

Health Services for Refugees in the United States: Policies and Recommendations

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Abstract

Some of refugees, who were forced to move out from a home country due to political or religious conflicts, war or natural or manmade disasters, resettle in another country. Resettlement in another country is challenging as refugees suffer from a number of mental and physical health problems. Under the Refugee Act of 1980, the United State (US) governments provide medical assistance as well as financial and immigration legal assistance. Yet, it is still challenging to ensure health and well-being of refugees who have diverse social and health conditions and needs. This study reviewed federal policies and limitations on refugee health in the US, which accepts the largest number of refugee resettlements in the world. The reviewed policies include health insurance policies, health promotion policies, the Survivors of Torture Program, and medical screening. Some refugees still have limited accessibility to services due to difficulties in understanding the healthcare system even when they are eligible for many of the services. While most policies on refugee health mainly focus on the early stage of resettlement and infectious disease screening, follow-up services for chronic conditions are essential to ensure health and well-being of refugees. Because social factors affect health of refugees, it is necessary to provide services that address social and health issues. There are several recommendations to improve policies and services to better serve refugee populations who resettled in the US. First, more comprehensive health promotion and education programs are necessary for refugees to better understand the US healthcare system and healthcare. Second, long-term follow-ups which include chronic health conditions are important to improve health of refugees. Lastly, social and health issues should be integrated with a bidirectional approach which supports both refugees and existing communities.

Keywords: refugees, physical and mental health, resettlement, federal policies, United States

1. Introduction

The United Nation High Commission for Refugees (UNHCR) Convention in 1951 describes a refugee as a person who is "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of 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, 2014a). There were more than 11 million refugees in the world in 2014 (UNHCR, 2015a). Approximately 8% of refugees resettle in another location (often another country) which provides safe and protected living environments to refugees (UNHCR, 2015b). The global resettlement needs have been increasing (UNHCR, 2015b). The United State (US) was the top country of resettlement in 2014 followed by Canada and Australia (UNHCR, 2014b). The top three countries of origin among refugees who submitted resettlement in 2014 include Syria, Congo and Myanmar (UNHCR, 2014b).

While resettlement provides safe living conditions to refugees, resettlement in another country is often challenging. Resettlement processes, language barriers, social isolation, and acculturation are inevitably stressful (Yako & Biswas, 2014). Refugees suffer from a number of mental health problems. Anxiety, depression, and Post Traumatic Stress Disorder (PTSD) are common mental health problems among refugees (Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015; Jamil, Farrag, Hakim-Larson, Kafaji, Abdulkhaleq, & Hammad, 2007). The causes of PTSD range from focal events to prolonged trauma and in the refugee case many times torture (Gjini et al., 2013). These mental health issues can be associated both with trauma suffered before and during relocation, as well as the barriers to acclimation existent in the countries of resettlement (Kirmayer et al., 2011).

In addition to mental health issues, long-term as well as acute physical health trends exist in the refugee populations who resettled in another country (Bhatta, Shakya, Assad, & Zullo, 2015; Redditt, Janakiram,

Graziano, & Rashid, 2015; Wagner et al., 2015). Refugees suffer from chronic conditions such as type 2 diabetes (Wagner et al., 2015), heart disease, hypertension, overweight/obesity and cancer (Bhatta, Shakya, Assad, & Zullo, 2015) as well as infectious diseases such as HIV, hepatitis B, and hepatitis C (Redditt, Janakiram, Graziano, & Rashid, 2015). Chronic conditions are often related to the lack of knowledge of nutrition (Rondinelli et al., 2011) and physical inactivity (Wieland et al., 2012). Although some infectious diseases are vaccine preventable, immunization rates among refugees are not necessarily high: for example, a rate of eliminated wild poliovirus immunity among recently resettled refugees in the US was less than 60% (Roscoe, Gilles, Reed, Messerschmidt, & Kinney, 2015). Some refugees have disabilities, however, disability services for refugees are very limited in the US (Mirza & Heinemann, 2012).

Ideally, nations that accept refugees as a tertiary resettlement country are capable of providing assistance to access to health care, housing, and financial opportunity. Each of the nations has a department of refugee health incorporated into the national government (e.g. Government of Canada, 2015; Office of Refugee Settlement, 2015). Refugees experience barriers to health care because of limited accessibility and availability of services (Edward & Hines-Martin, 2015). In addition, it is important to provide culturally appropriate health and health related services to refugees to ensure their well-being (Stewart et al., 2015). The US enacted the Refugee Act in 1980 (Kennedy, 1981). Under the Refugee Act of 1980, the US governments provide medical assistance as well as financial and immigration legal assistance (Office of Refugee Settlement, 2012). Yet, it is still challenging to ensure health and well-being of refugees who have diverse social and health conditions and needs. The purpose of this study is to review US federal refugee health policies and their limitations and to address recommendations to improve policies and services for refugees who resettled in the US. This study contributes to the increased knowledge about refugee health policies not only for the US but also for other developed countries which accept refugees.

2. Review of US Federal Policies and Limitations

2.1 Policies

The Office of Refugee Resettlement in the US Department of Health and Human Services has policies to ensure health and well-being of refugees (Office of Refugee Settlement, 2015). The Center for Disease Control and Prevention (CDC) offers pre- and post- arrival medical screening guidelines for refugees (CDC, 2015). The CDC's guidelines are to assist state health departments which actually provide services to refugees (CDC, 2015). Some states take more refugees than others (Office of Refugee Settlement, 2015). There are variations in services that offer to refugees across states (Office of Refugee Settlement, 2015).

2.2 Policy: Health insurance

The Refugee Medical Assistance (RMA) is available for up to eight months starting when they enter the US or are granted qualifying immigration status (Office of Refugee Resettlement, 2015). Medicaid or the Children's Health Insurance Program (CHIP) is available for refugees who meet the eligibility requirements of the programs. After refugees are on the RMA for eight months, they are eligible to apply for health insurance through the Market Place of the Patient Protection and Affordable Care Act (ACA).

2.3 Limitations: Health insurance policy

The percentage of uninsured individuals decreased from approximately 18% to 9% after the introduction of the ACA (Hall & Lord, 2014). However, it is predicted that 36 to 45 million individuals will still be uninsured by 2019 (Geyman, 2015). Low-income families reported barriers to insurance coverage, access to healthcare services, and healthcare costs (DeVoe, et al., 2007) These barriers remain regardless whether they are eligible for healthcare coverage through the ACA (Sommers, Maylone, Nguyen, Blendon, & Epstein, 2015). Research indicates that the lack of knowledge is a significant problem when promoting enrollment in the ACA insurance (Evans & Demko, 2014). Uninsured visits remain high, especially in states that opted out of Medicaid expansion (Angier, et al., 2015). Approximately 44% of refugees resettled in a state that did not expand Medicaid (Agrawal, & Venkatesh, 2015). Thus, not all refugees who are eligible for the ACA insurance would actually obtain health insurance. For example, one fourth of Iraqi refugees do not have health insurance (Taylor et al., 2014). Furthermore, refugees may need expanded health insurance coverage due to high burden of chronic conditions (Yun, Fuentes-Afflick, & Desai, 2012). Even though refugees are theoretically covered by health insurance, they still have a risk for being un- or under- insured.

2.4 Policy: Health promotion

In 2015, the Refugee Health Promotion Program (RHP), formerly the Refugee Preventive Health Program, has been implemented (Office of Refugee Resettlement, 2015). The RHP emphasizes health literacy and access to healthcare services and to affordable care, and provides services on screening, preventive care, interpreter services, and health education, from arrival to self-sufficiency.

2.5 Limitations: Health promotion policy

One of the major limitations of the health promotion policy is that it relies heavily on self-sufficiency in navigation of a complex system. In reality, since many refugees find it difficult to be self-sufficient in the short-term because of language barriers, limited opportunities to obtain stable employment, and physical and/or mental health problems, it is important to have longitudinal perspectives in policies and services (Beiser, 2006). Barriers to access to care experienced by refugees are complex and include not only language barriers and the lack of health insurance but also unemployment, the lack of transportation and distrust of physicians (Elwell, Junker, Sillau, & Aagaard, 2014).

2.6 Policy: Survivors of Torture Program

It is estimated that 5 to 35% of refugees have been tortured (Office of Refugee Resettlement, 2015). The US enacted the Torture Victims Relief Act (TVRA) in 1998 (TVRA) (Office of Refugee Resettlement, 2015). The TVRA aims at providing rehabilitation, social and legal services to survivors of torture and research and education programs to healthcare providers to better help survivors of torture.

2.7 Limitations: Survivors of torture policy

The services for survivors of torture focus on mental health services as survivors of torture have high prevalence of PTSD and depression (Asgary, Charpentier, & Burnett, 2013; Song, Kaplan, Tol, Subica, & de Jong, 2015). But, survivors of torture also have difficulties in the issues not directly related to health such as unstable housing (Song, et al., 2015) and financial and legal insecurity (Chu, Keller, & Rasmussen, 2013). In addition, social and health needs among survivors of torture are not necessarily well recognized (Asgary, Charpentier, & Burnett, 2013).

2.8 Policy: Pre- and post- medical screening

The pre-medical screening is conducted days to weeks before the arrival in the US and includes screening and treatment (if necessary) of infectious disease such as malaria, tuberculosis and parasites, and immunization (CDC, 2015). The post-medical screening is conducted in 30 to 90 days after the arrival in the US and involves screening of infectious disease, mental health, lead, nutrition and growth, and immunization (CDC, 2015).

2.9 Limitations Pre- and post- medical screening policy

Because some of the health issues that are found at medical screening can affect health of refugees for long-term after the arrival in the US, it is important for local healthcare providers to use the CDC's medical screening guidelines and to provide follow-ups (Shah et al., 2014). Even after refugees receive pre- and post- medical screening, they may suffer from unrecognized and/or untreated physical and mental health conditions (Rew, Clarke, Gossa, & Savin, 2014). It is also challenging to fully implement the CDC's guideline due to barriers of logistics and costs (Stauffer et al., 2013). Unlike people who are legally defined as refugees, legally defined asylum seekers, who suffer from similar health conditions to refugees, do not have prompt access to medical screening (Chai, Davies-Cole, & Cookson, 2013). For example, health services for refugees in the State of Utah are primarily designed for refugees who were on the refugee resettlement process initially approved by the Department of State and the Department of Homeland Security (Utah Department of Health, 2015). Asylum seekers can receive mental health services in Utah (Utah Department of Health, 2015) although they may not receive other health services for refugees.

3. Discussion

This study reviewed federal policies on refugee health in the US, which include health insurance, health promotion, the Survivors of Torture Program, and medical screening, and their limitations. There are three main findings. First, some of the refugees still have limited accessibility to services due to the difficulties in understanding the healthcare system and health care even when they are eligible for many of services. Second, while most policies on refugee health mainly focus on the early stage of resettlement and infectious disease screening, follow-up services for chronic conditions are essential to ensure health and well-being of refugees because health conditions from which refugees suffer can have long-term health effects. Third, because social factors would affect health of refugees, it is necessary to provide services that integrate social and health issues. The results of the review of the policies suggest that the current refugee health policies do not necessarily ensure the accessibility of the services for refugees. Besides language barriers and the lack of sufficient health insurance, the difficulties in understanding the healthcare system is a significant obstacle to utilize health care services for refugees (Mirza et al., 2014). In addition, the lack of knowledge is an issue that refugees do not utilize available services. For example, due to the lack of knowledge about cervical cancer or a Pap test, Bhutanese refugee women have a significant barrier to cervical cancer screening (Haworth, Margalit, Ross,

Nepal, & Soliman, 2014). The other example is that mental health among Hmong refugees and immigrants: While they suffer from mental health issues such as depression and PTSD, they are not aware of needs for mental health interventions because they are not sure about what mental health means (Collier, Munger, & Moua, 2012). More comprehensive health education programs should be provided to refugees to increase their knowledge of the US health care system and healthcare.

Based on the results of the review, it is recommended to add long-term follow-ups for chronic health conditions. While the CDC's medical screening mainly focuses on infectious diseases and acute conditions, it is necessary to cover chronic conditions and to provide repeated testing of infectious diseases in long-term to improve health of refugees (Dicker, Stauffer, Mamo, Nelson, & O'Fallon, 2010). One major issue with refugee health is the lack of follow-up with subsequent care after diagnosis or the beginning of a medication regiment (Kowatsch-Beyer, Norris-Turner, Love, Denkowski, & Wang, 2013). The scheduled appointments, telephone reminders and transportation arrangements helped increase the follow-up rates at a local public health clinic referred from medical screening for refugees (Kowatsch-Beyer et al., 2013).

Furthermore, the results of the review show that social factors would affect health of refugees. For example, unstable housing situation is associated with adverse mental health outcomes among refugees resettled in the US (Song, et al., 2015). Peer pressure in the refugee community can increase negative health behaviors such as tobacco smoking (Giuliani et al., 2008). Social development which includes the existing communities is important to reduce misunderstanding about refugees among residents in the existing communities and to improve social well-being of refugees (Sanders, 2006). Bidirectional approaches, which supports refugees and existing communities, are keys for successful resettlement (Smith, 2008). It is recommended that services for social and health issues would be better integrated from a bidirectional perspective.

4. Conclusion

This study reviewed US federal policies on refugee health and their limitations and made several recommendations to improve policies and services to better serve refugee populations who resettled in the US. First, more comprehensive health promotion and education programs are necessary for refugees to better understand the US healthcare system and healthcare. Second, long-term follow-ups which cover chronic health conditions are important to improve health of refugees. Third, social and health issues should be integrated with a bidirectional approach which supports both refugees and existing communities. The knowledge about effective health promotion programs for refugees needs to be increased. Longitudinal studies that analyze how the quality and quantity of available services for refugees affect their health should be developed. It is important to empirically test the impact of accessibility to health and social services on refugee health. Future research should examine the impact of policies on the health outcomes of refugees and focus on the implementation of policies and programming to provide easier facilitation for refugees to access healthcare.

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