidentiality and the use of a non-nonsensographer in sensitive situations highlight the need for better language training for health professionals. Ultimately, better language training will improve the quality of care, and in the long run, reduce the costs of delivery of services. While providing comprehensive language training to all medical personnel and staff is not feasible in most instances, health institutions that serve diverse cultural groups must institute fundamental cultural competency measures and training. Such measures should include the following interrelated strategies: the promotion of attitudes that are aware and tolerant of cultural and linguistic differences; a sustained effort to maintain awareness of the specific communities being served; and establishment of a health environment in which patients are comfortable communicating their concerns and beliefs.

• Health promotion strategies must be better tailored to the needs of immigrant populations. In a recent study of breast cancer detection in South Asian women, it was reported that women who had most recently moved to Canada (p<0.009) and those who were less proficient in English (p<0.009) were associated with decreased awareness of proper breast health. The dissemination of written and oral information from health providers to immigrants using culturally sensitive means will increase the effectiveness of such initiatives in patient education. While many official measures are currently in place, providers, including both the government and individual institutions, must implement novel approaches to bridging current cultural gaps. Initiatives in health promotion can be emphasized during opportune times, for instance at large cultural gatherings in local immigrant communities. Another approach is to actively strategize with community and religious leaders to organize forums where health information can be distributed in a coordinated and culturally appropriate manner. As an initial step in this direction, we believe that the federal and provincial governments should fund, prepare, and promote native-language health information for common health conditions, such as diabetes and hypertension. As with interpreter services, standards must be established to ensure that, at a minimum, key documents, such as health information and consent forms, are accessible in a range of languages, reflecting the growing diversity of the Canadian population beyond that of a traditionally English and French medium. In 1996, almost one in five people residing in Canada (17.4%) were born outside of the country, not including the Canadian-born children of these immigrants.

• Programs must be implemented better to address the unique and often overlooked needs of immigrant women. In addition to having unique gender-based health needs, the role and status of immigrant women in the household differ depending on cultural background, significantly affecting well-being and healthcare. Although there is considerable progress in women’s health, such as the creation of the Institute of Gender and Health, the government should continue its efforts to establish culturally accessible resources for the emerging population of immigrant women, by including in its health budget programs for domestic violence counseling and family planning initiatives that cater to the needs of immigrants. In a recent United States study examining South Asian women and the risk of domestic violence injury, Raj and Silverman found that women reporting more recent immigration (< 2 years) were more likely (OR = 3.10, CI = 90%) to have no knowledge of counseling services available to them.
Moving Towards the Future

Alter and colleagues recently examined utilization and perceptions of care among survivors of acute myocardial infarction (AMI) from different socioeconomic backgrounds in the Canadian nationalized healthcare system. Less affluent patients in the study cohort were more likely to be older, female, and of South Asian origin. Moreover, these patients were less likely to be referred for coronary angiography, cardiac rehabilitation, and to a cardiologist for consultation following discharge for AMI. The authors concluded that upper-middle class Canadians received preferential treatment, despite a publicly funded health care system that is required to ensure universal and equal access to care. Most troublesome is that recent immigrants to Canada experience a poverty rate of 27%, which is double the rate of 13% for other Canadian households. Although the economic status of immigrants in Canada is slowly improving, it is evident that in its current state, the Canadian healthcare system falls short in delivering equal and adequate services to this population of residents.

Official mandates such as Romanow’s Commission on the Future of Health Care in Canada have the ability to bridge the gap between academics examining immigrant health issues, community organizations and activists, and the populations they study. Without sufficient assessment, debate and proposition of specific remedies during this opportune time (ie. when Canadians are determined to reevaluate and remedy their health system) there is little hope for improvements at a level that will affect many new Canadians. While Romanow should be commended for broaching important topics of debate, he falls short in addressing the most vital and specific needs of a considerable Canadian immigrant population.

For many living in Canada, the promise of universal and accessible healthcare is futile unless the federal and provincial governments take certain measures to ensure culturally sensitive delivery of services. With the ever emerging immigrant population, there is a pressing need for the governments to initiate such efforts by earmarking appropriate and consistent funding in the health infrastructure to benefit future generations of Canadian immigrant populations.

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References