FEATURE

Part 4

Office interventions for poverty: racialized groups

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Introduction

IN THIS FOURTH ARTICLE OF OUR FIVE-PART SERIES ON MEDICAL INTERVENTIONS INTO POVERTY, WE LOOK AT RACIALIZED GROUPS THAT EXPERIENCE A DISPROPORTIONATE BURDEN OF THE HEALTH IMPACTS OF POVERTY, THROUGH A FOCUS ON TWO SPECIFIC GROUPS: ABORIGINAL PEOPLES AND NEW IMMIGRANTS AND REFUGEES.[a,b]

When a patient is both economically disadvantaged and a member of a marginalized social group, the health impact of poverty is increased, and we must refine the tools we use to address the patient's poverty.

While the four steps to addressing poverty discussed in the second article of this series — screen, adjust risk, intervene, and create a poverty reduction team (which appeared in the October 2013 OMR, accessible at www.oma.org) — may still apply to new immigrants and refugees or to patients who identify as Aboriginal, we must also consider these patients' social and cultural context, and the racism they experience. Indeed, the Public Health Agency of Canada considers culture among the key determinants of health.[1] This article will explore practical tools for, and approaches to, addressing poverty and providing patient-centred care to members of these marginalized and racialized groups.

Poverty is much higher among racialized Canadians in general, particularly in urban centres.[2,3] Racialized individuals are disproportionately represented among the working poor. Their work is often temporary, part time, or short term, and pays minimum wage or less.[4] Significant differences in health status and access to health care among racialized Canadians are not solely attributable to poverty.[5]

They may also encounter cultural and linguistic barriers to accessing health care and social services. Moreover, it is important to consider the diversity within these groups; urban Aboriginals, Métis, and immigrants from particular communities face specific stressors and health risks.[6]

There are far more differences than similarities between new immigrants, refugees, and Aboriginal Peoples, and addressing these groups together can be problematic. Nonetheless, newcomers and Aboriginal Peoples are culturally marginalized, and disproportionately suffer from the health impacts of poverty. In a clinical encounter involving a low-income patient from one of these groups, we may make similar adjustments in our approach to addressing their poverty.

Aboriginal Peoples

As a group, Aboriginal Peoples have distinct cultures that emphasize the importance of community, traditions, and respect for natural environments. Despite these protective factors, Aboriginal Peoples have the highest poverty rates and the worst health of all Canadians. Unemployment exceeds 70% on some reserves.[5] Aboriginal Canadians have higher rates of diabetes, obesity, smoking, cardiovascular disease, mental illness, suicide, substance misuse, and cancer, as well as higher premature mortality.[7-10]

Focusing on health statistics in the absence of a deeper understanding of their root causes risks promoting racist and paternalistic health care.[11,12] The health of Aboriginal Peoples reflects the combination of a legacy of colonialism, systemic racism, loss of language and connection to the land, environmental deprivation, and spiritual disconnectedness.[13-17]

Health care in Canada has been used in the past to promote the assimilation of Aboriginal Peoples.[18] As highlighted by recent evidence of medical experimentation in a residential school in Kenora, health-care providers have not always practised medicine or medical research with Aboriginal patients' best interests in mind.[19] This history of medical maltreatment has the poten-

tial to complicate contemporary physician-patient relationships. There is significant mistrust of governmental institutions and researchers, especially on reserve.

New Immigrants And Refugees

New immigrants tend to have lower overall mortality and better health status than their age-matched Canadian-born counterparts, a phenomenon known as the healthy immigrant effect. If someone is healthy enough to travel to Canada, he or she is, on average, healthier than an age-matched Canadian.[20] However, health status varies dramatically depending on birthplace, period of immigration, and area of residence.[21]

New immigrants are more likely to work in low-paying jobs, less likely to be employed, and more likely to live in poverty. Immigrants are often well-educated but have difficulty establishing themselves in jobs appropriate with their level of training.[22] Moreover, socioeconomic factors have a greater effect on health outcomes for immigrants than non-immigrants.[23]

Refugees are at higher risk of ill health than other immigrants due to past exposure to harmful living conditions, violence, and trauma. Some refugees have encountered war, poor sanitation, or specific disease vectors or exposures.[24]

Refugees and new immigrants with limited English-language or French-language proficiency often report a rapid decline in their health after arrival in Canada.[25] New immigrants generally, and refugees in particular, are more likely to report difficulty accessing health care.[26]

Intervention: Cultural Safety

Culturally safe health care is an approach to patient-centred care in the setting of cultural difference.

Cultural safety arose as a concern in New Zealand in the 1990s, as the country attempted to apply the far-reaching Treaty of Waitangi to health and social services.[27] Although cultural safety is described as a model of care for indigenous patients, it can be applied to other marginalized populations, including new immigrants and refugees.[28]

A health-care provider's own culture, and the assumptions that stem from that culture, affect clinical encounters. Knowledge of cultural differences is important in clinical encounters, but even more important is an understanding that past and present historical processes are connected to a patient's current health and social status.[29,30]

Cultural safety requires health-care providers to reflect on their own assumptions, as well as their own cultural position as a result of historical and societal factors.[31] The burden of cultural adaptation that results when intercultural interactions occur should be relieved from the patient whenever possible.[32,33] Cultural safety minimizes risk and allows for a safe healing environment.[34]

Interpreter services are a crucial

component of cultural safety. In addition to providing language translation, the interpreter can act as a cultural translator.[35] Interpreters may mediate potential conflicts, and act as medical educators and advocates.[36] Using family member interpreters is generally not appropriate as conflicting agendas may lead family members to alter the physician's message in order to tell the patient what they believe the patient should hear.[37]

When caring for Aboriginal patients, respect for traditional medicines and health practices are a critical component of cultural safety.[38] When Aboriginal Peoples are connected with traditional cultural and spiritual practices, their health improves.[39-42] Involvement with traditional culture and spirituality improves resilience and protects against health crises, such as suicide.[43-45] Culturally appropriate prenatal services can improve patient satisfaction with care, permit earlier initiation of care, and increase rates of breastfeeding among Aboriginal women.[46]

Intervention: Practice Accommodations

Physicians can optimize access to health care for populations that are socially marginalized by adjusting practice location, hours, and on-site supports. Aboriginal patients, new immigrants, and refugees may benefit from formal connections with cultural support networks and community services. Cultural safety training for clinic support staff is also important.[47]

Intervention: Specific Government Benefits

Finally, physicians should be aware of specific benefits that Aboriginals and new immigrants and refugees may be eligible for. First Nations people designated as "Status Indian," and Inuit who are registered with the federal government, are eligible for Health Canada's Non-Insured Health Benefits, which covers some services not provided by provincial or territorial health plans. These benefits originate in the "medicine chest" clause of Treaty 6: "That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent."[c,48]

Refugees and some refugee claimants are eligible for coverage under the federal government's Interim Federal Health Program. However, in June of 2012, the federal government implemented cuts to the program, which has led to confusion for refugee claimants and health-care providers. Some patients, including those waiting to register their refugee claim, lost some or all of their health-care coverage.[49] See the sidebars below for more information and resources.

Conclusion

Physicians can ensure that their practices take steps toward mitigating the negative impact of poverty on the health of Aboriginal Peoples, new immigrants, and refugees by engaging in culturally safe practices, by connecting with community groups, and by ensuring that their patients have applied for the government resources for which they may be eligible.

It is said that a society should be judged on the basis of how it treats its most vulnerable. Aboriginal Peoples, new immigrants and refugees are particularly vulnerable to poverty and a variety of health threats. As one of the world's richest countries, Canada can and should do much more to assist these marginalized groups to achieve their full human potential, and the highest possible level of health. ■

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Health-Care Coverage For Refugees And Claimants In Ontario

Prior to June 2012, all refugees and refugee claimants received uniform health-care coverage, which included services normally covered by provincial health-care plans, as well as dental, vision, physiotherapy, and medication coverage. Failed refugee claimants also received this coverage until their removal order came into effect.

Government-assisted refugees (GARs) continue to receive this coverage, but refugee claimants have been divided into those from Designated Countries of Origin (DCO) and non-DCO countries. DCO countries are those that the government has deemed unlikely to produce refugees; countries on this list include Hungary and Mexico. Claimants from non-DCO countries receive care equivalent to provincial health-care plans and are eligible to apply for social assistance. Claimants from DCO countries, and rejected claimants, receive no coverage for medical care except for diseases posing a risk to public health or safety.

Additional Resources

- **COSTI** provides educational, social, and employment services to help all immigrants in the Toronto area attain self-sufficiency in Canadian society: http://www.costi.org/
- **Anishnawbe Health Toronto**: http://www.aht.ca/
- **Aboriginal Cultural Safety Initiative**: http://www.aht.ca/aboriginal-culture-safety
- **Canadian Council for Refugees**: http://ccrweb.ca/
- **Health Canada**: http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/index-eng.php
- **Canadian Doctors for Refugee Care**: http://www.doctorsforrefugeecare.ca/
- **Indigenous Physicians Association of Canada**: http://ipac-amic.org/
- **Aboriginal Affairs and Northern Development Canada** — 1996 Royal Commission on Aboriginal Peoples: http://www.aadnc-aandc.gc.ca/eng/1100100014597/1100100014637#

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Endnotes

a. The term Aboriginal Peoples refers to the Indigenous Peoples of Canada, which includes First Nations, Inuit, and Métis people.

b. Per the Canadian Race Relations Foundation, "racialization" is the process through which groups come to be designated as different, and on that basis subjected to differential and unequal treatment. In the present context, "racialized groups" include those who may experience differential treatment on the basis of race, ethnicity, language, economics, religion, culture, politics, etc. That is, treated outside the norm and receiving unequal treatment based upon phenotypal features.

c. The Indian Agent was the local administrator of the Indian Act, appointed by the Government of Canada. He had extensive powers over the lives of the Aboriginal People in his jurisdiction, including their movement, governance, commerce, and the education of their children.

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