The Impact of Policy Changes on the Health of Recent Immigrants and Refugees in the Inner City

A Qualitative Study of Service Providers' Perspectives

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ABSTRACT

Background: Dramatic changes to health and social policy have taken place in Ontario over the last five years with few attempts to measure their impact on health outcomes. This study explored service providers' opinions about the impact of four major policy changes on the health of recent immigrant and refugee communities in Toronto's inner city.

Methods: Semi-structured key informant interviews.

Results: Reductions in funding for welfare, hospitals and community agencies were seen to have had major effects on the health of newcomers. Emergent themes included erosion of the social determinants of health, reduced access to health care, increased need for advocacy, deterioration in mental health, and an increase in wife abuse.

Conclusions: Several areas were identified where policy changes were perceived to have had a negative impact on the health of recent immigrants and refugees. This study provides insights for policy-makers, inner-city planners and researchers conducting population-based studies of immigrant health.

Twelve percent of individuals living in Toronto are recent immigrants, having arrived in Canada in the last five years.¹ In addition, about 7,000 individuals in Toronto are assigned refugee status annually.² While recent immigrants tend to be healthier than Canadian-born residents in terms of chronic disease and disability,³ they may face personal hardships that stem from social isolation, cultural adjustment and financial strain.⁴⁻⁶ Refugees are persons who cannot return to their countries because of a fear of persecution due to their belonging to a particular social, political or religious group. The health status of refugees tends to be poorer than that of recent immigrants.⁷ Together, these two groups of new Canadians represent an important and vulnerable inner city population.

Socio-economic factors have been shown to be more important in determining health for immigrants than for non-immigrants.⁵ Consequently, new Canadians may be particularly vulnerable to policy changes that affect their socio-economic environment. Policy changes resulting in reductions in services to newcomers may contribute to disruptions in social support systems, which then may threaten the health outcomes of individuals living in low-income, newcomer communities. While major changes in health and social policy have been implemented in Ontario (Table I), there have been few efforts to measure their impact on new Canadians.⁷

This qualitative study was designed to inform the development of research questions for a population-based quantitative analysis.⁸ We chose to explore the impact of four policy changes: 1) the reductions to hospital funding and hospital restructuring, 2) the reductions to funding of community-based health and social services, 3) the reductions in welfare payments, and 4) the implementation of user fees for prescriptions. The purpose of this study was to elicit service providers' opinions about the impact of these policy changes on the health of recent immigrant and refugee communities in Toronto's inner city.

METHODS

Research method

This exploratory study drew on the inductive approach advanced by grounded theory scholars.^{9,10} We used semi-structured, face-to-face interviews and followed standardized guidelines set out by Miles and Huberman.¹¹ This study received approval

The translation of the Abstract appears at the end of the article.

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TABLE 1

Summary of Important Health and Social Policy Changes in Ontario

Date	Policy/Project Affected	Type of Change	Group Affected
1993	Welfare Legislation – Ontario	\$100 deduction in benefits to recent immigrants whose sponsorship has deteriorated.	Low-income recent immigrants.
1994	Ontario Health Insurance Plan (OHIP)	3-month wait before new immigrants are eligible for OHIP insurance.	Recent immigrants.
1995	Interim Federal Health Program	Refugees and refugee claimants provided limited health coverage by the federal government.	Refugee and Refugee claimants.
1995	Social Housing Projects - Ontario	Cancelled 385 planned social housing projects in Ontario. This included 80 projects in Metro and 23 projects in the (former) City of Toronto.	Marginally-housed and low-income groups.
1995*	Welfare and Family Benefits – Ontario	The Provincial Government of Ontario instituted a 21.6% reduction in welfare payments.	All welfare and family benefits recipients except those with disabilities and seniors. Provincially funded social service agencies and others.
1996*	Canada Assistance Plan	Changed to Canada Health and Social Transfer – Reduction of 23% for health, welfare, social services and post-secondary education.	Unemployment insurance recipients.
1996	Federal Unemployment Insurance	Reduced the amount and duration of benefits.	Low-income groups and seniors.
1996*	Ontario Drug Benefit Plan	Low-income individuals or families face a \$2 co-payment for prescriptions. Seniors who are not low-income pay dispensing fees and a \$100 yearly deductible.	Low-income groups.
1997	Welfare Legislation – Ontario	Bill 142 enacted. Replaced welfare legislation with the Ontario Works Act and the Ontario Disability Support Program Act. Eligibility requirements for welfare were tightened.	Tenants.
1997	Tenant Protection Act	Bill 96 instituted “vacancy decontrol” which allows landlords to move rents to market value when their units become vacant.	Residents of Toronto requiring hospital services.
1997*	Health Services – Toronto	Recommendation of Health Services Restructuring Commission resulting in the closures of two hospitals and amalgamation of three hospitals in central Toronto. Also recommended a 14% reduction of in-patient psychiatric beds in Toronto by the year 2003.	Unemployed workers.
1997	Federal Employment Insurance	Eligibility based on number of hours worked rather than number of weeks worked, allowed part-time workers eligibility but increased the number of hours required to be eligible.	

* These four policy changes were the primary focus of this study.

from the Research Ethics Board at the University of Toronto.

Sampling and recruitment

Through clinical experience and collaboration with community health workers, a list was developed of community agencies that provide services to new Canadians in the inner city of Toronto. Using purposive sampling to maximize diversity among our participants, we recruited key informants from these agencies who represented a variety of cultural backgrounds and occupational roles that may have influenced their opinions about the impacts of policy changes.¹² This sampling strategy allowed us to describe the central themes that cut across heterogeneous programs and participant roles.¹² Following an initial telephone invitation to participate, key informants were sent additional study information prior to the interview, including an outline of the interview questions.

Data collection

The interviews were conducted in the community agencies by the first author. Informed consent was obtained prior to each interview and confidentiality was discussed. The interviewer followed a guide containing questions

and probes that encouraged respondents to reflect on the impact of the policy changes on the health of newcomer communities and related programs and services. The development of the interview tool was facilitated by the authors' community-based clinical and research experience and aided by consultation with community groups. Some examples of the questions asked are: “What impact, if any, did hospital closures have on the health of the immigrant and refugee communities that you serve?” “What changes, if any, did your organization make in response to the reduction of social services funding?” Interviews ranged from 45 to 90 minutes long, were tape-recorded and transcribed *verbatim*. Reviewing the tapes and transcripts on an ongoing basis allowed monitoring of the reliability of the data collection.

Analysis

The method of data analysis was qualitative content analysis – the process of identifying, coding and categorizing patterns.¹² One reviewer (LS) read and open-coded the entire set of transcripts. Upon completion, the entire set of transcripts was reviewed again, codes were applied back to the data, the coding scheme was refined and cate-

gories were established. A second reviewer (JC) independently reviewed the complete set of transcripts. The initial coding scheme was challenged and then systematically re-applied to the data by the second reviewer. In the first stage of the analysis, the data were explored and categories were used to organize the codes into meaningful clusters. Data were categorized by specific policy change (e.g., welfare reductions, hospital funding, etc.) and by focus of impact (e.g., immigrant community, service agency, etc.). Data matrices were developed that allowed systematic comparison of the respondents' perceptions of impact with respect to each policy change.¹¹ Emerging themes were evaluated. Disagreements in coding and discrepancies in interpretation were discussed and decided by consensus.

To ensure the trustworthiness of the analysis, a second researcher reviewed an audit trail to affirm that conclusions were supported by the data. Validity was addressed at various stages of the analysis through consultation with an interdisciplinary research team that included health professionals, social scientists and community liaison workers, as well as through discussion at two panels related to the impact of policy on immigrant health.

TABLE II
Characteristics of Community Agencies

Agency	Type	Size*	% New-comers	% Social Assistance	% No Health Coverage	Funding Cuts?	Personnel Cuts?	Service Cuts?
1	Social	Small	100%	>50%	<50%	Yes	No	No
2	Health	Large	30%	60-75%	<50%	Yes	Yes	Yes
3	Health	Mid	40%	25%	<50%	Yes	Yes	No
4	Health	Mid	>90%	50%	70%	No	No	No
5	Health	Large	>50%	95%	20%	Yes	Yes	Yes
6	Social	Small	50%	NK	NK	Yes	Yes	Yes
7	Health	Large	40%	NK	15%	Yes	Yes	Yes
8	Social	Small	100%	25%	<50%	Yes	Yes	Yes
9	Health	Large	50%	>50%	30%	Yes	Yes	No

* Estimated budgets (small = less than \$1 million, mid = \$1 - \$2 million, large = more than \$2 million).
NK = not known

TABLE III
Summary of Emergent Themes and Impacts Grouped by Policy Change

- A: Reductions in hospital funding and hospital restructuring
 - Early discharge
 - Inadequate home-care services
 - Increased care-giver burden
- B: Reductions to funding of community-based health and social services
 - Increased barriers to access
 - Increased need for advocacy
 - Provider burn-out
 - Lack of affordable housing
- C: Reductions in welfare payments
 - Diminished quality of life
 - Mental health issues
 - Wife abuse

TABLE IV
The Effects of Reductions to Hospital Funding

- a) Early discharge
"What we have noticed is that people are definitely being kicked out of hospitals earlier ... we are seeing sicker people at home and hospital."
- b) Inadequate home-care services
"We had asked for homemakers or nurses and they would just be really, really sticky. It has never really recovered to the levels it was in the mid-1990s. A woman with dementia that's wandering all over the place was told she was not appropriate. I had to advocate and ... we would find that somewhere down the line, someone had refused her. That happens fairly frequently."
- c) Increased caregiver burden
"People have to go back to their family for support. Sometimes their married daughter or son will have to stay with them for a few days after their discharge. It makes it very difficult because they have their own children to take care of. For the Chinese and Vietnamese - they take care of the seniors, even though they have a lot of difficulties, they try to take care of them. ... However, it does not mean that there is no problem ... because they draw resources from their families, it seems that there is no problem."

RESULTS

Key informants

Ten key informants were interviewed representing nine community agencies that serve newcomers. Seven key informants were women and three were men. The cultural background of the participants varied, with representation from Asia, Africa, Europe, North America and Latin America. They had worked at their agencies an average of 7 years (range 4-15). They included two physicians who provided clinical care to newcomers, two registered nurses who were involved in clinical care and community health promotion, four community workers, and two executive directors who were involved in program planning, administration and staffing of programs related to immigrant and refugee health.

Characteristics of the community agencies and their clients are described in Table II.

Themes

A summary of themes that emerged through the interviews is depicted in Table III.

A. Reductions in hospital funding and hospital restructuring

Between 1996 and 1998, the provincial government in Ontario reduced funding for hospitals by over 10%.^{13,14} All of the key informants working in health service agencies identified negative impacts resulting from the changes to hospital funding. Key informants felt that funding reductions had resulted in a scarcity of beds that led hospitals to discharge patients into the community earlier than was warranted. Services such as home-care were under increasing strain to care for sicker patients in the community. Consequently both service providers and families faced increased caregiver burdens.

These problems were felt to be particularly difficult for newcomer groups for two reasons. First, newcomers may face language barriers and a lack of familiarity with the system that results in a greater need for advocacy from service providers than that required from Canadian-born clients. Second, many key informants described a culturally-specific notion of familial duty that leads to greater caregiver burden, since new immigrant families tend to assume more of the responsibility for the care of their family members than is

typical of a Canadian-born family (see Table IV).

B. Reductions in funding of community-based health and social services

At the time of the reduction in federal transfer payments, provincial support for community-based health and social service agencies was broadly reduced. Some reports indicate that services targeted at new immigrants and refugee groups were disproportionately affected.¹⁵⁻¹⁷ Key informants believed that these service losses had broad effects for new Canadians, including: 1) increased barriers to access, 2) increased need for advocacy, 3) increased provider stress, and 4) housing problems (See Table V).

Key informants identified an urgent need for interpretation services, case-management and culturally-appropriate food-bank services. However, funding restrictions had precluded attempts to improve the accessibility of such services for new Canadians. Moreover, changes to health insurance legislation were perceived to have exacerbated existing barriers to access. Six of the key informants noted that a new three-month wait for OHIP eligibility for landed

immigrants had caused significant access problems. Unlike landed immigrants, refugee claimants have immediate health care coverage through the Federal Interim Health Program.¹⁸ However, key informants indicated that this plan is inadequate because it is less comprehensive than the provincial plan and it is burdensome for physicians to negotiate.

According to our participants, new Canadians with inadequate health coverage are seeking care at provincially funded community health centres. Staff at these agencies are under pressure to provide care for communities with growing needs from a shrinking pool of social and health service resources. Seven of the ten key informants believed that diminishing services have led to an increasing need for patient advocacy that has left less time for other functions such as counselling, preventive care and case-management. This situation has led to a significant amount of stress and staff burnout.

In addition, nine out of ten key informants noted that there was a scarcity of affordable housing that seemed to be worsening. In new immigrant communities, this placed an extra burden on families to provide housing for their relatives.

C. Reductions in welfare payments

There was a consensus among our key informants that the 21.6% reduction in welfare benefits and the changes to the qualifying rules have had significant deleterious impacts on immigrant communities in the following areas: 1) quality of life, 2) mental health issues, and 3) wife abuse (see Table VI).

Many of the key informants noted a deepening of poverty in their communities. Newcomers were seen to have become more focused on meeting their basic needs, often at the cost of personal development and quality of life. Similarly, benefit reductions were seen to have contributed to an increase in mental health problems within immigrant communities. In addition to financial strain, low-income individuals were coping with stress that stems from negotiating the increasingly restricted social service system. Increased stress and diminished support were seen to be related to worsening of mood disorders and increases in suicidality.

Nine of ten participants felt that wife abuse was increasing as a result of conditions exacerbated by the policy changes. Key informants argued that benefit reductions have

TABLE V

The Effects of Reductions in Social Spending

- a) Increased barriers to access
 "Refugees no longer covered by OHIP are on this interim federal health plan. We have had problems with accessibility to specialists through that because it is very cumbersome to make those claims (to the federal interim health plan) and some specialists are refusing to see those patients. There is a very clear guideline as to what things are covered. Psychiatry is one of the surprising ones - you are allowed one consultation and that's it. So if you have someone who is very sick with depression or post-traumatic stress disorder because they have been tortured or incarcerated, it is often quite hard to get repeat consultations and ongoing care."
 "Well people are kind of bashing down our door and we have a waiting list of 60-80 people often at a time. A lot of them are without health cards and may be not able to access other services."
- b) Increased need for advocacy
 "It is very obvious when compared with before, that we spend more and more time to go after home care and welfare on the phone and to advocate for people. Because sometimes when we advocate successfully, the services lasts for a few weeks and then they quit. Then, we have to call them again. So, more time is used in going after the service providers to ask for services and more time has been taken away from counselling."
- c) Provider burn-out
 "The need has increased. I have watched it the six years I have been here and I can tell you. I have seen it in the patients' behaviour. I have seen it in the numbers. I see it in the staff's faces. And I hear it. And I see them crying. And I see them take money out of their own pockets. I see them go to the fridge and feed people. I don't like what I see. They burn out. They can't debrief. They go from one [person] to another to another to another."
- d) Lack of affordable housing
 "Some of them move from one relative's home to another. Sometimes when they cannot find a place to stay, if they are single they will try to sneak in and sleep in the malls. They sneak in before it is closed for one or two nights and then they try to find other places in a relative's house. Sometimes they are in and out of shelters. In a way, they are homeless, but they are not on the streets."

TABLE VI

The Effects of Reductions in Welfare Benefits

- a) Diminished quality of life
 "When you are doing community development and people move along in the continuum, their self-esteem improves. They begin to take control. They feel a sense of control. They organise. ... You help them to go back to school. They get a job. All that has been turned backwards with the cuts. What the cuts have done, is they have put most people back at Maslow's bottom rungs, so that your whole day is spent securing food and shelter, or worrying about how you are going to pay the rent and buy groceries too."
- b) Mental health issues
 "We have had two or three people a year as a practice who successfully committed suicide. One was my patient. She was on family benefits and quite an ill person. My impression of the last year of her life ... she had lots of medical problems, drug abuse problems ... she was constantly bringing in these forms and the benefits were being eroded and she was trying to get this and that, and having to advocate for her all the time."
- c) Wife abuse
 "I think the biggest impact of welfare cuts on women and children is that more women have to tolerate abuse, because for them [housing] is very difficult to find... I mean, even though they are on welfare, the welfare money is not sufficient for them to pay the rent ... Before, they gave first and last. ...[Now] they do not pay last month rent. So, how can they get a decent place to stay? Especially if they have small children - three to four children."

limited the ability of women to leave abusive situations. Since 1993, recent immigrants who have had a breakdown in sponsorship and who subsequently require welfare support, are subject to an additional \$100 monthly deduction from their benefits.^{19,20} Those who were aware of this policy uniformly viewed it as detrimental to the well-being of new immigrants – and particularly so to immigrant women since it served to further reduce their financial autonomy.

D. Implementation of user fees for prescriptions

Since July 1996, low-income individuals and families have faced a new \$2 co-payment for prescriptions.^{21,22} The majority of key informants (7 of 10) felt that prescription

user fees had not had a significant impact on patients' adherence to medications. Many key informants noted that community pharmacies were waiving the \$2 user fee. In this sense, community pharmacies, and not low-income communities, absorbed the burden of this funding reduction.

DISCUSSION

Key informants expressed considerable concern about the impact of recent health and social policy changes on the wellbeing of immigrant and refugee communities in inner-city Toronto.

Immigrant women were seen to have been particularly affected by the policy changes. While seniors and the disabled had been

exempted from the welfare benefit reductions, the reductions were applied to single mothers. Moreover, recent immigrants face an additional \$100 reduction in benefits if their relationship with their sponsor has deteriorated. These changes may increase the vulnerability of immigrant women to abuse from their partners by limiting their financial autonomy. Women, who are most likely to be the primary caregivers in their families, also tended to bear the burden of cuts to home care and community support services.

Gathering qualitative accounts from community service agency workers was valuable because it identified key issues of concern to communities that can now guide our population database analyses.^{23,24} Some impacts of policy changes, such as the increased need for advocacy and the meanings attributed to these changes by individuals, are best explored using qualitative methods. Importantly, interpretation of the data collected from participants must be viewed with an understanding of the conceptual framework that the key informants and the researchers were working within.²⁵ The service providers' viewpoint represents one perspective in the complex relationship between policy, healthcare and health. Further research that includes the perspective of new Canadians themselves is essential. It may also be the case that the responses of key informants reflect not merely the impacts of policy changes on immigrants and refugees, but also relate to inner-city populations in general.

Our small sample size may have limited the generalizability of our conclusions. However, external validity was bolstered by the maximum variation sampling, since shared themes derive their significance from having emerged out of the heterogeneity of our sample.¹² Our key informants' interest in policy or activism may have influenced their willingness to participate and could be a source of bias. However, only two individuals we approached refused to participate in the study; in both cases, the reason stated was lack of time and not lack of interest.

A recent qualitative study by Raphael et al. explored the concept of government policies as a threat to health in Toronto communities.²⁶ The authors argued that public health workers should be involved in policy development at the planning stage rather than focussing on programs meant to ameliorate the effects of policy decisions. Our study, while focussing on immigrant and refugee groups, lends fur-

ther support to Raphael's recommendations. On many levels, changes to health and social policy were seen to have had a detrimental effect on the health of new immigrant and refugee groups. Health care providers in the inner city of Toronto are finding it challenging to meet the increasing health needs of this population in the face of increasingly strained resources. In keeping with the principles of public health, government agencies should ensure that policy changes promote rather than threaten the public health goal of universal and equitable access to the basic conditions that are necessary to achieve health.

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RÉSUMÉ

Contexte : Il y a eu de profonds bouleversements des politiques sanitaires et sociales de l'Ontario au cours des cinq dernières années, mais on en a très peu mesuré les incidences sur la santé. Notre étude porte sur les opinions de prestataires de services quant aux incidences de quatre grands changements d'orientation sur la santé des nouveaux immigrants et réfugiés des quartiers déshérités de Toronto.

Méthode : Entretiens semi-directifs avec des informateurs clés.

Résultats : Selon nos informateurs, les compressions dans les budgets de l'aide sociale, des hôpitaux et des organismes communautaires ont eu des effets importants sur la santé des nouveaux arrivants : érosion des déterminants sociaux de la santé, restriction de l'accès aux soins, besoin accru de défense des intérêts, détérioration de la santé mentale et augmentation de la violence conjugale.

Conclusions : Dans plusieurs domaines, les changements d'orientation auraient eu des effets nuisibles sur la santé des immigrants et des réfugiés nouvellement arrivés. Les résultats de l'étude peuvent éclairer les décideurs, les planificateurs des quartiers déshérités et les chercheurs qui mènent des études représentatives sur la santé des immigrants.