Health Care Access for Refugees and Immigrants with Precarious Status

Public Health and Human Right Challenges

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ABSTRACT

Migration flux is being transformed by globalization, and the number of people with either undocumented or with a precarious status is growing in Canada. There are no epidemiological data on the health and social consequences of this situation, but clinicians working in primary care with migrants and refugees are increasingly worried about the associated morbidity. This commentary summarizes findings from a pilot study with health professionals in the Montreal area and suggests that the uninsured population predicament is a national problem. Although ethical and legal issues associated with data collection by clinicians, institutions and governments need to be examined, estimating the public health consequences and long-term cost associated with problems in access to health care due to migratory status should be a priority. Current regulations and administrative policies appear to be at odds with the principles of equal rights set out by the Canadian Charter of Rights and Freedoms and the UN Convention on the Rights of the Child. Beyond the commitment of individual clinicians, Canadian medical associations should take an advocacy role and scrutinize the ethical and medical implications of the present system.

Key words: Access to health care; immigrants; legal status; rights

RÉSUMÉ

La mondialisation transforme les mouvements migratoires et le nombre de personnes sans papiers ou ayant un statut précaire augmente progressivement au Canada. Il n'y a pas de données épidémiologiques au sujet des conséquences sociales et de santé de cette situation, mais les cliniciens qui travaillent au niveau des soins de première ligne auprès des immigrants et des réfugiés sont de plus en plus préoccupés par la morbidité associée. Ce commentaire résume les résultats d'un projet pilote examinant les perceptions de professionnels de la santé de la région Montréalaise. Les résultats suggèrent que les soins de santé aux personnes non assurées sont un problème d'envergure nationale et qu'il est urgent d'estimer, en termes de santé publique, les conséquences d'un accès restreint aux soins à cause du statut migratoire, même si cette documentation soulève en elle-même des questions éthiques et légales qui doivent préalablement être examinées. Les politiques et procédures actuelles semblent être en contradiction avec certains des principes d'équité mis de l'avant par la Charte canadienne des droits et libertés et avec la Convention des Nations Unies sur les Droits de l'Enfant. Au-delà de l'engagement de cliniciens individuels, les associations médicales canadiennes doivent assumer un rôle de protection des populations vulnérables et examiner de façon attentive les questions éthiques et médicales posées par le système de soins de santé actuel.

Mots clés : accès aux soins de santé; immigrants; statut migratoire; droits

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As international migration control policies have become a burning issue in Western countries, migratory regulations have converged on trying to better control the movement of foreigners across territorial borders. Canada has been pressured to crack down on irregular migration and is slowly complying with the new requirements of the Canada-US security cooperation agenda. Meanwhile, the differences in wealth and stability between countries of the Northern and Southern hemispheres are not diminishing. These ever-growing disparities fuel migratory movements, as they have always done. People living in countries torn by war, suffering under dictatorships or ravaged by famine, drought or floods, continue to arrive, legally or not; the absence of meaningful prospects for the future, for oneself or one's children, is a powerful incentive for migration. These global migratory phenomena have transformed the traditional immigration landscape of Canada. Although difficult to ascertain, the number of undocumented workers is growing, and estimates run between 100,000 and 300,000¹ at the same time that the gray zone, constituted by people with precarious status and limited access to health coverage, is widening.²

There are no Canadian data on the health and social consequences of this situation. However, the bulk of the evidence from the United States directly links lack of medical insurance with lower quality and quantity of medical care use, and with important morbidity for both adults and children.³⁻⁹ A growing number of clinicians working in primary care with migrant and refugee populations are alarmed because they feel that access to health care is increasingly difficult for undocumented and uninsured families.¹⁰ In contrast, health care institutions may focus on what they perceive to be a potential financial burden, while not recognizing that this situation may endanger the life and violate basic rights of individuals and so constitutes an ethical dilemma.¹¹

To determine if further research is warranted to assess the public health impact of this situation and to better inform clinicians, institutions and policy-makers, we conducted a pilot project in Montreal documenting the perceptions of health care professionals and community organization workers of the problems faced by recent

migrants in accessing care through the health care system. A detailed presentation of the results have been published.¹² Here we address the implications of the findings for health professionals and public health policy.

The survey involved 20 semi-structured interviews conducted with health care professionals and individuals working in community organizations in Montreal. Participants were asked about health problems they had observed over the previous three years, resulting from poor access to the health care system for reasons related to the migration status.

1. The participants confirmed the difficulty of estimating the magnitude of the problem of access to health care for persons with precarious migratory status. Clinicians who provide care to these families usually perform such tasks discreetly, at the margins of their institutions, in order to protect their clients – a practice which isolates both the patients and the clinicians themselves from fellow team members. Most health professionals, however, reported that because of the changes in migratory politics and the more restrictive policies of health institutions, they felt increasingly burdened by the number of and the extent of care needed by uninsured vulnerable patients. For example, at the provincial level, Quebec has adopted a regulation postponing the coverage of health care for new immigrants to three months after their arrival. This has resulted in a number of health problems, including the near death of a child because of delayed surgery for appendicitis.¹³ At the institutional levels, some Montreal hospitals have now posted signs in their waiting rooms and emergencies, advising people that uninsured clients will have to pay for services received, thus actively discouraging help-seeking in this already vulnerable population.
2. There was also a consensus among the participants about the high levels of morbidity associated with the problem of access to care. Both health care workers and community organization workers alike felt that many, if not most, of the patients with precarious status presenting with acute health

crises had delayed seeking care. Among the numerous consequences were shortcomings in treatment and poor follow-up for chronic conditions like hypertension and diabetes, problems of access to treatment for tuberculosis and HIV, and worsening of mental health problems. Perinatal care was reported as an area of numerous difficulties ranging from absence of any prenatal care, to: serious complications of eclampsia and ectopic pregnancy, complicated labours and an increased rate of C-sections, aggravated by the refusal of anesthesiologists to proceed with an epidural on the basis that it is an “unnecessary” measure. In the case of children and youth, problems included delayed surgical interventions, prolonged absence of adequate care for acute mental health conditions (post-traumatic stress disorder and depression), and unavailability of rehabilitation services for children with autism and other developmental problems. Although mortality data are not available, one coroner we interviewed reported that in the last year he had identified four cases of wrongful death that he considered directly related to migration status concerns.¹⁴

3. Both health care workers and community organization workers alike noted that the burden of finding appropriate health care for migrants with undocumented status falls disproportionately on those few organizations willing to fight for the latter's rights. Community organizations and health clinics spend a considerable amount of time trying to negotiate for services to be made accessible to individuals, to correct and update paperwork, and to protect their patients from bills or collection agencies. Health care workers often tell patients to come directly to their office rather than presenting at the front desk, or process patients without keeping records of it. While some managers tacitly accept that health care workers provide care to those without documentation or coverage, others encourage employees to refuse services. Frustration with institutional policies that are at odds with the core values of the health profes-

sions is widespread among the health care workers interviewed, who must constantly work around the system for patients who they feel have an intrinsic right to health care. Because some institutions have reported undocumented patients to immigration authorities, several participants also noted that health services may not always be safe for this population, and that these incidents clearly reinforce distrust and subsequent delays in care.

Our results coincide in several ways with Caulford and Vali's¹⁰ observations in Toronto, suggesting that the predicament of the uninsured population is a national problem. We believe that more research on this topic is urgently needed and there is already evidence that policies should be revised at both federal and provincial levels. This is particularly crucial in the area of infectious diseases where the gap between presumed universality and reality of care should be scrutinized. Recently, New Zealand has adopted a procedure facilitating regularization of undocumented Zimbabwean immigrants irrespective of medical status, due to continuing concerns that HIV-positive individuals would be unlikely to come forward for treatment without clear protection from deportation.^{15,16} Internationally and locally, groups are finding innovative solutions that take into account the vulnerability and fear of persons with precarious status in order to be able to implement successful public health intervention and prevention programs.¹⁷ In Toronto, the Davenport Perth Neighborhood Centre is advocating in innovative ways to create a more accepting climate in which undocumented and precarious status people can receive the care they deserve.¹⁸

Estimating the public health consequences and long-term cost of the morbidity associated with access to health care problems should be a research priority. This would target not only the domain of infectious diseases but also the economic and social costs associated with the inadequate treatment of medical conditions and mental health problems, as well as losses in productivity.^{7,8,19} Because a significant proportion of the recently migrated population does, in fact, eventually transition to fully insured residents of Canada, the added costs of waiting to treat conditions

until they become more serious will be absorbed by the system at a later time. Such costs very likely outweigh any short-term savings for the system achieved by not providing health care coverage.¹⁹

Access to health care is recognized as a basic human right that transcends issues of citizenship or political status. From a human rights perspective, regulations and administrative policies highlighted by this study target specific vulnerable groups within Canada, and are completely at odds with the Equality Rights set out by the Canadian Charter of Rights and Freedoms. This is true as well in the case of youth and children as Canada is also a co-signer of the UN Convention on the Rights of the Child¹⁷ which urges states to respect, among others, the right to protection (articles 19 and 25), health care (article 24), and rehabilitation (article 28), and clearly specifies that this should be irrespective of origin or status of the child or parents.

There needs to be an open discussion of the ethical stance that underlies our role as care providers and its relationship to citizenship status and health insurance.²⁰ In Europe, pediatricians have taken a leading role in advocating for the application of this UN convention to immigrant, refugee and "paperless" children.²⁰ Swedish pediatricians have even openly defied a state policy to exclude asylum-seeking children from medical care when their asylum claim was denied, resulting in the creation of a special state-funded health program for these children.²¹ More recently, the Transcultural Centre of the County of Stockholm has published guidelines for the psychiatric treatment of asylum seekers that insist on the provision of comprehen-

sive care for all individuals regardless of their status.

It is time for Canadian health professionals to mobilize themselves to address this human rights issue. One channel for advocacy on behalf of refugee and migrant families dealing with a precarious status could be through national professional medical associations. These organizations can put the issue of universal access to care for persons living in Canada high on their agenda in discussions with policy-makers. Another level of advocacy and intervention is needed with the health care institutions, in order to create forums to discuss the ethical dimension of the problem of access to care and to develop strategies to improve the present situation which is causing grave violations of human rights.

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