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Responsiveness of the Canadian Health Care System Towards Newcomers

by

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Highlights

- There remains a great deal of variation in the health statuses of those living in Canada in spite of the existence of the *Canada Health Act*.
- Among those with particular health care needs are newcomers to Canada, specifically those with a precarious immigration status such as asylum seekers, and those with a high-risk profile such as refugees arriving in Canada from conflict-laden areas.
- Barriers to accessing care for which newcomers are eligible, include fear of jeopardizing immigration applications by seeking care, language barriers, culturally inappropriate care, and difficulties navigating the health system.
- Canada has responded to certain needs for access to care by implementing the Interim Federal Health Program (IFHP); however, serious difficulties with accessing services through the IFHP remain.
- There are several approaches Canada could take to improve the responsiveness of the system even further.

Executive Summary

There remains a great deal of variation in the health status of those living in Canada in spite of the existence of the *Canada Health Act*. The Act was developed with a focus on "equalizing" health status by "equalizing" access to services, once thought to be the prime determinant of health. Today, among those with particular health care needs are newcomers to Canada, specifically those with a precarious immigration status such as asylum seekers, and those with a high-risk profile such as refugees arriving in Canada from conflict-laden areas. Specific newcomer needs are often not examined on a systematic basis. This paper describes variation in health care needs according to immigration classification and addresses the following question: How well does the Canadian health care system respond to the needs of newcomers?

'Canadian health care system' refers here to services provided or supported by any level of government; 'newcomers' for the purposes of this paper focuses on the following mobile populations: permanent residents, those with employment authorizations, international students, refugees, and asylum seekers. The extent to which this question can be addressed is constrained by page and time limitations set by the Commission. Furthermore, there was insufficient time to permit extensive verification of results. This paper is not meant to be an exhaustive review of the literature, or of services offered. Rather, it is meant to present enough detailed information to allow general comparisons of service provision to these populations across Canadian provinces and territories, and five countries (Australia, Netherlands, New Zealand, Sweden, and United Kingdom). These comparisons will offer a point of departure for discussion on the extent to which Canada is responding optimally to the needs of this marginalized group.

Newcomers' health likely varies by migration history although databases are inadequate to answer this question directly. Migrants not forced out of their countries of origin are expected to have lower health-risk profiles than those forced out. Newcomers are known to under-utilize services and some Canadians likely prefer that only limited access to services be available to newcomers. Barriers to accessing care for which they are eligible include fear of jeopardizing immigration applications by seeking care, language barriers, culturally inappropriate care, and difficulties navigating the health system. Optimal care is thought to be based on core values of access, inclusion, empowerment, user-defined services, holism, respect, cultural sensitivity, community development, collaboration, accountability, orientation towards positive change, and reliability (Canadian Council for Refugees 1998).

Information on service access from all provinces and territories was sought, collated, and tabulated for comparison. Certain countries were selected for comparison purposes based on similarity of immigration patterns, economic systems, and health care system structures. The vast majority of information was obtained through extensive searches of governmental and non-governmental web sites and their cited documents, and by subsequently contacting individuals and organizations via e-mail for missing information. Information was sought from ministries of health, government health insurance agencies, ministries of immigration, regional health and social service agencies, main municipal/provincial/territorial/national offices, and non-governmental organizations (NGOs) including both those that act as umbrella organizations for other NGOs and those directly serving migrants. Google, Yahoo and Alta Vista search engines were employed. Electronic databases of literature were also used to supplement information.

Bibliographic references from identified texts were sought for review. The Canadian Council for Refugees 'list server' was used to identify case examples of access issues for newcomers.

Canada has responded to certain needs for access to care by implementing the Interim Federal Health Program (IFHP). However, serious difficulties with accessing services through this program remain, including delays in immigration processing times, errors in form completion, limitation of coverage to essential services only, and the administrative burden placed on service providers. Other comparable countries have generally not created a separate funding mechanism for health care for refugees and asylum seekers but rather, have limited access to available services according to immigration class and length of time in the country.

Across Canada and at the national level there are several special programs for newcomers that respond to many of the "best practice" guidelines. "Best practice" examples from other countries that Canada may wish to consider include New Zealand's language law requiring interpreter services for everyone in need and Australia's extended interpreter services, as well as multidisciplinary resettlement centres in New Zealand that provide a range of services to newly arrived refugees on a regular basis. Endeavours spanning more than one country that may interest Canada include the EU Networks, which address common resettlement issues, and the ICRT, to which several Canadian agencies already participate.

In conclusion, Canada has been moderately responsive to the health needs of newcomers. There are several other approaches Canada could choose to take to improve the responsiveness of the system even further. These include reducing the administrative burden of the IFHP on health care providers and reducing the time to access that program, offering interpretation services widely, and improving the content of health databanks to allow the examination of newcomers' health and health care according to immigration class.

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Introduction

There remains a great deal of variation in the health status of those living in Canada in spite of the existence of the *Canada Health Act*. The Act was developed with a focus on "equalizing" health status by "equalizing" access to services, once thought to be the prime determinant of health. Today, among those with particular health care needs are newcomers to Canada, specifically those with a precarious immigration status such as asylum seekers, and those with a high-risk profile such as refugees arriving in Canada from conflict-laden areas. Specific newcomer needs are often not examined on a systematic basis. This paper describes variation in health care needs according to immigration classification and addresses the question: How well does the Canadian health care system respond to the needs of newcomers?

Scope of the Paper

This paper aims to address the following question: How well does the Canadian health care system respond to the needs of newcomers? 'Canadian health care system' refers here to services provided or supported by any level of government; 'newcomers', for the purposes of this paper, focus on the following mobile populations: permanent residents, those with employment authorization, international students, refugees, and asylum seekers. The extent to which this question can be addressed is constrained by page and time limitations set by the Commission. Furthermore, there was insufficient time to permit extensive verification of results. The paper is not meant to be an exhaustive review of the literature, or of services offered; it is meant to present enough detailed information to allow general comparisons of service provision to this population across Canadian provinces and territories, and five countries (Australia, Netherlands, New Zealand, Sweden, and United Kingdom). These comparisons will offer a point of departure for a discussion on the extent to which Canada is responding optimally to the needs of this marginalized group.

Background

Marginalized Sub-Groups in Canada

Canadians and others living in Canada are, on the whole, a healthy group (Organisation for Economic Co-operation and Development 2001), although there remain important differences in sub-population health even after the application of the *Canada Health Act* guaranteed access to hospital and physician services for most people. If differences remain even with "universal" access to services, then factors other than service must play a role and this has been clearly outlined in the Ottawa Charter (World Health Organization 1986). Categories of health determinants are those based on the work of the federal, provincial, and territorial Health Ministers and include: income and social status, social support networks, education, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services (Huff and Kline 1999; Minister of Supply and Services Canada 1994). Each category affects health in a different way.

If the goal of the various levels of government in Canada is to maximize the health of its population, then potential governmental responses must be viewed in this broad framework. With this in mind, marginalized groups can be defined as those disadvantaged in relation to one or several of the identified determinants of health. These then might include the physically or mentally disadvantaged, aboriginals, people living in poverty, or newcomers, to name but a few.

Newcomers as a Potentially Marginalized Group

One in six people in Canada is a newcomer (Statistics Canada 1996) and newest migrants to Canada are more likely to be visible minorities, to come from less developed countries, and to be younger than those who arrived previously. Newcomers are a heterogeneous group. They include, for example, those arriving in Canada in the *independent class* of immigrants including investors with a great deal of economic and other resources, *family members* arriving to be reunified with their families and therefore often having a social support structure in place upon arrival, and *refugees*, who may have significant histories of violence, varied economic and educational resources, and a reduced social support structure. *Landed immigrant* is a term used interchangeably with *permanent resident*, with the latter term used preferentially in several countries (and consequently used in this text). Table 1summarizes Canadian immigration figures.

Each category of newcomers has different resettlement needs and the administrative classification of the migrant determines accessibility and eligibility to government health and social services. Studies of newcomers have been unable to address the effect of this heterogeneity because it would require the application of specific sampling strategies to ensure an adequate number of individuals in the various administrative classes of immigrants.

Table 1
Newcomers to Canada: Data for 2000

Newcomer Category		Number
Permanent residents (landed status)	Family class	60,515
	Economic class	132,118
	Live-in caregivers	2,784
	Provincial nominees	1,252
	Deferred removal order class	297
	Post-determination refugee claimants in Canada class	163
Temporary workers		86,225
Students		63,618
Landed refugees (Convention refugees)	Government sponsored	10,661
	Privately sponsored	2,905
	Dependents abroad	3,486
	Landed in Canada	12,978
Refugee claimants/Asylum seekers (includes temporary residents allowed to remain in Canada on humanitarian grounds – those from countries on the moratorium list, those with minister's permits and those with a refugee history but who have not filed a refugee claim)		35,368

Sources: Citizenship and Immigration Canada, 2001a; Citizenship and Immigration Canada, 2001b.

Existing national databases are inadequate to address the complexity of health determinants faced by newcomers (Dunn and Dyck 1998). The Canadian Census, for example, provides population figures for mother-tongue and language spoken at home, number of landed immigrants received (all categories) and when they were received (i.e., ≤ 3 or 5 previous years), non-permanent residents, ethnic origin, members of the "black" community, and religious affiliation (Gravel and Battaglini 2000). Migration history and associated risks and effects can not be specified with data aggregated in this way. Birth and death data provide other relevant statistics but again, without the level of detail needed to examine issues specific to various classes of migrant. The migration histories presented by certain newcomers and variation in service access by immigration class suggest that an important number of newcomers should be considered marginalized, with those in the refugee and asylum seeking class with the most precarious health status.

"Refugees" refers to 'Convention refugees' in the vast majority of cases in that they meet the UNHCR definition of a refugee: "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country." (UNHCR 2000). Assignment of an immigration

classification of "refugee" occurs in two main ways in Canada: i) Having been selected overseas through UNHCR channels; and ii) Through a successful request for asylum. Requests for asylum are assessed by Immigration Refugee Boards (IRBs). Individuals are classified as 'asylum seekers' until their case has been assessed by an IRB. Requests for asylum can be made at two points. The first is at the border, and these individuals are labelled "border claimants" or "port-of-entry claimants". The second is in the country, and these cases are labelled "inland claimants". The distinction between "refugee", "border claimant" and "inland claimant" is important because it suggests that different health determinants are operating to various degrees in the lives of these individuals which, in turn, will affect their health status and their response to illness. This administrative classification distinction further defines which health services may be accessed and when. Details of these aspects will be discussed below.

Immigration to Canada over the last decades has grown to 17.4% of the total population (Statistics Canada 2000). Of an immigration total of three and one-half million from 1979 to 1999, 531,417 persons were refugees, with an average of 24,000/year over the last five years (7,000 of whom were selected through UNHCR channels) (Citizenship and Immigration Canada 2000). The source regions for migration over this period have been mainly Asia, the Pacific, Africa, and the Middle-East. It should be noted that refugees, asylum seekers, and illegal immigrants concentrate in Canada's major urban centres, and thus the burden of health care falls disproportionately on those areas.

The Needs of Newcomers

The Health of Newcomers to Canada

Differences between the experiences of those in the various immigration classes have been reviewed (Gravel and Battaglini 2000). When examined together, newcomers are multi-ethnic, their mother-tongue and language used vary, and they have a variety of religious traditions, lifestyles, and political alliances. As opposed to "refugees", "independent" or "family" immigrants choose to come to Canada and are motivated to leave their country and re-establish themselves in a new country in the hope of a better life. Their departure is planned and they are able to return to their countries of origin if they so choose. On the other hand, "refugees" are forced to leave their country to ensure their survival and they are not able to return to their country of origin. All immigrants will go through phases of adjustment however the permanent, forced nature of the refugee migration experience makes their integration into society more difficult (Sundquist et al. 2000, 357-65).

These variations in migration scenarios suggest that several health determinants related to migration need to be considered (Gagnon, Merry and Robinson 2002). These include: whether departure from the country of origin was of a forced nature, whether the individual comes from a rural versus an urban area, experience of war in the source country, camp experience, history of torture or abuse, family separation, 'like community' in the new country, length of time in the new country, official language ability, discrimination experience, and change in social status. Additional bio-psychosocial determinants particularly relevant to migrants include: usual *vs* receiving-country diet, nutritional status, infectious disease exposure, social isolation, stress/anxiety, stress management strategies, depression, post-traumatic stress disorder, somatization, services available/received (western and traditional), official language proficiency and culture matching with provider. Women face additional risks, which suggest consideration of factors including: sex and gender-based violence (including rape), post-abortion care, and STI/HIV exposure and pregnancies resulting from rape.

Immigrants Generally

Immigrants to Canada and the United States have been found to be healthier than their North American counterparts although they lose this advantage over time (Chen, Ng and Wilkins 1996, 33-45; Parakulam 2000, 311-14; Pomerleau 1997, 337-45; Rumbaut 1996, 337-91; Weeks 2000, 327-34). Immigrants must meet certain health and other criteria to be accepted into Canada and they must have enough economic resources to complete the process of immigration, which likely results in a "healthy immigrant" effect. Individuals of various immigration classes are usually not separated out in such reports. Thus it is likely that the health status of "economic" or "family" immigrants overwhelms the data on newcomers in other classes due to the volume of immigrants in that category [90% of all immigrants fall into either the economic class or the family class (Citizenship and Immigration Canada 2001a)].

Refugee Health

Canadian studies focusing on the health of refugees or asylum seekers examined general health (Thonneau, Gratton and Desrosiers 1990, 182-86) and mental health (Beiser et al. 1995,

67-72; Beiser and Edwards 1994, 73-86; Beiser and Fleming 1986, 627-39; Beiser and Hyman 1997, 996-1002; Dillmann, Pablo and Wilson 1993, 253-58; Stephenson 1995, 1631-42). The general health of refugees and asylum seekers to Canada was described in two studies. The first, conducted in Calgary, sheds light on *the health of government-sponsored refugees in Canada* (that is, those selected overseas via UNHCR channels; in the "refugee" class). Health problems identified most often in the 1,104 government-sponsored refugees that arrived in Calgary in the early 1990's included upper respiratory tract infections (17.8%), impaired vision (15.4%), dental emergencies (12.8%), ear infections (7.4%), gynaecological problems (6.1%), and obstetrical conditions (5.6%). Twenty-two (5.8%) required emergency hospitalization (Dillmann, Pablo and Wilson 1993, 253-58).

The second, conducted in Montreal in 1985-86, sheds light on *the health of refugees that seek asylum in Canada at the border or once in the country* (as opposed to via UNHCR channels – that is, "asylum seekers" (Thonneau, Gratton and Desrosiers 1990, 182-86). 1,994 applicants received a medical examination at a clinic identified by the Quebec government as the care provider for refugee applicants. 87% were considered to be in good health, 3% had a major handicap or chronic illness, and 10% were in poor health. Health problems identified included nutritional deficiencies, stunted growth, anaemia, parasitic infections, syphilis, risk for tuberculosis, inadequate vaccination, and evidence of physical torture. Other more recently arrived refugee groups have been found to have a similar health profile with malnutrition, dehydration, gastrointestinal problems, scabies, head lice, minor skin conditions, and hepatitis B identified (Kent 2000, 256).

A review of the mental health of refugees and immigrants to Canada, (Beiser and Edwards 1994, 73-86) based largely on the experiences of Southeast Asian refugees, showed that exposure to catastrophic stress such as torture and rape may lead to post-traumatic stress disorder, women are at increased risk of mental disorder over time, and adolescent and older women may be at higher risk due to the conflicting expectations of parents versus peers in the case of adolescents and in the greater value placed on youthfulness over wisdom in the case of elderly people (Beiser, Dion, Gotowiec, Hyman and Vu 1995, 67-72; Beiser and Edwards 1994, 73-86). Unemployment was suggested as being an important problem since refugees admitted for compassionate reasons may not have employable backgrounds. Extended separation from family was also suggested as having a harmful psychological impact. On the other hand, resettlement was thought to be facilitated by having adequate sources of material support, the presence of like-ethnic communities (which may provide a psychological sense of community for some ethnic groups), and individual psychological hardiness.

Higher-Risk Groups

As previously mentioned, female refugees are exposed to even greater health risks because of issues related to childbearing and sexual health. Children are another at-risk subgroup due to their vulnerability and the numbers arriving unaccompanied in Canada are growing (Citizenship and Immigration Canada 2001a). Trafficked migrants are yet another high-risk category (United Nations High Commissioner for Refugees 1998). The United Nations estimates that 4 million individuals are trafficked internationally each year. Of these, 700,000 are women or children. Trafficking is said to occur when a migrant is illicitly recruited and/or moved by means

of deception or coercion for the purpose of economically or otherwise exploiting the migrant, under conditions that violate their fundamental human rights (International Organization for Migration 2001). Promises of good jobs from human smugglers or dreams of a better life often lead migrants to purchase irregular or illegal immigration services without knowledge of the risks involved (Gushulak and MacPherson 2000, 67-78). The number of trafficked migrants and the degree of risk in the method of transport may be increasing (International Organization for Migration 2001). Poor living and working conditions stimulate irregular migration and these same factors are associated with poor health. Other higher risk migrant groups include those placed in dependant positions, such as those with a fiancé and a temporary work visa, and those participating in the live-in caregiver program.

Canadians' Values about Responding to Newcomers' Needs

Canadians' attitudes towards immigration and immigration policy have been compared to those of other country nationals using data gathered from national surveys conducted in each of the countries between 1970 and 1995 (Simon and Lynch 1999, 455-67). More Canadians favoured increasing immigration than did Americans, yet at the peak, the number accounted for only 17% of the population. Those preferring a decrease ranged from 32 to 55%, with an average of 42%, lower than the Australia average by over 20 points and the U.K. average by 10 points. The U.S. average was closest, ranging from 33 to 66% of U.S. respondents preferring a decrease, with an average of 49.7%. Responses to a 1993 Canadian question on how the increase in the number of immigrants arriving from Asia, the West Indies, and other mainly 'third world' countries was viewed, only 20% said it was a good thing. Determinants of negative attitudes towards immigration have been found to be the result of a complex interrelationship of factors that include unemployment rates and racism (Palmer 1996, 180-92). In the absence of other data, these studies might suggest that some Canadians do not support providing services to newcomers although this cannot be confirmed; if this was found to be true, there may be variation in degree of support depending on immigration class (humanitarian versus non-humanitarian).

Potential Barriers to Access and Use

Immigrants have been found to underutilize health services for which they are eligible (Hyman 2001). Barriers to services used by migrants are several but can be divided into three broad categories. The first is fear of accessing the system believing they might be considered a burden on the system and accessing care would therefore be detrimental to their immigration applications (personal communication, A. Li); the second relates to culturally inappropriate care and language barriers; the third with difficulties navigating the system. There is a large body of literature describing the effects of culturally inappropriate care across various multicultural groups. In general, it is suggested that health care providers learn about their individual patient's cultural concepts, family structure, and practices at the outset of developing a working relationship (Hamilton 1996, 585-87). The professional can then offer culturally acceptable explanations of health-related matters.

Developing a trusting relationship can be further hampered when patient and provider do not speak a common language (Bowen 2000; Davies and Yoshida 1981, 22-3). In these cases, a

interpreter may be required, which compromises the patient's privacy; often a family member is sought to provide this service, resulting in altered power dynamics within the family. Counselling services are extremely difficult to manage in these situations. Delays in seeking care, reduced comprehension, reduced compliance, and harmful health outcomes are associated with language barriers. Informed consent for care is difficult to obtain under these conditions.

Difficulties navigating "the system" are not unique to newcomers but are compounded by language and cultural barriers and the newcomer's expectations, which are usually based on experiences with the system in the country of origin. Another "system" barrier is the under-representation of immigrant and racial minorities, especially women, in health care professions (with foreign-earned credentials an issue), on boards of directors of hospitals, universities and other major institutions that set health care policies (Simms 1996).

"Best Practice" Guidelines for Health Services Delivery for Newcomers

The Canadian Council for Refugees has published *Best Settlement Practices* in which guidelines for best practices are outlined (Canadian Council for Refugees 1998). Services should: 1) Be accessible to all who need them. 2) Be offered in an inclusive manner, respectful of, and sensitive to, diversity. 3) Empower clients. 4) Respond to needs as defined by users. 5) Take account of the complex, multifaceted, interrelated dimensions of settlement and integration. 6) Be delivered in a manner that fully respects the rights and dignity of the individual. 7) Be delivered in a manner that is culturally sensitive. 8) Promote the development of newcomer communities and newcomer participation in the wider community, and develop communities that are welcoming of newcomers. 9) Be delivered in a spirit of collaboration. 10) Be made accountable to the communities served. 11) Be oriented towards promoting positive change in the lives of newcomers and in the capacity of society to offer equality of opportunity for all. 12) Be based on reliable, up-to-date information. Although not drafted specifically for health services delivery, these guidelines offer a framework by which the Canadian health care system can be examined to determine how well the needs of newcomers are being met. National standards developed in the United States may also be useful (U.S. Department of Health and Human Services 2001).

Summary of Newcomers' Needs

Newcomer health likely varies by migration history, although databases are inadequate to answer this question directly. Migrants not forced out of their country of origin are expected to have a lower health-risk profile than those forced out. Newcomers are known to under-utilize services and some Canadians likely prefer that limited access to services be available to newcomers. Barriers to accessing care for which they are eligible include fear of jeopardizing immigration applications by seeking care, language barriers, culturally inappropriate care, and difficulties in navigating the system. Optimal care is thought to be based on core values of access, inclusion, empowerment, user-defined services, holism, respect, cultural sensitivity, community development, collaboration, accountability, orientation towards positive change, and reliability (Canadian Council for Refugees 1998).

Governmental Responses to the Health Needs of Newcomers

Methods

Information on access to services from all provinces and territories (regardless of volume of immigration) were sought, collated, and tabulated for comparison. Certain countries were selected for comparison purposes based on similarity of immigration patterns, economic systems, and health care system structures. The vast majority of information was obtained through extensive searches of governmental and non-governmental web sites and their cited documents, and by subsequently contacting individuals and organizations via e-mail for missing information. Information was sought from ministries of health, government health insurance agencies, ministries of immigration, regional health and social service agencies, main municipal, provincial, territorial and national offices, and non-governmental organizations (NGOs) including both those that act as umbrella organizations for other NGOs and those directly serving migrants. Google, Yahoo and Alta Vista search engines were employed. Electronic databases of literature were also used to supplement information. Bibliographic references from identified texts were sought for review. The Canadian Council for Refugees list server was used to identify case examples of access issues for newcomers.

Access to Services

Tables 1-6 (in Appendix) provide details on access to services. The legend for the tables is presented first and the bibliography of documents used to compile information found in the tables follows the final table.

Inter-Provincial / Territorial Comparisons

The *Canada Health Act* guarantees access to hospitalization and physician services for Canadians (Romanow 2002). Other health services vary by province, including other professional services (e.g., nurses), preventive care, home care, long-term care, dental care, and pharmacare (out of hospital). The extent of coverage is detailed in Table 1 and shows that some non-medical professional services are covered in nine provinces/territories, some preventive services in five, home care in five, long-term care in two, some dental care in eleven, and some pharmacare in eight.

Access to these services varies by province according to the immigration class of the individual. These include: permanent residents, those with employment authorizations, students, student's spouses, refugees, and asylum seekers. Provincial/territorial variation in access to services by immigration status is detailed in Table 2. As can be seen, landed immigrants have access to the same services as Canadians. Those with employment authorizations have the same access depending on the valid duration of the authorization; in all but three provinces, the authorization must be for 6 or 12 months. Students and their spouses are specifically not covered in four provinces. Either the provincial plans or the Interim Federal Health Program (IFHP) (described below) variously cover refugees. Asylum seekers are not covered under provincial plans but rather under the IFHP.

The point in time during the immigration process at which they are covered for these services also varies considerably and is detailed in Table 3. The time at which coverage begins for all immigration classes except refugees and asylum seekers is up to 3 months for all provinces, except Nova Scotia where those with an employment authorization have access after 6 months and students after 12 months. Time to access health plans for provinces and territories that offer refugees coverage varies, with the shortest being the Northwest Territories where access is upon arrival. There is a 2-3 week delay in Quebec, a 3-month delay in British Columbia and Ontario, while in Manitoba the timing depends on the employment authorization. The least amount of information is available for asylum seekers. However, reports from British Columbia suggest a 1-4 week delay, for Quebec, same day to 10 weeks, and for Ontario, 4 weeks to 6 months. Variation in access for individuals in these latter two immigration classes suggests a greater dependence on the IFHP.

Care Assured Directly by the Canadian Government

The IFHP was put in place for humanitarian reasons to allow refugee claimants (asylum seekers), Convention refugees, and others in humanitarian designated classes to receive essential health care (Citizenship and Immigration Canada 1998). It is not meant to replace provincial health plans and does not provide the same extent of coverage as for permanent residents. Eligibility for this program is determined by a demonstrated lack of funds, which is assessed by an immigration officer and this, only once eligibility to make a refugee claim has been approved and if the claimant is not covered by a private or public health plan.

IFHP benefits are limited to essential health services for the treatment and prevention of serious medical/dental conditions, essential prescription medications, contraception, prenatal and obstetrical care, and the Immigration Medical Examination (limited to identification of active tuberculosis, syphilis, and acute psychiatric disorders (personal communication, B.D. Gushulak). Prior approval is required for a complete physical examination, diagnostic services (unless short-term complications are seen), ongoing psychiatrist's care, and psychotherapy/counselling, among others. Alternative and over-the-counter medications and root canals, among other treatments, are expressly not covered.

Even with the IFHP, certain asylum seekers have no health insurance for some periods of time due primarily to delays in processing their requests to apply for refugee status. Thus, those who are awaiting eligibility determination to make a refugee claim have no coverage. Health and social services provision during this waiting period varies according to services available through local NGOs and community health centres. Inland claimants have the most difficulty. According to one respondent to a CCR list-serve question regarding variation in service availability, refugees in Ontario can wait up to one year to obtain coverage (personal communication, South Etobicoke Community Legal Services, Toronto), although the usual delay in Montreal is reported to be 3 weeks (personal communication, D. Isaacs). As recently as April 8, 2002, in Toronto, people were said to be lining up overnight in order to submit their applications for refugee status (personal communication, E.F. Khaki). Port-of-entry asylum seekers could receive the necessary forms as they enter the country or up to one month thereafter. If there are problems with their “Notification of Intention to Make a Refugee Claim” form, it can be returned to them and further delays occur in obtaining IFHP coverage.

Concerns with regards to the IFHP have been summarized by the Canadian Council for Refugees (CCR) based on reports from 27 of their members and from *A Report on the Experience of Sponsors of Kosovar Refugees in Ontario,* by the Centre for Refugee Studies (CRS) and the Centre of Excellence for Research on Immigration and Settlement (CERIS) (personal communication, R. Hogue). These included: 1) Difficulty in accessing IFHP-covered services by those eligible due, in large part, to a lack of willingness on the part of potential providers to process IFHP forms or a lack of knowledge about it. (Difficulty in accessing services is exacerbated in areas where there is a shortage of health professionals.) 2) Processing difficulties at the IFHP office, including pre-authorization for certain conditions and late reimbursement to providers. 3) Absence of coverage for certain conditions, dental care being cited most often. These difficulties result in fewer service options available for a needy population (personal communications, P. Dongier; A. Li).

This feedback on IFHP must be interpreted cautiously given the apparent absence of a representative survey; however, it suggests that health care coverage for refugees and asylum seekers and services received by them are not uniform, and the rate at which they have access to services differs from one province to the next. No such difference in health care coverage can be seen for other classes of immigrants or for people born in Canada.

International Comparisons

Coverage of health services in Australia, the Netherlands, New Zealand, Sweden, and the United Kingdom is detailed in Table 4. The most complete coverage seems to be available in the Netherlands. Four of the five countries cover hospitalization, while three completely cover physician services and some other professional services. Preventive care is widely covered in two countries. The greatest variation by country is seen for home care, long-term care, dental care, and out-of-hospital pharmacare. Coverage for dental care, for example, ranges from no coverage in Australia to complete care and treatment for a specified time period in the United Kingdom, and to full preventive care and treatment in the Netherlands.

Access to these services varies by country according to the individual's immigration class including: permanent residents, those with an employment authorization, students, refugees, and asylum seekers. Access to services by immigration class in selected countries is detailed in Table 5. Residents have the greatest access and students the least. Refugees have immediate access to the same health care as nationals in every country. Asylum seekers have access to the same health care as nationals in the Netherlands, New Zealand and the United Kingdom.

Information describing the point in time during the immigration process at which newcomers are covered for these services was more difficult to obtain. Available information is detailed in Table 6. Non-humanitarian immigrants have a waiting period ranging from three months in Sweden to two years in Australia. Refugees have immediate coverage in three of the countries examined. Asylum seekers theoretically have immediate access, although processing time for their applications results in documented delayed access to services in at least New Zealand and the United Kingdom.

Summary of Access to Services

Canada has responded to certain needs for access to care by implementing the IFH Program. However, there remain serious difficulties with accessing services through this program, including delays in immigration processing times, errors in completing forms, limitation to coverage of essential services only, and the administrative burden placed on service providers. Other comparable countries have generally not created a separate funding mechanism for health care for refugees and asylum seekers, but rather have limited access to available services according to immigration class and length of time in the country.

"Best Practice" Examples

Inter-Provincial / Territorial

"Best practice" examples from various provinces were too numerous to describe here. Advocacy and networking are activities of groups focusing on immigrant resettlement issues (Mosaic 2002) and umbrella organizations representing them (la Table de concertation des organismes au service des personnes réfugiées et immigrantes (TCRI) 2001; Ontario Council of Agencies Serving Immigrants 2002; The Affiliation of Multicultural Societies and Service Agencies (AMSSA) 2002). Several specialized service agencies are in existence. These include agencies focusing on culturally appropriate mental (Kirmayer 2002; Régie régionale de la santé et des service sociaux de Montréal-Centre 1996) and physical health services (Lorion and Dion 1999), and interpreter data banks (Régie régionale de la santé et des services sociaux de Montréal-Centre 2002). The concerns of female immigrants have been highlighted in some areas (Maritime Centre of Excellence for Women's Health 2000; Riverdale Immigrant Women's Centre 2002), and guidelines for practices have been published (Ministère de la Santé et des Services sociaux 1999). Umbrella and direct service agencies are variously supported and often rely on government funds to some extent.

Federal / National

There were some "best practice" examples at the federal level. Among these, the Metropolis Project, which was awarded the Public Service Award for Excellence in Policy Development in 1999-2000 (Canadian Heritage Multiculturalism 2000). This project brings together policy makers from three levels of government, NGOs and researchers, in an effort to broadly examine the effects of migration on Canadian cities. Several federal departments partner to fund the project. Four research Centres of Excellence (in Toronto, Vancouver, Montreal, and the Prairies) have their own partnerships with local NGOs and policy makers (Metropolis Canada 2002). There is also an international component of the project involving several countries.

Another initiative at the national level that appears promising is the Multilingual-Health-Education Network (Multilingual Health Education Net 2002). This network is funded by Health Canada and Heritage Canada with the goal of improving standards and procedures for translating patient education and instructional material. It is a non-profit alliance of Canadian health agencies focused on improving service delivery by making translated documents easily available to providers and the public.

The Canadian Council for Refugees (CCR), The Canadian Network for the Health of Survivors of Torture and Organized Violence (RIVO), the National Organization of Immigrant and Visible Minority Women (NOIVMWC), and the Canadian Council on Multicultural Health (CCMH) are agencies offering important resettlement direct service or policy work nationally.

International

"Best practice" examples from various countries and regions of the world were identified. Of specific interest to Canada were: the New Zealand language law and resettlement program, the Australian translation services, and the European Union Networks on Reception, Integration and Voluntary Repatriation. New Zealand law states that every individual has the legal right to an interpreter for health services to ensure their informed consent and this service must be provided by the treating agency (New Zealand Ministry of Health 2002). *Refugee Health Care: A Handbook for Health Professionals* is a handbook developed by the New Zealand Ministry of Health in conjunction with several community and professional organizations (Kizito 2001). Approaches to care for refugees and asylum seekers are discussed, including care provided at the Mangere Refugee Resettlement Centre. Here, refugees spend six weeks upon their arrival; they receive health screening and care, English lessons, a basic orientation to New Zealand, and money to pay for essentials.

There are currently six Health Care Interpreter Service (HCIS) centres covering the State of New South Wales in Australia (New South Wales 2002). This service consists of professional interpreting services provided free of charge in more than 50 languages to people using public health services (which are the majority) in areas around Sydney. In metropolitan areas, these services are available 24 hours a day, seven days a week, depending on urgency. In some areas, they are also available for telemedicine consultations. Other country-specific "best practice" programs in the European Union have been described elsewhere (ECRE Task Force on Integration 2000).

The European Union Networks on Reception, Integration, and Voluntary Repatriation (EU Networks) is a project financed by the European Union focussing on improving the integration of refugees in member countries (EU Networks on Integration of Refugees 2002). It aims to develop issue-oriented networks on relevant themes such as education, language and vocational training, health, reception, and voluntary return. Activities have included: maintaining an inventory of integration activities, developing good practice guidelines, and publishing reports of interviews with refugees from all 15 member countries.

The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international organization of health professionals which promotes and supports the rehabilitation of torture victims and the prevention of torture worldwide (International Rehabilitation Council for Torture Victims 2002). It works with 200 rehabilitation programs internationally, including several in Canada. It monitors torture globally and intervenes in conflict situations. It is at least partially supported by the European Union, the United Nations Voluntary Fund for Victims of Torture, and the Oak Foundation.

Summary of "Best Practice" Examples

Across Canada and at the national level, there are several special programs for newcomers that respond to many of the "best practice" guidelines. "Best practice" examples from other countries that Canada may wish to consider include New Zealand's language law requiring interpreter services for everyone in need and Australia's extended interpreter services, as well as multidisciplinary resettlement centres in New Zealand that provide a range of services to newly arrived refugees on a regular basis. Endeavours spanning more than one country that may be of interest to Canada include the EU Networks, which address common resettlement issues, and ICRT, to which several Canadian agencies already participate.

Comment

Remaining Dilemmas, Challenges, and Choices

Service Gaps

The existence of a separate financing structure for health services for refugees and asylum seekers (the IFHP) offers humanitarian-class immigrants coverage for basic services; however, there are no built-in incentives for service providers to accommodate the needs of these individuals due to the heavy administrative burden placed on providers. Other barriers include periods of time without access to care due to immigration processing delays and coverage for care not included in the IFHP. Language was repeatedly cited as a barrier throughout the country and although the Multilingual-Health-Education Network has been set up to help lower these barriers through written documentation, a more pro-active approach is needed. The notion that care might be provided in the absence of truly informed consent as a result of language difficulties is of some concern.

Inadequate Information and Data Sources

Information available on the Web describing health services directed towards newcomers to Canada is limited; for most provinces, there is no mention of 'immigrant' on web sites designed to provide information to users about accessing services for which they are eligible. Federal and provincial health databases are currently inadequate to assess the extent to which immigration class and migration history affect health outcomes and services use, because data on immigration class and migration history are not included in databases at a level of detail that would allow such comparisons. Thus, the effect of any changes in policy or structure of the health care system will be difficult to evaluate among this population group due to the invisibility of newcomers within existing databases. Furthermore, there is little population-based research in this area.

Public Opinion on Immigration

A portion of the Canadian population may believe that Canada is already providing too many benefits to newcomers. When contrasted against Canada's commitment to the 1951 Convention as well as care provided by other countries however, the level of care offered by Canada to its newcomers at greatest risk appears moderate. One approach to meeting the needs of both the public and of newcomers might be to decrease immigration processing time as much as possible such that those not meeting refugee criteria could be identified rapidly, while simultaneously covering those at greatest risk for health decline while awaiting an IRB decision on their application.

Recommendations

Issue 1: Administrative burden on health care professionals providing care under the IFHP

Potential Actions

1. Reduce cumbersome processing requirements for reimbursement of services provided.
2. Develop a health care card system such as the one that exists for the provinces as a reasonable alternative to the current system.
3. Develop and distribute pamphlets and other information resources on the IFHP to health care providers.
4. Create financial or other incentives for health care providers to provide care to individuals covered by the IFHP.

Issue 2: Eligibility delays for the IFHP

Potential Actions

1. Monitor length of time to eligibility for the IFHP from the date of entry into the country until the date of eligibility to determine bottlenecks and permit benchmarking.
2. Reduce processing time for acknowledging reception of applications for asylum so that individuals eligible for IFHP can access health services as soon as possible.

Issue 3: Limited service coverage under the IFHP

Potential Actions

1. Expand services covered under the IFHP. Especially consider mental health services (given the psychological and emotional implications of the migration histories of individuals covered by this program) and dental services.
2. Expand coverage directly to specialized centres (e.g., for victims of trauma or violence), especially in urban areas.

Issue 4: Lack of access to appropriate care and to informed consent among people who do not speak an official language

Potential Actions

1. Establish translation in health care as a right for newcomers.
2. Set up local and/or national telephone interpreter services.
3. Form alliances with NGOs dedicated to providing translation services.
4. Fund training in the development of national professional standards of practice to increase cultural sensitivity toward newcomers and to reduce language and ethno-cultural barriers.
5. Develop resource materials on ethno-cultural care for professionals.
6. Finance ethno-cultural liaison staff in hospitals and community health centres to work with various ethnic groups and to help newcomers “navigate” the system.

7. Form an umbrella organization in North America (similar to the EU Networks in Europe) which would be designed to support the work of NGOs and governmental agencies in providing services to immigrants of all classes. This could reduce duplication of services and offer the benefit of sharing effective resettlement strategies.

Issue 5: Paucity of data upon which to build sound policies and practices

Potential Actions

1. Include information in federal and provincial databases that reflect immigration class, migration history, visible minority status, and official language proficiency so that implications of health risk status and access to care can be more readily quantified.
2. Require documentation of gender and age impacts of both Citizenship and Immigration Canada and Health Canada procedures to assess the effectiveness of our responses to newcomers at greatest risk.
3. Collect and regularly report on data regarding job skills, Canadian certification in specialities, and time to employment in area of speciality, considering the importance of gainful, meaningful employment as a key determinant of health.

Issue 6: Paucity of easily available information on eligibility of newcomers to services

Potential Actions

1. Have information about exact coverage of health services for newcomers readily available on relevant national and provincial web sites and in other written and electronic resources.
2. Create an information system (e.g., 1-800 number) for newcomers covered by IFHP and elsewhere, on the most efficient way to access various specific services.

Issue 7: Health care financing structure not taking into consideration the urban-rural discrepancy of service provision to newcomers

Potential Actions

1. Re-structure financing for health services according to the geographic distribution of newcomers.
2. Offer differentially more services in urban areas.

Conclusion

Canada has been moderately responsive to the health needs of newcomers. There are several approaches that Canada could take to improve the responsiveness of the system even further. These include reducing the administrative burden of the IFHP on health care providers and reducing the time to access the program, offering interpretation services widely, and improving the content of health databanks to allow the examination of newcomers' health and health care according to immigration class.

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Appendix

Legend for Tables 1 to 6	
Code	Definition
A	Subject to means testing
B	Including spouse and dependents
C	Authorization must be valid for a minimum of 6 months
D	Authorization must be valid for a minimum of 12 months
F	Covered by the Interim Federal Health Program
G	Group-specific coverage
H	Covered if provided in hospital
I	Information incomplete/unclear
J	Immediately once granted this status
N	Not applicable
O	Spouse and dependents must submit individual requests to be included in a claimant's application
P	Partially
R	Retroactive
S	Surgical procedures
T	Varies depending on length of time for claimant status application to be processed
U	Upon arrival
V	Variable
X	No
Y	Yes
Z	Certain services covered

Table 1
Health Care Services Covered for Canadians

Health Care System Components	Alberta	British Columbia	Manitoba	New Brunswick	Newfound-land & Labrador	North West Territories	Nova Scotia	Nunavut	Ontario	Prince Edward Island	Quebec	Saskat-chewan	Yukon
Hospitalization	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Physician Services	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
Other Professional Services	YP[b]G[c]	Y[d]	Y[e]G[f]	Y[g]	I	I	Y[h]		P[i]G[j]	Z[k]	I	P[l]	Y[m]G[n]
Preventive Care	YG[o]	I	I	I	I	I[p]	G[q]		I	Y[r]	I[s]	Y G[t]	Y
Home Care	Y[u]	I	Y	I	I	I	I		Y	I	I P[v]	P	I
Long-Term Care	Y	I	I	I	I	I	I		I	Y[w]	I	I	I
Dental Care	G[x]	HS[y]	HPS	PS	HPS	S[z]G[aa]	HG[bb]		G[cc] HPS	HPS	G[dd]PS	P	I
Pharmacare (out of hospital)	I	I	I	G[ee]	I	G[ff]	G[gg]		GP[hh]	GP[ii]	P	P	G[ij]

NWT Health Care Coverage in Effect

[a] Excludes healthcare coverage provided by federal government to certain groups (Aboriginals, veterans, and inmates)
[b] Chiropractic services, podiatry, physical therapy, respiratory therapy, occupational therapy, speech pathology services, some oral and maxillae-facial services from oral surgeons.
[c] Optometry services covered for those 19 and under or 65 and over.
[d] Surgical, psychiatric, ophthalmologic, diagnostic and anaesthesia services when referred by physician.
[e] Surgical, diagnostic and chiropractic services when referred by physician. Ambulance services not covered.
[f] Optometry services covered for those 19 and under or 65 and over.
[g] Community mental health services.
[h] Ambulance, chiropractic, and optometric services not covered.
[i] Podiatric, chiropractic and osteopathic services.
[j] Ophthalmologic services available every 2 years for those 20-64 years of age and once a year for those under 20 or 65 and over.
[k] When referred by physician.
[l] Physiotherapy, occupational therapy, ambulance, optometric and mental health services.
[m] Mental health services.
[n] Glasses and eye examinations for children of low-income families under the Children's Drug and Optical Program (CDOP).
[o] Children covered for immunization programs.
[p] Yearly physicals not covered.
[q] The Optometric Program provides preventative routine vision care for children 10 and under, and for seniors 65 and over.

[r] Covered if provided in an accredited facility.
[s] Smoking cessation medication covered.
[t] Screening mammography for women aged 50-69.
[u] Home respite and palliative care.
[v] Light and heavy housekeeping, meal preparation, and errand running.
[w] If provided in an accredited facility.
[x] Some services covered for seniors.
[y] Related to severe congenital abnormalities.
[z] Services specific to injuries related to jaw injury or disease.
[aa] Seniors 60 and over.
[bb] Coverage for children up to the age of 10.
[cc] Children qualifying for the Children in Need of Treatment Program.
[dd] Children 10 and under and those receiving financial assistance.
[ee] For seniors, children in care, and those with certain diseases/conditions.
[ff] Seniors 60 and over and those with diseases/conditions covered by the extended health benefits plan.
[gg] The Senior's Pharmacare program covers adults 65 and over.
[hh] For those eligible for the Ontario Drug Benefits Program.
[ii] Drug cost assistance schemes available to those with specific diseases/conditions.
[jj] Seniors 65 and over and their spouse if 60 and over.

Table 2
Health Services Coverage (refer to Table 1) as per Immigration Status: Canada

Categories of Immigration Status	Alberta	British Columbia	Manitoba	New Brunswick	Newfound-land & Labrador	North West Territories	Nova Scotia	Nunavut	Ontario	Prince Edward Island	Quebec	Saskat-chewan	Yukon
Permanent Residents	Y	Y	Y	YB	Y	Y	Y		Y	Y	YBO	Y	I
People with Employment Authorization	YBD	YB	YBD	YBOD[a]	Y[b]BD	YD	Y	NWT Health Care Coverage in Effect	YBC	YC	YBOC	YB[c]	I
Students	YD	Y	X	X	X	Y	Y		I	X	Y[d]BO	Y	I
Spouses of Students	Y	Y	X	X	X	I	I		I	X	Y[e]O	I	I
Refugees	Y	F[f]	FY[g]	Y	I	I	Y		Y	I	YBO	FY[h]	I
Refugee Claimants/ Asylum Seekers	F	F	F	F	F	F	F		F	F	F	F	F

[a] Those married to or dependent of an eligible N.B. resident are also entitled to coverage.
[b] Employment authorization must be issued before coming to Canada for a named Newfoundland employer for a specific job within the province.
[c] If spouse does not arrive within the 12-month period following the arrival of the person with employment authorization, coverage differs.
[d] Students from countries not included in the "social security agreement" (*entente de sécurité sociale*) with Quebec are not covered.
[e] Spouses of students from countries not included in the "social security agreement" (*entente de sécurité sociale*) with Quebec are not covered.
[f] Eligible for supplementary benefits including physiotherapy, massage therapy, chiropractic and naturopathic services, and surgical and non-surgical podiatry with a combined annual limit of 10 visits per year.
[g] Covered by IFHP up until when employment authorization is granted.
[h] May be eligible if in possession of valid employment authorization, student authorization, or a Minister's permit issued by Citizenship and Immigration Canada.

Table 3
Time Period Between Arrival and Eligibility for Health Services Coverage as per Immigration Status: Canada

Categories of Immigration Status	Alberta	British Columbia	Manitoba	New Brunswick	Newfound-land & Labrador	North West Territories	Nova Scotia	Nunavut	Ontario	Prince Edward Island	Quebec	Saskat-chewan	Yukon
Permanent Residents	U[a]	Up to 3 months	U[b] or the 1st day of the 3rd month	3 months	I	U	I		3 months	U[c]	Up to 3 months	1st day of 3rd month	I
People with Employment Authorization	3 months	Up to 3 months	U or the 1st day of the 3rd month	3 months	I	U	After 6 months R[d]		3 months	U	Up to 3 months	1st day of 3rd month	I
Students	3 months	Up to 3 months	N	N	N	U	1st day after 13th month[e]	NWT Health Care Coverage in Effect.	I	N	U[f]	1st day of 3rd month	I
Spouses of Students	3 months	Up to 3 months	N	N	N	I	I		I	N	U[g]	N	I
Refugees	I	3 months	V[h]	I	N	J	I		Min. 3 months[i]	I	2-3 weeks	N	I
Refugee Claimants/ Asylum Seeker	T	1-4 weeks[j]	T	T	T	T	T		V[k]	T	V[l]	T	T

[a] If application is received within the 3 months following arrival, coverage is effective upon arrival. For applications received after the required time the effective date is determined at the time of registration.

[b] Or as soon as immigration status is confirmed, for within-country applicants.

[c] Those establishing residence in P.E.I. may be eligible on the first day they become resident of the province.

[d] Those with employment visas: after residing 6 months retroactive coverage back to the date of arrival provided they have not been absent for more than 31 days from N.S. and are intending to be employed for the following 6 months. Those with employment authorization: eligible to apply for coverage on the 1st day of the 7th month provided that they have not been absent from N.S. for more than 31 days.

[e] Provided they have not been absent from N.S. for more than 31 consecutive days. Coverage begins on 1st day of 7th month if student is working as a teaching or research assistant at a university in N.S.

[f] Students from countries not included in the "social security agreement" (*entente de sécurité sociale*) with Quebec are not covered.

[g] Spouses of students from countries not included in the "social security agreement" (*entente de sécurité sociale*) with Quebec are not covered.

[h] IFHP coverage in effect until employment authorization is issued at which time provincial coverage takes effect.

[i] Eligible 3 months after the landing fee is paid.

[j] May be delayed by sudden influx of claimants who are detained (priority cases). Port-of-entry claimants are covered immediately.

[k] 4-6 weeks if claimed at port of entry. Otherwise, 4-6 months.

[l] Port-of-entry claimants are covered upon arrival. May take 1-10 weeks for inland claimants depending on completeness of their application.

Table 4
Health Care Services Covered for Citizens According to Country

Health Care System Component	**Canada**[a]	Australia	Netherlands	New Zealand	Sweden	United Kingdom
Hospitalization	**Y**	Y	Y	Y	P G[b]	Y[c]
Physician Services	**Y**	Y	Y	P[d] G[e]	P G[f]	Y
Other Professional Services	**V**	Y G[g]	Y	P G[h]	P G[i]	Y G[j]
Preventive Care	**V**	I	Y[k] G[l]	G[m]	G[n]	Y
Home Care	**V**	I	Y[o]	P A	G[p]	A
Long-Term Care	**V**	I	Y	I	Y	A
Dental Care	**V**	X	Y[q]	G[r]	P G[s]	H G[t]
Pharmacare (out of hospital)	**V**	P G[u]	Y[v]	G[w]	P[x] G[y]	G[z]

[a] Refer to Table 1.
[b] Those under 20 are exempt from fees, and medical expenses are capped.
[c] Includes medication, dental treatment and optical services within hospital. Those with low income are entitled to travel assistance to and from hospital.
[d] Most health care provided free of charge with the exception of primary health care for which a fee-for-service exists.
[e] Children under 6, those with a "community services card" (low income), those with a "high-use health card" (more than 12 visits per years to a GP for a particular condition), and families who require more than 20 subsidized prescriptions per year are exempted from service fees.
[f] Those under 20 are exempt from fees, and medical expenses are capped.
[g] Ambulance services covered for those on government pension and those with low income.
[h] Children under 6, those with a "community services card" (low income), those with a "high-use health card" (more than 12 visits per years to a GP for a particular condition), and families who require more than 20 subsidized prescriptions per year are exempted from service fees.
[i] Those under 20 are exempt from fees, and medical expenses are capped.
[j] Those over 60, children under 16, those under 19 who are in full-time education, those on income support, and those with specific ophthalmologic conditions (or a family history of these conditions) are entitled to optical care. Hearing aids and their maintenance are also covered.
[k] Covers genetic testing for hereditary conditions, and thrombosis preventative services.
[l] Hepatitis B testing in pregnant women, PKU testing of neonates, and immunization of children.
[m] Children are covered for immunizations. Children, those over 65 and those with specific chronic medical conditions are covered for influenza vaccination.
[n] Children under "school age" are provided with vaccinations, health checks, consultations, and certain types of treatment free of charge at children's clinics. Health education provided in schools. Prenatal care covered.
[o] Aids, medical devices, maternity care (including domestic services) and home dialysis services are also covered.
[p] Elderly, and disabled are provided with medical service, nursing and technical aids.
[q] Includes preventive maintenance.
[r] Children are eligible for free dental care until their 18th birthday.
[s] Those 20 and under are covered.
[t] Children under 19, pregnant women (up to 12 months post-birth), those on low-income support or disabled persons or those receiving working family tax credits are entitled to free dental services.
[u] Costs for those with concession cards (students, elderly and disabled) and for families are capped.
[v] With a limit to reimbursement.
[w] Children under 6, those with a "community services card" (low income), those with a "high-use health card" (more than 12 visits per years to a GP for a particular condition), and families who require more than 20 subsidized prescriptions per year are exempted from service fees.
[x] Total annual costs are capped.
[y] Insulin is free for children under 18.
[z] Children under 16 or under 19 if in full-time education, and those 60 and over are covered. Pregnant women are entitled to prescriptions with an exemption certificate, those on income support.

Table 5
Health Services Coverage (refer to Table 4) as per Immigration Status: According to Country

Categories of Immigration Status	**Canada**[a]	Australia	Netherlands	New Zealand	Sweden	United Kingdom
Permanent Residents	**Y**	Y[b] B	Y[c]	Y[d]	Y[e]	Y[f]B
People with Employment Authorization	**V**	Y	I	Z[g]G[h]	X	Y[i]B
Students	**V**	X	X	XG[j]	X	Y[k]
Refugees	**Y**	Y	Y	Y[l]	Y	YB
Refugee Claimants/ Asylum Seekers	**Y**[m]	Y[n]G[o]	Y	Y	P[p]G[q]	YB[r]

[a] Refer to Table 2.
[b] Australia has reciprocal healthcare arrangements with some countries and residents from these countries are covered for basic healthcare services in Australia.
[c] The Netherlands has reciprocal healthcare arrangements with some countries and residents of these countries are also covered for basic healthcare services in the Netherlands.
[d] New Zealand has reciprocal healthcare arrangements with some countries and residents of these countries are also covered for basic healthcare services in New Zealand.
[e] Sweden has reciprocal healthcare arrangements with some countries and residents of these countries are also covered for basic healthcare services in Sweden.
[f] Nationals of the European Economic Areas are variably covered according to country of origin, and nationals of countries with which the United Kingdom has a reciprocal health care agreement are also covered.
[g] Anyone suffering from an accidental injury is covered.
[h] Teachers funded by the Ministry of Education's Foreign Language Teaching Assistantship Scheme are eligible for all services. Children of eligible persons have access to all services. Those with a valid temporary residence permit for two or more years are entitled to access public health services.
[i] Includes unpaid workers in certain voluntary organizations, and students and trainees that are required to work for 12 weeks during their first year.
[j] Students funded by the Ministry of Foreign Affairs' Official Development Assistance Programme, their partners and their children are eligible for all health services.
[k] Short-term (less than 6 months) students who are from countries that do not have a health care agreement with the United Kingdom are not entitled to coverage.
[l] Including multidisciplinary trauma counselling.
[m] Under the Interim Federal Health Program (IFHP).
[n] Must hold a valid visa with work rights in order to be covered.
[o] Claimants without visas are given financial assistance to cover healthcare and counselling services under the Asylum Seeker Assistance Scheme (ASA). Medical, dental and specialist treatment is available for unauthorized immigrants in detention centres as medically required.
[p] Adult asylum seekers qualify for subsidized emergency medical and dental care; prescription medications and costs are capped.
[q] Asylum seeking children are entitled to same health care as Swedish children. Maternity care, preventive child and antenatal care and dental care for children under 18 are free.
[r] Claimants/asylum seekers may also apply for exemption from standard charges for prescriptions, dental treatment, sight tests, glasses, wigs, and fabric supports and transportation fares to and from hospital.

Table 6
Time Period Between Arrival and Eligibility for Health Services Coverage as per Immigration Status: According to Country

Categories of Immigration Status	**Canada**[a]	Australia	Netherlands	New Zealand	Sweden	United Kingdom
Permanent Residents	**V**	2 years	I	I	3 mos.	I[b]
People with Employment Authorization	**V**	2 years	I	I	N	U
Students	**V**	N	N	N	N	U
Refugees	**V**	J	J	V[c]	J	V[d]
Refugee Claimants/ Asylum Seekers	**V**	6 months [e]	U	V[f]	U	V[g]

[a] Refer to Table 3.
[b] A person living in the United Kingdom for a settled purpose for more than six months is covered.
[c] Length of time for obtaining the Community Services Card, which entitles refugees to coverage, may vary.
[d] There is a registration process for determining free entitlement to services and this may delay access to coverage. For exemption from standard charges, there is also an application process, which is only available in English, is lengthy and requires renewal after 6 months.
[e] It takes 6 months for eligible claimants to be given financial assistance under the Asylum Seeker Assistance Scheme (ASA). There is immediate coverage for those in detention centres and for those with valid visas with work rights.
[f] Length of time for obtaining the Community Services Card, which entitles asylum seekers to coverage, may vary. Eligible only once they have lodged a claim and are awaiting a hearing.
[g] There is a registration process for determining free entitlement to services and this may delay access to coverage. For exemption from standard charges, there is also an application process, which is only available in English, is lengthy and requires renewal after 6 months.

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