The Healthy Immigrant Effect:
A Policy Perspective

By

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Abstract

The Healthy Immigrant Effect (HIE) is the term given to the phenomena of immigrants arriving to Canada with stronger health than their Canadian-born counterparts. However, immigrant health experiences a steep decline over time since migration to reach the Canadian-born population's health levels or lower. This paper examines the HIE from a policy perspective in the Canadian context by centering on the barriers and facilitators of migrant health. Data was used from the 2018 Canadian Community Health Survey to observe variations among immigrants and the Canadian-born population in both self-perceived health status and the variables related to health service utilization using logistic and linear regression models. A comprehensive policy model is recommended to make immigrant health a priority for both federal and provincial governments, including a migrant sensitive health strategy complemented by mandatory cultural sensitivity training for providers and administrators, and the inclusion of migrant-specific variables in the national health census.

Keywords: immigrant health; healthy immigrant effect; health policy; migration

Dedication

For my parents.

Acknowledgements

I would like to thank my supervisor, Maureen Maloney, for her support and direction throughout this process. I would also like to thank my family and friends for their encouragement and support during the entirety of my masters program.

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List of Acronyms

AMSSA	Affiliation of Multicultural Societies and Service Agencies of BC
BC	British Columbia
CCHS	Canadian Community Health Survey
EU	European Union
HIE	Healthy Immigrant Effect
HC	Health Canada
HSU	Health Service Utilization
IOM	International Organization for Migration
IRCC	Immigrant, Refugees and Citizenship Canada
IRPA	Immigration Refugee Protection Act
LAC	Library and Archives Canada
MCIIT	Ministry of Citizenship, Immigration and International Trade
MHBC	Multicultural Health Brokers Cooperative
MSP	Medical Services Plan
NPHS	National Population Health Survey
OCASI	Ontario Council of Agencies Serving Immigrants
OHIP	Ontario Health Insurance Plan
PHSA	Provincial Health Services Authority
RDC	Research Data Centre
SFU	Simon Fraser University
SMP	Skilled Migrant Programme
UK	United Kingdom
US	United States
WHO	World Health Organization

Executive Summary

23 percent of Canada's population is foreign-born. As enforced by selection mechanisms, immigrants arrive young, healthy, and skilled (referred to as the Healthy Immigrant Effect (HIE)) and consequently lower health care costs and contribute to a productive workforce. However, extensive research on immigrant health has shown that Immigrants face a steeper decline in health over time, measured through standard health indicators, than the Canadian-born population. This well-observed phenomenon has not been a priority for the Canadian government to address thus far. This study seeks to address the problem of too many immigrants experiencing poorer health over time in Canada. For immigrants to succeed and contribute to the economic growth of the country, they must arrive, and remain, healthy. Therefore, research and data on the health of immigrants is of great importance to public health, economic analysis, and immigration policy in Canada.

Although the HIE has been long observed in Canada, factors for declining immigrant health over time have not been well understood. The literature points to a range of barriers and facilitators of health care access and utilization that are unique to immigrants. A jurisdictional scan of comparable immigrant-receiving countries identified patterns in policy and practice that influence immigrant health directly and indirectly. Quantitative analysis was used to observe the data on immigrants in comparison to their Canadian-born counterparts using the 2018 cycle of the Canadian Community Health Survey, highlighting the persistence of variance between the two groups.

Three policy options were identified to address this problem with a comprehensive approach. An evaluation framework with primary objectives of the protection of health and equity in access to health services was used to assess policy options. It is argued that the responsibility of immigrant health lies with federal and provincial governments. As such, the primary recommendation of a migrant sensitive health strategy will prioritize this issue nationally and require all levels of government to put forward policies with considerations for migrant health. Secondary policy options of cultural sensitivity training for health care professional and stronger monitoring of migrant health over time complement the strategy.

Chapter 1.

Introduction and Policy Problem

The healthy immigrant effect (HIE) is the term given to the phenomena of immigrants reporting stronger health at the time of arrival in Canada compared to the Canadian-born population. This effect has been studied and well-documented in immigrant-receiving countries such as Canada as early as1996 (Biddle, Kennedy, McDonald, 2007). However, this effect significantly reduces within a relatively short period of time – five to ten years post-immigration – resulting in similar to or poorer health than their Canadian-born counterparts. The HIE has been studied extensively and the impact still persists in Canada among a variety of immigrant types (Lu and Ng, 2019). It is important to note that the HIE applies most strongly to immigrants who choose to migrate and less so to groups such as refugees and asylum seekers. This study will mostly focus on self-selected immigrants; however, due to limitations in research for self-selected immigrants, analysis and policy options will be inclusive of all migrant groups.

The selection mechanisms for immigrants admiited to Canada are one of the key drivers of the HIE. Self-selection occurs by immigrants who have desirable characteristics of success in the migration process, such as higher education levels, language proficiency, and employable skills. State-driven selection mechanisms are related to the policy and legislation in place that impacts who is accepted as an immigrant. This includes grouping immigrants who may be more successful in integrating and contributing to Canadian society into categories such as economic class or skilled workers. Legislation such as the *Immigration Refugee Protection Act (IRPA)* directly impacts who is granted admission into Canada for long term stay. The IRPA was recently amended to include new categories of migrants who would not require a medical admissibility test, such as refugees and family-class applicants (Lu and Ng, 2019).

Selection mechanisms may explain why the HIE exists to a large extent; however it does not explain why the health of immigrants declines over time so significantly. Within the HIE literature, there is consensus that greater research into the factors

influencing the HIE is required to understand the root causes in order to take steps to address them. Some preliminary studies have shown factors such as challenges accessing health care services and significant dietary changes as possible contributors to this decline (Fuller-Thomson, Noack, and George, 2011); however the research is not extensive and does not allow for causal links to be drawn.

The provincial jurisdiction of health care poses a challenge in equal care across the country, and further creates a challenge in understanding the decline in immigrant health over time. To this point, there has not been research looking specifically at the variance and unique characteristics of the regions that may be acting as barriers or facilitators of health outcomes.

The health of immigrants over time has not been a central focus of policy making; the preservation and improvement of immigrant health needs to be prioritized at the national level. This study aims to address the following policy problem: Too many immigrants are experiencing poorer health over time in Canada. There is a need to explore the barriers for the maintenance of stronger health among immigrants and the facilitators of a significant gap between the health of immigrants and non-immigrants in order to identify and propose policy options that contribute to equity in health status. This research will add to the literature in the field by investigating the contrast between the health of immigrants and non-immigrants over time in Canada from a barriers and facilitators approach with the purpose of identifying possible solutions from a policy perspective.

This project uses a mixed-method research approach, including a literature review, three descriptive jurisdictional scans, and quantitative analysis using datasets in the Statistics Canada Research Data Centre (RDC). The analysis will use the 2018 Canadian Community Health Survey (CCHS) to observe health indicators and barriers and facilitators of health care access. The outcomes of the research were used to identify the following policy options that will effectively target declining immigrant health: 1) migrant sensitive health strategy; 2) cultural sensitivity training for professionals; 3) monitoring of migrant health. The policy options were analyzed using an evaluation framework with the key objectives of protection of health and equity in access to health services.

Chapter 2.

Background

International migration describes the movement of individuals across an international border away from their place of origin to settle in a new country. Migration occurs for a number of reasons; in a more globalized world, many migrate for business, cultural exchange, education, or to seek a new home for their families. Much of global migration has also been due to involuntary needs of relocation including conflict, persecution, environmental degradation and natural disasters, and lack of security or opportunity in one's home country (McAuliffe and Ruhs, 2017). The number of international migrants has increased significantly over the last couple of decades, reaching 244 million people in 2015, which equals 3.3% of the global population (McAuliffe and Ruhs, 2017). Although growing, this value is still a small portion of the population and most people remain in their country of birth.

Canada has been experiencing a growing number of immigrants admitted year after year from 205,000 in the year 2000 to 303,200 in 2018, increasing the foreign-born population to 23% of the national population (Statistics Canada, 2019). With larger incoming numbers, the health of immigrants continues to shape the health profile of all Canadians (Z.M. Vang et al, 2017).

Migration policy is a key issue for most immigrant-receiving countries, including Canada. With an aging population and low reproduction rates, migration is a significant part of Canada's population and economic growth. The admitted immigrant population is largely young, healthy, and skilled—as Canada's selection policies enforce—and they consequently lower health care costs and contribute to a productive workforce (Kennedy et al. 2014). As important as immigrants are for the future of Canada, policy focused on sustaining and supporting immigrant health goes without much consideration. For immigrants to succeed and contribute to the economic growth of the country, they must arrive, and remain, healthy. Therefore, research and data on the health of immigrants is of great importance to public health, economic analysis, and immigration policy in Canada.

Chapter 3.

Methodology

A mixed-method research approach including a literature review, jurisdictional scan, and quantitative analysis, is used to investigate the two primary research questions to examine the Healthy Immigrant Effect:

1. Is the healthy immigrant effect persistent over time for new immigrants in Canada?
2. What are the barriers and facilitators that contribute to the health of immigrants in Canada?

3.1 Literature Review

The methodology for this project begins with a literature review of related Canadian and international research. The review includes peer-reviewed academic articles, book chapters, government webpages, and websites of organizations and related programs. The literature review supports the narrowing of the problem through a thorough analysis of the existing data.

3.2 Jurisdictional Scan

The jurisdictional scan consists of three comparable countries to Canada: United States, Australia, and the United Kingdom. These three immigrant-receiving countries were chosen for their comparability of immigrant distribution, annual immigration flow and admission requirements, and advanced health systems. The cases will aid in understanding experiences of immigrants within different contexts and political systems, and the impact of varying policy on the health of immigrant populations.

3.3 Quantitative Analysis

Understanding the variables associated with the HIE is an important part of the research. Quantitative analysis conducted using microdata files accessed through the Research Data Centre (RDC) supports the exploration of the relevant variables. The

analysis used data from the Canadian Community Health Survey (CCHS) 2018 cycle for the most recent data available.

The CCHS contains information related to the experience of Canadians with the health care system such as access to a regular family physician as well as indicators of barriers to access that may have a relationship with individual health status. Through the data, the variation in interactions with the health care system and health service utilization by both the Canadian-born population and immigrants was identified.

The analysis consists of both descriptive statistics and regression modeling. Descriptive statistics look at the characteristics of immigrants over time. The CCHS data is weighted using the bootstrap method for more accurate variance statistics. The regression analysis connects independent variables to dependent variables within the CCHS Annual Component. The data was analyzed using the statistical program Stata.

Table 3.1. List of variables observed within the CCHS 2018 Cycle

CCHS – Annual Component 2008 and 2018
Dependent Variables:
Self-perceived health of person
Difficulties seeing a specialist
Regular provider of person
Barriers to improving health of person
Usual place for care for minor problem
Independent Variables:
Immigrant status of person, category
Years since immigration of immigrant, category
Sex of person, category
Geography

3.4 Study Limitations

The limitations of this methodology are twofold. The data analysis is limited due to the following factors: 1) CCHS data is captured with variable surveys over the last two decades and therefore does not allow for greater longitudinal analysis of the same survey questions; 2) CCHS questions related to health care access and utilization are optional and therefore do not allow for comparative analysis.

Secondly, qualitative surveys or interviews were not conducted due to time and an evaluation of the extent to which it would add to the study. Speaking with allied health professionals and organizations supporting migrant health could have provided further qualitative understanding of the issue from the perspective of those working within the health care system and interacting with both immigrant and Canadian-born individuals and families.

Chapter 4.

The Healthy Immigrant Effect

The healthy immigrant effect (HIE) is identified as the phenomenon whereby immigrants arrive healthier than the native-born population in the receiving country. As time passes, however, the health of immigrants tends to converge, and often, fall below the levels of the receiving population. This section will highlight the measurement of the HIE and provide evidence from a Canadian perspective.

The measures most commonly used to provide evidence for the HIE are self-perceived health, Health Utilities Index, disability, mental health, chronic conditions, and mortality (Newbold, 2017). Consistency in the measures used to identify and compare the health of populations is important. Therefore, the two main measures used in most studies to determine the HIE are chronic condition diagnoses and self-perceived general health status. Chronic conditions can include diagnoses of any of the following: cancer, heart disease (including coronary heart disease, angina, heart attack, and other), diabetes, arthritis, and hypertension. Although a subjective measure, self-reported general health status has continued to be an indicator of health and allows individuals to consider a rating of their health status overall based on a five-point scale: poor, fair, good, very good, and excellent. When observed through self-reported health, the measure of the HIE has remained the same or similar in the 10-year span of 2000-2010 in Canada (Blair and Schneeberg, 2013).

A number of surveys have captured the variation in reporting of the two main health measures between immigrants and native-born Canadians, including the National Population Health Survey (NPHS) and the CCHS. Table 4.1 below displays evidence for the HIE based on the NPHS, which followed randomly selected individuals over the period of 1994-2000. This survey included Canadians who were native-born, foreign-born and recently arrived immigrants. The results displayed most clearly the shift in reporting of both chronic conditions and fair or poor health status for recent immigrants captured beginning in 1994. The variation among population groups is significant, with a 20 percent increase in recent immigrants reporting chronic conditions compared to a 10 percent increase in native-born Canadians, as well as a 13 percent increase in reporting

fair or poor health by recent immigrants from last captured date of 2000/01 (Newbold, 2017).

Table 4.1. Difference in reporting of chronic conditions and self-perceived health status between immigrants, recent immigrants, and non-immigrants in Canada, from 1994-2000

% Fair or Poor Health	**1994/95**	**2000/01**
All Immigrants	10.1%	15.9%
Recent Immigrants (arrived 1990-1994)	3.9%	17.0%
Non-Immigrants	9.1%	12.6%
% Reporting Chronic Conditions		
All Immigrants	55.7%	69.0%
Recent Immigrants (arrived 1990-1994)	26.5%	46.2%
Non-Immigrants	55.9%	65.8%

Source: Reproduced from Newbold (2017). Results based on NPHS 1994/95-2000/01

A number of variables are identified as impacting the HIE. The health advantage of recent immigrants is especially strong for visible minorities, and persists when adjusted for differences in age, economic status, or health behaviors between the visible minority groups (Kobayashi and Prus, 2012). This group arrives healthiest but is also most likely to experience declining health (Newbold, 2017). In a study comparing immigrant health in four immigrant-receiving countries, it was identified that immigrants from developing countries experience a stronger decline in health than those from developed countries (Kennedy et al, 2014). However, it is interesting to note that immigrants from developed countries are also healthier than the native-born in their new country and their country of origin – such as Americans who migrate to Canada in comparison with their American-born and Canadian-born counterparts (Kennedy et al, 2014). Looking closely at Canada, Table 4.2 below shows the breakdown of immigrants based on region of origin. The two primary measures of health are compared between immigrants and native-born Canadians from the same regions of origin.

Table 4.2. Difference in prevalence (%) of chronic conditions and self-assessed health status between immigrants and non-immigrants by region of origin, Canada

Region of Origin	**Chronic Conditions**	**Self-Assessed Health**
All Foreign-Born	- 0.11	0.11
Middle East	- 0.11	0.00
South Asia	- 0.09	0.13
East/Southeast Asia	- 0.15	0.17
Continental Europe	- 0.09	0.14
Africa	- 0.10	0.00
Central America (including Mexico)	- 0.18	0.12
South America	- 0.21	- 0.13

Source: Kennedy et al, 2014

This numerical representation of the health of immigrants in comparison to native-born individuals from the same regional backgrounds is supportive of the strength of the HIE. For example, Middle Eastern immigrants are compared with Canadians whose parents or grandparents were born in the Middle East. This comparison displays stronger support of the HIE as being directly linked to immigrant status and not such factors as ethnicity, while observing that ethnicity contributes to a variance in the extent of the HIE. Additionally, most immigrants from different regions experience a narrow range of variation in the measures. Understanding the evidence for the HIE is an important first step to specific and focused strides toward supporting the health of immigrants over time.

Chapter 5.

Factors For Stronger Immigrant Health at Arrival

The HIE has been widely accepted as a phenomenon present in most immigrant receiving developed countries. The literature outlines a number of potential explanations for the reasons why this may be, including: state level selection mechanisms such as health screening or selection criteria; immigrant self-selection where the healthiest (and often wealthiest) individuals are more likely to migrate; and the salmon bias where the least successful immigrants may return home within a short time post migration.

Migrants are a self-selected segment of the population – not every individual has the health, economic, and educational ability to undergo migration. Quantifiable factors such as education level, as well as unobservable factors such as resilience, contribute to whether or not individuals and families choose to migrate (Z.M. Vang et al, 2017). The migration process is not easy and for that reason alone only a small portion of the population can undergo it. The decision to migrate is based on a comparison of costs and benefits, and the evaluation of implications for individuals and families in the country they migrate to as compared to their country of origin. Costs of migration are not minimal and continue to rise, meaning the population who migrates will have the means to take the journey and will have greater certainty of the benefits gained in the receiving country; hence, the costs of migration will be too high for those who may be unsure of the potential benefits of their migration (Kennedy et al, 2014). Characteristics beyond wealth that are correlated with successful migration are education and skills, which are positively correlated with health status. Recent immigrants (within 10 years of migration) are twice as likely to be university educated than their Canadian-born counterparts (Kennedy et al, 2014). With the increasing costs of migration and the self-selection factors considered, the gap in health between migrants and their associated non-migrant counterparts will continue to grow in magnitude.

State imposed selection is in the form of policies and procedures that immigrants must abide by before they are permitted admittance. The positive health and social selection is a result of processes such as undergoing a medical examination and a point system selecting for greater human capital (Z.M. Vang et al, 2017). Many immigrant-

receiving countries actively court highly skilled immigrants. Canada attracts younger and more educated immigrants through a skilled immigrant intake system that gives points based on age, education and language proficiency levels (Kennedy et al, 2014). These systems support an incoming population that can contribute to labour market success in the host country. The existence of medical examinations for admissibility has also proven to be a contributing factor for a healthier immigrant intake. Medical examinations are primarily in place to reduce potential health and economic burden on the receiving country. Canada has a low rejection rate based solely on the medical exam; however, the mere existence of the exam may turn away potential applicants due to fears of their health conditions being a barrier (Z.M. Vang et al, 2017).

Without the application of the medical examination on certain immigrant groups, the HIE is still proven to exist. The *Immigration Refugee Protection Act (IRPA),* passed in 2001, increased the categories of immigrants who would not require a medical admissibility test, such as refugees and family-class applicants (Lu and Ng, 2019). Variation in health exists between various immigrant groups, however in the report by Lu and Ng they state that health advantages persist in immigrants who have arrived under the recent IRPA, even after adjustment for socioeconomic and health factors (2019). This indicates that state imposed selection mechanisms do not hold sole responsibility in the explanation for the HIE.

Further, not all migrants will choose to settle in their host country upon arrival. The return of less successful migrants to their countries of origin is known as the *salmon bias* and it can reduce the already small advantaged portion of the population who choose to migrate (Z.M. Vang et al, 2017). The salmon bias is described as selective return migration of those who are less healthy or economically successful to their source countries (Diaz et al, 2016). The evidence for the salmon bias is limited, though has been identified as a possible contributor of negative health selection for Mexican migrants in the US and Turkish migrants in Germany (Wallace and Kulu, 2014). The decision to return home may be more strongly motivated by the availability of health care and social services in the host country, as well as ties to culture and family in the origin country of individuals (Wallace and Kulu, 2014). For example, research has suggested that improved healthcare access and broadening social networks for Turkish immigrants in Germany have removed health-related motives from Turks' decisions to return home

(Razum et al., 2006). The potential motivators for individuals to return to their countries of origin are an important consideration for overall health status of immigrants over time.

Chapter 6.

Factors For Declining Immigrant Health Over Time

The reasons behind the deteriorating health of immigrants over time are not empirically identified and understood; however, multiple possible explanations have been recognized through preliminary research on specific groups of immigrants.

Acculturation is one such identified explanation. Defined as the temporal process by which individuals adopt the behaviours and attitudes of the host society, acculturation impacts the health of immigrants over time (Wallace and Kalu, 2014). Although the process is associated with both positive and negative health behaviours, health status declines with acculturation (Wallace and Kalu, 2014). With acculturation, culture and norms of migrant groups shift to include riskier behaviour, such as increased alcohol consumption and reduced physical activity, and a significant shift in diet (Wallace and Kalu, 2014). For Mediterranean migrants, diet is identified as vital to chronic disease protection (Darmon and Khlat, 2001), and this is identified as a key determinant of health decline for most migrant groups in the US and Europe. In Canada, acculturation has been associated with increased alcohol consumption, smoking, and dietary changes that decline health status over time (Gee et al., 2003).

A scoping review by Kalich, Heinemann and Ghahari identified multiple studies highlighting the experience of immigrants with the health care system being stifled by barriers (2016). Some such barriers include, cultural differences, language, lack of information about how to access or navigate services, lack of health literacy, and the need for self-advocacy within the health care system. Newbold and Danforth (2003) discuss the impact of culturally specific belief patterns of illness, health, and health seeking behaviors on approaches to illness and health. Across multiple studies, gender was also a determinant of health status and decline. Female immigrants reported lower self-reported health compared to their female Canadian-born counterparts as well as both immigrant and Canadian-born males (Newbold and Danforth, 2003). However, this variation was not captured to be significant across populations and time and therefore the analysis maintains male and female immigrants together as a group.

An assumption could be made that as immigrants integrate into the rest of Canadian society, they learn the skills necessary to navigate the health care system. However, the data shows that the decline in health is most apparent ten years post immigration. Therefore this suggests that greater research is required to understand why the barriers persist and whether specific groups are impacted more. This recommendation for further research was found in numerous articles where this significant limitation of further understanding the barriers of health care access exists.

Immigrants have also shown a reduced rate of health service utilization (HSU) compared to the Canadian-born population. Recent immigrants face barriers to the use of health services due to factors such as language or cultural differences and difficulties navigating a new health care system (McDonald and Kennedy, 2004). The barriers faced by immigrants may result in an increased likelihood in conditions persisting undiagnosed (McDonald and Kennedy, 2004). A list of barriers and facilitators impacting immigrants' access to health care more directly include: (1) cultural barriers; (2) language/communication; (3) organization and quality of services; (4) health literacy; and (5) social capital (Batista et al, 2018). Social capital includes social networks and supports, contributing significantly to integration and health status. Recognizing the importance of these factors, it is important to define how they fit with the concept of access.

The concept of access is explored and defined from a systems perspective by Penchansky and Thomas (1981). *Access* is defined as a concept representing the degree of suitability between the clients and the system, and includes the following dimensions:

Availability – the relationship of the supply and type of existing services to the clients' demands based on needs, and ability to access those services

Accessibility – relationship between location of the supply and location of clients

Accommodation – relationship between the manner in which the supply is organized to accept clients and the clients' demands to acquire those services (e.g. evening and weekend clinic hours)

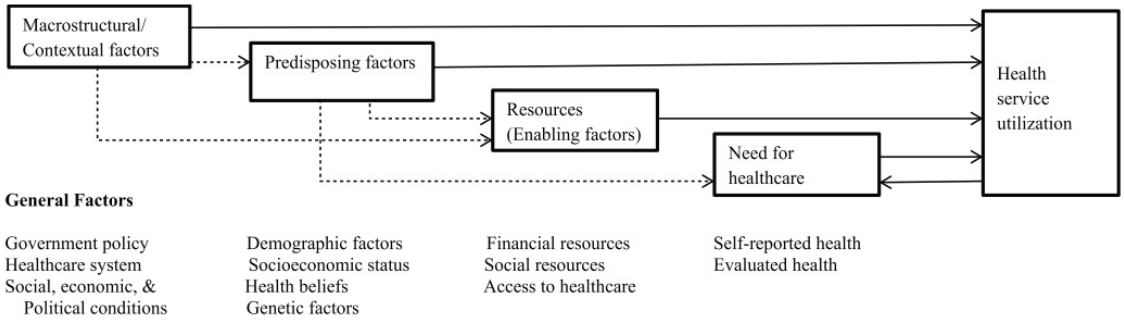
Affordability – relationship between the prices of supply and the client's coverage or ability to pay

Acceptability – relationship between clients' attitudes about personal and practice characteristics of providers and the actual characteristics of providers, and vice versa for provider's perception of clients' characteristics (e.g. consumer reaction to attributes such as sex, age, ethnicity, type of facility and neighbourhood of provider)

These definitions support an understanding of the complexity of access and the considerations necessary to inform a health system that is accessible to all, and that will encourage its utilization.

The multitude of factors that influence the HSU of immigrants are often left out of the discourse of health care and motivators of its utilization (Yang and Hwang, 2016). As a consequence, underutilization of health services is directly linked with poorer health conditions, including more serious health problems escalated due to the lack of early intervention, longer hospital stays, and heightened mortality rates (Yang and Hwang, 2016). The Andersen health behaviour model is the leading theoretical model helping to explain the individual's interaction with the health care system. Since its initial version in 1968, the model has been reworked with consideration of its limitations three times to reach Phase 4 in 1995. The various versions highlight five categories of determinants to health care use. These include: predisposition to health service use, such as demographics and health beliefs; enabling factors, such as income and health insurance; perceived need for care; health care system, including policy, resources and organization; and external environment, which includes physical, political, and economic factors. A simplified pathway from the Andersen model is presented below in Figure 6.1, with additional factors identified by Yang and Hwang (2016). In the model, direct effects on HSU are detailed by solid lines, and indirect effects by dotted lines to display the connection to HSU.

Figure 6.1. Analytical framework for health service utilization



Source: Yang and Hwang, 2016.

Identifying a gap, Yang and Hwang add to the Andersen health behaviour model, detailing immigrant specific factors that contribute to HSU. The factors are divided into the following categories: (a) immigrant-specific health needs or conditions; (b) homeland-based financial and social resources; (c) immigrant-specific predisposing factors including immigration status, signifying vulnerability or invulnerability to receive health care; assimilation, indicating immigrants' adaption to the host society that leads them to behave similarly to the native-born in HSU, and immigrant ethnic culture, betokening the cultural tradition of immigrant groups that offers alternatives to standard professional health care; and (d) context of emigration, context of reception, and HSU in the homeland. This addition to the research is a key step towards understanding the complexities of migrant HSU. This research has not been used in a practical application and will require more time before it can consider these factors in how health systems interact with migrants.

Chapter 7.

Immigrant Health Services in Canada

In Canada the jurisdiction of health care falls primarily under the provincial government. However, the federal government still plays a significant role in the creation of health and immigration policy. A description of programming at the federal, provincial and local levels are detailed, presenting evidence of the jurisdictional complexity of this issue in Canada.

7.1 Federal

The federal government is responsible for the establishment and administration of national standards for the health care system through the Canada Health Act. The federal ministries most directly involved in the health of immigrants are *Immigrant, Refugees and Citizenship Canada* (IRCC) and *Health Canada* (HC). Although neither is directly involved in providing health services, IRCC offers the Interim Federal Health Program (IFHP) as of 2016, providing basic coverage until individuals are eligible for provincial or territorial health insurance. Specifically:

> *"…limited, temporary coverage of health-care costs for specific groups of people. These groups include protected persons, including resettled refugees, refugee claimants, victims of human trafficking, and certain persons detained under the Immigration and Refugee Protection Act during their period of ineligibility for provincial or territorial health insurance"* and *"…coverage for certain pre-departure medical services for refugees coming to Canada for resettlement"* (Government of Canada, 2020)

As part of their mandate, IRCC provides funding to some organizations working closely with migrant services. The Affiliation of Multicultural Societies and Service Agencies of BC (AMSSA) is a provincial initiative funded by IRCC (in conjunction with other federal departments and the provincial government) to support the diversity of needs in the province. AMSSA facilitates collaborative leadership, knowledge exchange and stakeholder engagement to support agencies that serve immigrants and build culturally inclusive communities. Their website contains a page on health and wellness, as well as immigrant health specifically, with links to various supports. HSU is included in the work of organizations such as this who support in the acculturation process.

HC provides general information through their “Just for You – Immigrants” page on their website, summarizing the Canadian health care system and providing various links to different resources. The resources, however, are information heavy and not practically useful. Other than this resource, no specific actions by HC were identified to support immigrant health from any perspective.

7.2 Provincial

British Columbia (BC) and Ontario were selected to highlight the provincial efforts on the issue of migrant health. In BC, the provincial government has compiled a comprehensive “*Newcomers Guide*,” available in 15 languages, that includes a Health Care chapter. This chapter is thorough in terms of covering content and has links to many websites for various different resources within the health care system, such as finding a doctor and registering for the *Medical Services Plan* (MSP). For immigrants requiring language assistance, the Provincial Language Service exists to provide this service. However, an interpreter can only be booked through a doctor or hospital for the patient.

In Ontario, the website *Settlement.org* provides an online platform where all necessary services for newcomers are explained and a number of links are provided for clarity. Under the Health tab, there is detailed information on how to access the Ontario Health Insurance Plan (OHIP) and various links for specialized health care topics, such as Refugee Health. The website is managed by the charity group Ontario Council of Agencies Serving Immigrants (OCASI) and is funded by IRCC and the Ontario Ministry of Citizenship, Immigration and International Trade (MCIIT). OCASI is a platform for advocacy and education as well, supporting all aspects of immigrant life and addressing policy gaps. The collaborative effort between the three groups establishes a shared space for all new residents of Ontario and contributes to the ease of finding information by providing a comprehensive website. The website was only available in English and French, however, with no links to language resources. Online resources only extend so far in providing support.

7.3 Local

With a lack of government-run programming, communities have come together to support migrant health through the establishment of migrant health resource centers.

One such organization is the Multicultural Health Brokers Cooperative (MHBC) in Edmonton, Alberta. Migrant resource centres have been established through the efforts of migrants to offer services and facilitate migrants' access to health care. The MHBC operates with assistance from public and private partners, and aims to reduce adverse social determinants of health for the migrant population in Edmonton.

A number of initiatives have also been implemented in Toronto. The Access Alliance Multicultural Community Health Centre "*provides services and addresses system inequities to improve health outcomes for the most vulnerable immigrants, refugees, and their communities*". There is a focus on primary care that meets the needs of the multicultural community in Toronto, as well as research and advocacy to raise awareness around issues specific to the health of migrants. The scope of their research includes mental health, migrant youth and children, and prenatal health among others.

SickKids Hospital in Toronto, ON offers a training program on cultural competency, called the Cultural Competence Training Initiative. This Initiative includes modules with the following titles: Valuing Diversity in Healthcare; Refugee and Immigrant Health; Cross-Cultural Communication; Health Literacy in Clinical Practice; and Parenting Across Cultures. The comprehensive scope of the modules supports the learning of providers and can contribute to strengthening service delivery. Though directed towards clinicians, these modules are available publicly.

In Vancouver, Initiatives at academic institutions have attempted to foster relationships between migrant groups and medical students through initiatives such as the Refugee Health Initiative at University of British Columbia (UBC). This short-lived program (in place in 2016-2017) paired medical students with new refugee families to support in their navigation of the health care system.

Some individuals have also attempted to establish organizations to support migrant health integration, such as Refugee Health Vancouver, in place from 2015-2017 with support from Vancouver Coastal Health. Though the initiative is no longer being funded, the tools they have created for health literacy and system navigation are still available as baseline tools. This initiative also shows there is room for individuals to make an impact through new initiatives that fill the gaps of the work of larger institutions, yet still collaborate with them for funding and implementation.

UBC has also been a part of implementing a cultural safety training program within its medical school to address the lack of culturally appropriate and safe health care specifically for Indigenous peoples in BC. The San'yas Indigenous Cultural Safety Training program was developed by Provincial Health Services Authority (PHSA) to address inequalities and obstacles that have emerged within Canada's health care system over the years (Dolski, 2016). The training is offered to anyone who is within the health care system, including researchers, institutions, universities, and health care professionals. For many who work in health care, it is now mandatory as part of their training. This initiative has trained over 50,000 so far and is expanding to other provinces (PHSA, 2019). This model of online training had been found to be effective for Indigenous cultural competency education.

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To fill the jurisdictional gap, Individuals and organizations exert the majority of direct effort at the local or regional level. Federal and provincial governments offer funding for local efforts; however direct strategies are not defined under their mandates. The responsibility for a group making up nearly a quarter of the national population rests with government, and a focused approach is needed to make migrant health a priority across the nation.

Chapter 8.

Jurisdictional Scan

Cross-jurisdictional analysis of variance in immigrant health and its related variables allow for a deeper understanding of the issue and it's possible solutions from a global perspective. Australia, the United Kingdom (UK), and the United States (US) were chosen as jurisdictions to cross-examine with Canada based on similar migration patterns, health systems, and demographic distribution. Policy landscape comparisons support the development of policy options. These immigrant-receiving countries experience similar levels of the HIE as measured in two main ways: self-reported chronic conditions and self-assessed general health status. Table 8.1 below gives an overview of immigration patterns for the four countries being examined. Values are current to 2018 unless otherwise stated.

Table 8.1. Indicators of health measured compared between foreign-born and native-born population, in four immigrant-receiving countries, 2018

Jurisdiction	**Foreign-Born (% of population)**	**Yearly Immigrant Intake (N)**	**Difference in Prevalence of Chronic Conditions for Foreign Born**	**Difference in Prevalence of Self-Assessed Health Status for Foreign Born**
Canada	23%	303,200	-0.11*	+0.11*
Australia	29%	190,000	-0.09*	+0.03
United Kingdom	14%	625,000	-0.06*	-0.06*
United States	14%	578,081 (2017)	-0.17*	+0.01

*An * indicates a statistical significant difference at the 5% level of significance*

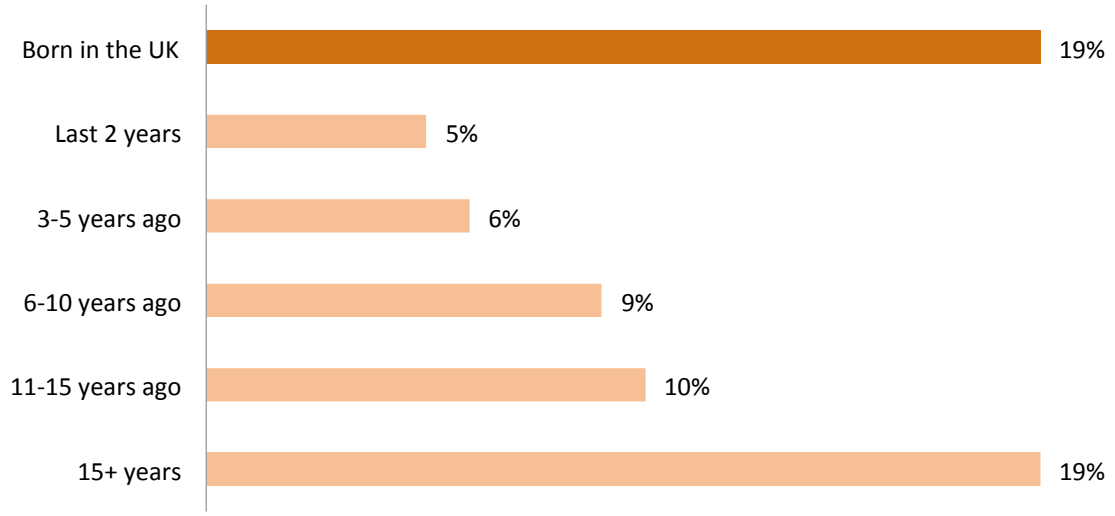
The demographic included in the findings of the table are adults 21-65 who have immigrated within 10 years of the survey date (with an average time since migration of five years). The results were pooled from national census surveys in each of the four immigrant receiving countries. A negative value in the difference in chronic disease diagnoses means there is lesser prevalence among the foreign-born population. A positive value in the difference in self-assessed health status means there is stronger self-assessed health among the foreign-born population. As observed, there is variation in the experience of chronic conditions and self-assessed health status among the four countries. Immigrants in the US experience the greatest difference in chronic condition diagnoses, with immigrants experiencing lower rates by 17 percent. The UK and Canada both experience equal rates of difference in both chronic diseases and self-assessed health among their foreign-born population; however, Canada experiences a larger difference of 11 percent for both indicators compared to the UK's 6 percent. Australia falls in between with 9 percent difference in chronic disease prevalence, and not a statistically significant difference in self-assessed health status with just 3 percent. A descriptive scope of the population and policy landscape in each country is outlined to support an understanding of the immigrant health experience.

8.1 United Kingdom

Due to its position within the European Union (EU) and its close proximity to many other countries, the UK experiences a regular inflow and outflow of migration. In 2018, 625,000 immigrated into the UK and 351,000 emigrated out – leaving a 273,000 net increase in the population through migration (OECD, 2019). Of the countries in focus, the UK has the most regularity of migration flow (which may now be impacted by Brexit).

The healthy immigrant effect has been identified in the UK for various immigrant groups, and immigrant health status has been observed as reducing with length of stay (Wallace and Kulu, 2014). The graph below, from the Migration Observatory at the University of Oxford, shows the measure of immigrants who report having a limiting health problem with time since migration and compared to the native-born, controlled for factors such as age and sex (2018).

Figure 8.1. Percentage of immigrants reporting a limiting health problem compared to the UK born population, UK, 2018



Source: Migration Observatory, Oxford University

Where firm evidence of the existence of inequities is clear, it is still unclear what the causes for those inequities in access to health may be. Results are insufficiently clear to point to specific policy implications in the UK (Goddard and Smith, 2001).

A EU study of best practices identified nine themes for strong health care for immigrants when they interviewed 134 experts from 16 countries in the EU on what they believe constituted best practice in the delivery of health care to migrants. The researchers used the Delphi method to bring the group toward a consensus and the following best-practice themes were identified from their responses: (1) easy and equal access to health care; (2) empowerment of migrants; (3) culturally-sensitive health care services; (4) quality of care; (5) patient/health care provider communication; (6) respect towards migrants; (7) networking in and outside health services; (8) targeted outreach activities; and (9) availability of data about specificities in migrant health care and prevention (Deville et al, 2011).

A key suggestion from the study was the creation of an EU Charter on culturally-sensitive health care for all citizens. The Charter would place culturally-sensitive health on the agenda for policy makers at all levels and would ask for a commitment from governments in creating and supporting appropriate care for the diversity of citizens in

the EU (Deville et al, 2011). Since the release of this article, no such steps have been taken to implement a change.

At a smaller scale, similar to the initiative at UBC described above, the University of Oxford has implemented a student refugee health initiative out of their medical school program to support the learning of the students in cultural competency and create a model of care for vulnerable migrant groups (Dixon et al, 2018).

8.2 United States

In 2015, the US had the largest foreign-born population in the world made up of 45 million individuals, with Hispanic Americans as the largest immigrant group (OECD, 2019).

Salmon bias is identified as a strong contributor to better health in Mexican migrants in the US (Diaz, Koning, and Martinez-Donate, 2016). Specifically, the literature suggests selective return migration occurs as Mexican migrants reach older age – implying the disease burden at old age is carried back to Mexico. Mexicans who stay have health insurance, are more educated, have greater language proficiency, and experience better social integration (Diaz, Koning, and Martinez-Donate, 2016). The literature identifies that stronger health care is important in keeping immigrants and supporting their health.

The literature focusing on Mexican immigrants show that those living in the United States are less likely to visit a physician than native-born Mexicans or whites (Ortega et al. 2007). Moreover, nearly half a million Mexican-origin individuals living in California cross into Mexico to receive medical care (Horton and Cole 2011). Given the adoption of universal health coverage in Mexico in recent years, medical returns may be an increasingly relevant mechanism of return in the current period (Arenas et al. 2015; Knaul et al. 2012). Due to the unaffordability or undesirability of health care in the US, it is expected that selection is driven—or magnified—by those seeking medical attention in their country of origin.

Policy in the US is the key contributor to immigrant health. Under the *Personal Responsibility and Work Opportunity Reconciliatory Act* of 1996—which was not intended to impact health policy—new legal immigrants are not eligible for publicly

funded services such as Medicaid for the first five years of residency (Lebrun, 2012). This policy is directly inhibiting early intervention and health-promoting behaviour by taking away the possibility for a new immigrant to access health services. And as would be expected, their HSU declined significantly after the implementation of this law (Lebrun, 2012). Additionally, many immigrants cannot rely on the medical system in the US for a multitude of reasons. Some Latino immigrants have crossed back to Mexico for health care services because they have greater trust in the services the doctors provide, receive more holistic care, and have generally easier and more affordable access to health services (Yang and Hwang, 2016). Without a publicly funded health care system in the US, many feel doctors are only motivated by money and lack the understanding and sensitivity to their unique needs (Yang and Hwang, 2016).

It is significant to note that Hispanics have the highest uninsured rates of any racial or ethnic group within the United States. In 2017, the Census Bureau reported that 49.0 percent of Hispanics had private insurance coverage, as compared to 75.4 percent for non-Hispanic whites, according to the US Department of Health and Human Services Office of Minority Health (2019). Those from Mexico and Central America face the largest uninsured rates, with 19.3 and 27.2 percent respectively. The role of insurance and health policy is a key driver of a reduction in the health of immigrants over length of stay in the US. Thus, in the US, access is often considered to refer merely to whether or not the individual is insured (Goddard and Smith, 2001).

In 2000, the United States Department of Health and Human Services issued national standards for culturally and linguistically appropriate health services, addressing health care organization practices related to staff-patient interactions, staff development, community involvement, data collection, and administration (Lebrun, 2012). With the exception of previously mandated language access provisions, the standards did not have the force of law and were limited in their effectiveness. However, they did become a benchmark for a wave of voluntary efforts by health care providers, and provided the impetus for subsequent state laws and standards for hospitals and health plans.

The Institutes of Medicine have recently called for standardization of how data related to patient race, ethnicity and preferred language are collected, with the intent of using this information to design interventions aimed at the reduction of health disparities among different population groups (IOM, 2010). The Immigrant Health Initiative, lead by

the National Heath Institute, funds research aimed to understand risk and protective factors and challenges affecting the health of US immigrant populations as a result of the immigration experience and to promote health equity. An increase in monitoring health through data and information supports future efforts within the country.

8.3 Australia

Australia's foreign-born population makes up 28 percent of the total population. The highest intake is from the UK, with 1.3 million individuals who arrived in 2015 (OECD, 2019). Australia has one of the most complicated immigration processes, making it difficult for many individuals and families to apply and contributing greatly to the existence of the HIE in the country. The most common form of migration is through the Skilled Migration Programme (SMP). The SMP requires a medical exam, chest x-ray, and potentially lab tests from an approved panel doctor. Immediate family members may also be tested, even if they are not also migrating (Parliament of Australia, 2010). Results are then sent to the Department of Home Affairs to assess them and make a recommendation. Medical assessments include screening for tuberculosis, HIV/AIDS, pregnancy, and hepatitis B and C. Testing positive for any of these conditions may result in denied entry or requirement to undergo treatment and be tested again before entry can be advised. In the case of pregnancy, the mother may be required to give birth to the child prior to a visa being finalized.

As can be predicted from the stringent admission requirements, immigrant health is stronger than the native-born in Australia. Additionally, it is noted that immigrants from non-English speaking countries have a lower incidence of chronic disease upon arrival. One study looked to the incidence of chronic disease for those born in Australia, and found there was an incidence of 0.359 compared to 0.370 for immigrants born in Europe, and 0.260 for immigrants born outside of Europe (Biddle, Kennedy, and McDonald, 2007). These results are aligned with findings in Canada where non-European immigrants experience a greater HIE (Trovado and Newbold, 2017). Health assimilation patterns are identified here with findings of increasingly similar incidence of chronic illness over time between immigrants and non-immigrants.

A study on the experiences of migrants in Australia found that migrants perceive many differences in the Australian healthcare system including language, health system,

and culture – hindering their engagement with services (Au et al, 2019). Not surprisingly, refugees often preferred health practitioners who were of their same background with good understanding of refugee and cultural issues and valued practical information to medical information. The observations of migrant engagement with services lead to a deeper look into barriers and enablers faced in accessing healthcare services. These experiences can be conceptualised using Penchansky and Thomas' definition of access, described above (Au et al, 2019).

The perspective that diverse communities are homogenous and therefore solutions can be homogenous is detrimental to the effectiveness of any interventions. 28 percent of Australia's population is culturally and linguistically diverse in background and therefore requires health care services that support diverse needs (Henderson and Kendall, 2010). Bilingual community-based navigators were used in one region of Australia to accompany culturally and linguistically diverse individuals in their experiences within the health system. Navigators helped to improve accessibility and health service usage among this group (Henderson and Kendall, 2011). This intervention was identified through consultation with culturally diverse groups in different regions of Australia to understand their patterns of HSU. Bringing communities together to learn from their experiences is identified as an important approach to create more equitable health systems.

Chapter 9.

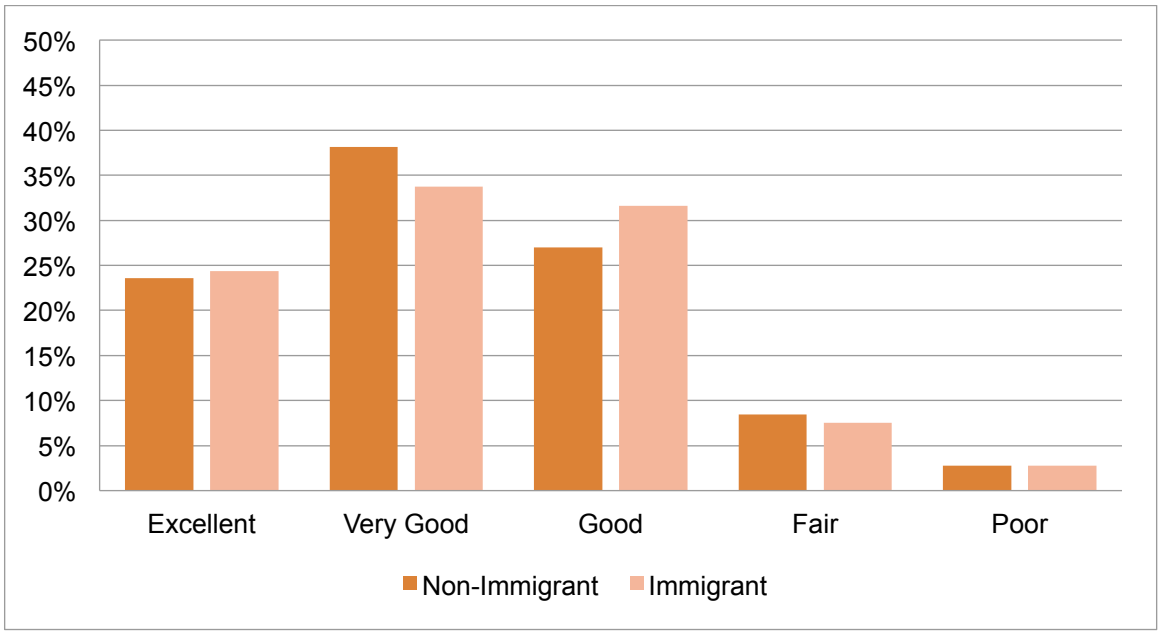
Quantitative Results

To support the findings from previous research and observe the latest captured data on the topic, quantitative analysis was performed using the 2018 CCHS results. The data was used to further analyze the research questions, repeated here for reference: 1) What are the barriers and facilitators that contribute to the health of immigrants in Canada? And 2) Is the reduction in health status over the length of time since migration changing over time among Canadian immigrants? Findings are divided into variables analyzed.

9.1 Self-Perceived Health Status

Self-perceived health status is a key indicator of the HIE. To measure self-perceived health status, Canadians are asked, “In general, would you say your health is…?” and are given options from excellent to poor. When comparing the general immigrant population with the general non-immigrant population in their response to this question, there is minimal variance between the two, as shown in figure 9.1.

Figure 9.1. Self-perceived health by immigration status, 2018



The minimal variance is due in part to the composition of immigrants surveyed. As representative of the immigrant population at large, immigrants surveyed are largely long-term inhabitants defined in this study as having lived in Canada for more than 15 years (55%). This results in the need to break up the composition of immigrants by years since immigration to observe how duration of time living in Canada impacts health status, and to compare findings in the literature that point to a decline in reported health status with time in Canada.

From the data, it was observed that the proportion of those responding with a perceived negative health status (fair or poor) increases with increasing time in Canada since immigration. This observation meets the outcomes from previous research, and indicates the HIE experiences the same decline as has been observed in previous studies. The table below outlines the variation in responses over length of stay in Canada. Immigrants are divided in five-year intervals for length of stay; new immigrants are defined as individuals living in Canada for five or less years, and individuals are defined as long-term inhabitants if living in Canada for more than 15 years.

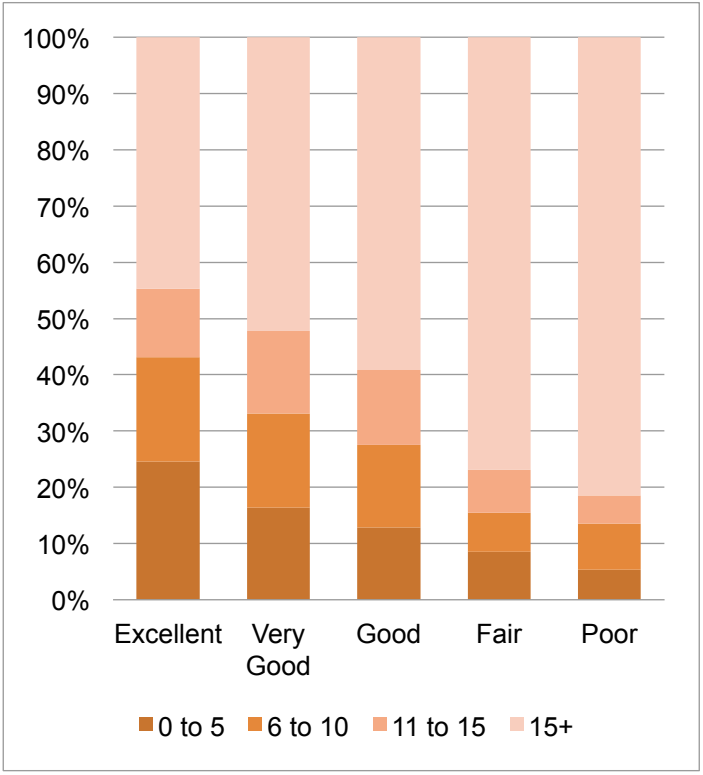
Table 9.1. Self-perceived health status by years in Canada since immigration, 2018

	0 to 5	**6 to 10**	**11 to 15**	**15+**
Excellent	36.3%	28.9%	22.9%	19.6%
Very Good	33.8%	36.6%	40.8%	32.1%
Good	24.9%	29.7%	32.7%	33.8%
Fair	3.9%	3.3%	4.4%	10.4%
Poor	0.9%	1.5%	1.1%	4.1%

It was observed that the percentage of those reporting *Excellent* health status declined by nearly 17 percent as new immigrants become long-term inhabitants, and similarly the percentage of those reporting *Fair* or *Poor* health status increases by nearly 10 percent in that time period. The observed differences indicate that time since migration is an important part of understanding the patterns in immigrant health and addressing barriers early on to prevent a large dip in self-perceived health status.

To visually display the change in response rates for each health status category, the graph to the right shows the proportion of immigrants in each time-since-immigration category within each response category. Long-term immigrants, displayed in the lightest shade, overwhelmingly make up the largest proportion of *Fair* and *Poor* responses. Although this group represents the largest proportion (n) of immigrants in general, the reporting distribution is stark in each response category.

Figure 9.2. Proportion of immigrants in each time-since-immigration category, within each response category, 2018



With this observation confirmed, there remains a question of how the HIE compares for recent immigrants over time. This most recent data supports findings in previous studies in observing that self-perceived health of immigrants to Canada has not changed over the last two decades. Using CCHS data from a study by Blair and Schneeberg (2014) for self-perceived health of recent immigrants in 2000 and 2009, it was possible to compare responses across two decades. Observing response rates in 2000, 2009 and 2018, it is found that not only are recent immigrants still identifying better health, there is an increasing trend in immigrants who respond with an excellent health status (Table 9.2).

Table 9.2. Self-perceived health status, recent immigrants (<10 years since immigration)

	2000	2009	2018
Excellent	28.0%	29.3%	32.6%
Very Good	34.4%	38.3%	35.2%
Good	31.1%	26.1%	27.3%
Fair	5.0%	5.6%	3.6%
Poor	1.5%	0.7%	1.2%

In consideration of assimilation patterns in health status over the length of stay in Canada, it is concerning to see that new immigrants are reporting as healthier than new immigrants in the last two decades. If similar health assimilation patterns persist, there may be an implication of a greater drop in health status over time for more recent immigrant cohorts.

9.2 Barriers to improving Health

Questions regarding efforts to improve health and subsequent barriers were one of many questions that were not mandatory within the questionnaire, however a significant enough number of Canadians responded to assess variance between immigrants and non-immigrants. As could be predicted, one third of all Canadians said they think there are things they can do to improve their health. However, when asked whether potential barriers are faced to make those improvements, immigrants were 1.35 times more likely to answer *yes*. This was observed to be significant when regressed, with a p-value of 0.003.

Subsequent questions asked about specific barriers to improving health were not analyzed due to an insufficient sample size to allow comparison between immigrant and non-immigrant groups, due to the non-mandatory nature of the questions. Some barriers that were specified include: lack of will power, work schedule, disability or health condition, family responsibilities, addiction, stress, financial constraints, availability, transportation, and weather conditions. Further research into these barriers is necessary to draw linkages to immigrant status.

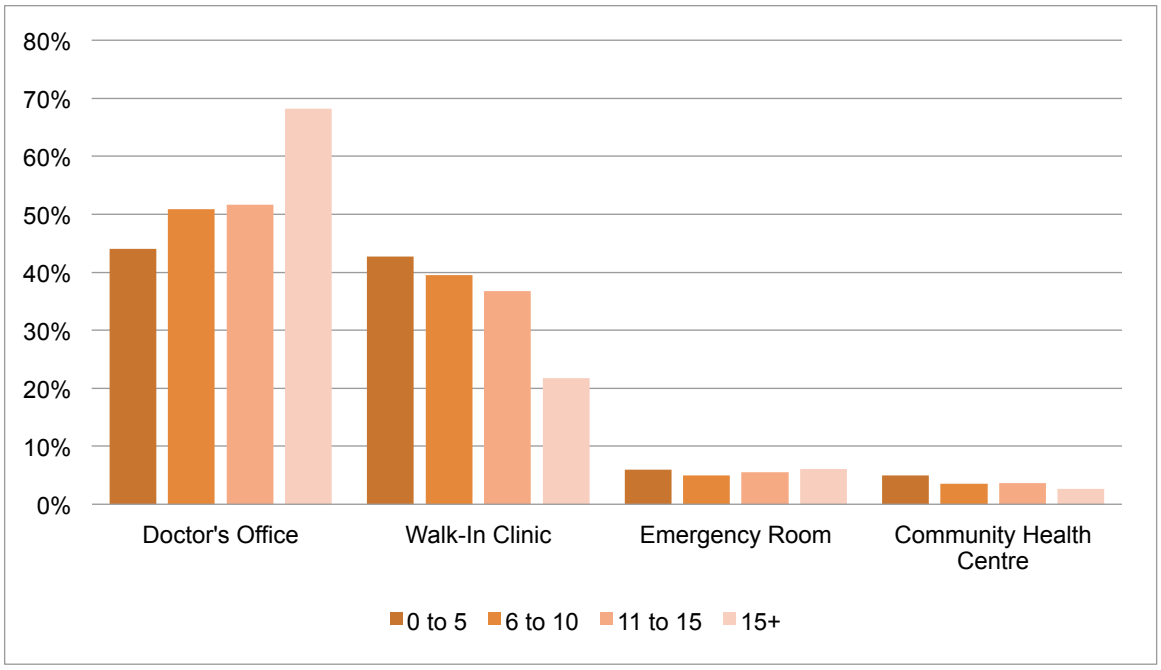
9.3 Access to a Regular Provider

Using a regression model, immigrants' access to a regular provider was slightly lower than the native-born population with an odds ratio of 0.92; however, this was not statistically significant (p-value of 0.14). This observation contributes to the findings in the literature where utilization of a regular provider (e.g. family doctor) is seen to not systematically differ between immigrants and non-immigrants (Graetz et al, 2017). Access to a regular provider is not identified as a key contributor to health status when observing the general population; however comparing access over time since immigration provides some insight to the relationship between assimilation and health care use, as described in the next subsection.

9.4 Usual Place For Care For Minor Problems

When looking at the entire immigrant population in comparison to the Canadian-born, there is no indication that emergency rooms and walk-in clinics are used more commonly than continuous care options, as the literature suggests (Deville et al, 2011; Devillanova and Frattini, 2016). However, when broken down by years since immigration, the variation becomes clearer. The data shows that with increasing years lived in Canada, immigrants increasingly tend to use a doctor's office as a usual place for care for minor problems and reduce their use of walk-in clinics. This observation is an important indicator of the increased use of care options that constitute continuous care models, and gives insight into whether assimilation leads to greater use of continuous care models.

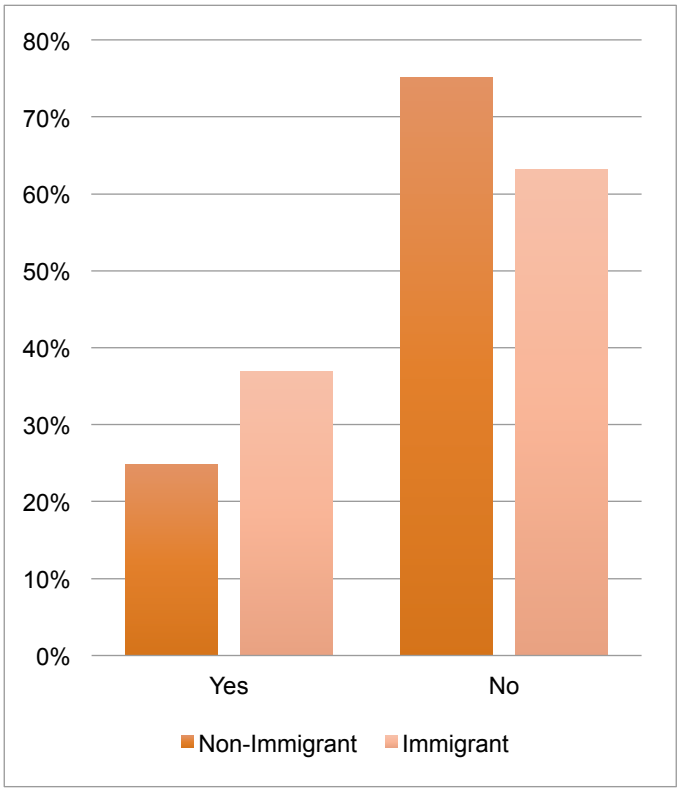
Figure 9.3. Proportion of immigrants reporting use of usual place for care by years since immigration, 2018



9.5 Difficulty Seeing a Specialist

The data findings also revealed immigrants, on average, experience greater difficulty attaining specialist care. When asked, “In the past 12 months, did you ever experience any difficulties getting the specialist care you needed for a diagnosis or consultation?”, immigrants stated yes by 12 percentage points more than non-immigrants. The lower use of specialists inpatient and outpatient care by migrants was identified in the literature however barriers to accessing and utilizing specialist care have not been researched systematically to present correlated variables and present possible solutions (Deville et al, 2011; Graetz et al, 2017).

Figure 9.4 Proportion of Canadians who reported difficulty accessing specialist care, 2018



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A limitation within the analysis was the non-mandatory nature of questions related to access to, utilization of, and satisfaction with health care services. This is a key limitation in understanding the experiences of immigrants and non-immigrants with the health care system and related outcomes and is a barrier to advancing any efforts on this issue.

The results provide consistent insight into the HIE and patterns of health decline over time. The evidence also proves there are significant gaps in the research to help understand the explanatory factors for these results and the need for more specific data collection to address the gaps in immigrant health.

Chapter 10.

Policy Alternatives

The factors contributing to the existence of the healthy immigrant effect, such as selection mechanisms, are not to be the focus of the possible policy solutions. The policy approach must address health inequities among immigrants in comparison with the Canadian-born population over their length of stay. The foundation for the analysis of policy options is based on an understanding of the Right to Health and priorities set out in the Global Consultation on Migrant Health by the World Health Organization (WHO).

10.1 The Right to Health

Health as a human right for all was first expressed at the international level in the 1948 Constitution of the WHO. It was then reiterated in the *Universal Declaration of Human Rights*, Article 25, and in several legally binding international human rights treaties thereafter. The African Commission on Human and Peoples' Rights has held that "enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms" (IOM and WHO, 2010). Similarly, the failure to protect human rights can have adverse consequences for health and wellbeing.

The central formulation of the right to health is included in Article 12 of the International Covenant on Economic, Social and Cultural Rights, to which Canada has been a signatory since 1976 (Government of Canada, 2020). Canada however does not include a right to health its domestic human rights instruments. Article 12.1 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", which is abbreviated to the "right to health" (IOM and WHO, 2010). The scope and content of this specific right is based on general comment No. 14 of the Committee on Economic, Social and Cultural rights. It includes the requirement that, within a country, health facilities, services and goods must be available in satisfactory quantity, be accessible and affordable to everyone without discrimination, be culturally acceptable (e.g. respectful of medical ethics and sensitive to gender and culture) and be of quality. Another important aspect is the participation of the population in all health-

related decision-making at the community, national and international levels, including migrants (IOM and WHO, 2010).

In relation to health and migration, a rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of migration and health-related policies and programs. Positive interactions with the health system promote both wellness and social inclusion. In good health, migrants can become productive and integrated members of society, contributing to the social and economic development of both host countries and countries of origin.

It is essential to ensure that all people, from migrants to health care providers to policy makers, are aware of the right to health, the needs of migrants, and the resources available to them. Migrants must be made aware of and feel confident in the health care system; to understand the importance of utilizing health care as a means for not only a remedy post-disease or illness but also as preventive tool. Migrants should participate in health service delivery, policy design, and program planning and evaluation. Additionally, the health workforce should be trained about issues related to migration health to better promote preventative health care. Awareness and education of researchers, policy-makers, and those involved in social and economic planning on migration health should be raised in general to promote migrant well-being as a whole.

10.2 Policy Framework: Global Consultation on Migrant Health

The 2010 Global Consultation on Migrant Health held in Spain in March 2010, was convened as a result of the 2008 World Health Assembly Resolution on the Health of Migrants. It was a joint effort by the WHO, International Organization for Migration (IOM), and the Government of Spain. The IOM was established in 1951 and is the leading inter-governmental organization in the field of migration, working alongside governments and organizations on all migration-related issues. The Consultation's main objective was asking Member States to take action on migrant-sensitive health policies and practices and directs the WHO to promote migrant health on the international level. The subsequent WHO report, titled "Health of migrants − the way forward," is used here as a framework for policy options to direct actionable solutions to complex problems.

The report outlines key priorities falling into the following thematic areas (IOM, 2010):

Monitoring migrant health: ensure the standardization and comparability of data on migrant health; support the appropriate aggregation and assembling of migrant health information; map good practices in monitoring migrant health, policy models, and health system models.

Policy and legal frameworks: adopt relevant international standards on the protection of migrants and respect for rights to health in national law and practice; implement national health policies that promote equal access to health services for migrants; extend social protections in health and improve social security for all migrants.

Migrant sensitive health systems: ensure that health services are delivered to migrants in a culturally and linguistically appropriate way; enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration; deliver migrant inclusive services in a comprehensive, coordinated, and financially sustainable fashion.

Partnerships, networks & multi country frameworks: establish and support migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination; address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development).

10.3 Policy Options

The key priorities outlined in the WHO report make up the framework for the three policy options identified. From the analysis above, it is clear that government action within the immigrant-receiving countries in focus is lacking to address the issue of migrant health and frequently migrant groups are left to address the issue themselves through the establishment of networks and coalitions. The continuation of this form of action will not result in systemic and long-term change; government action is necessary. Each option presented is connected to one or more of the thematic areas from the report, is described from a Canadian perspective, and placed under a governmental

jurisdiction. Each option includes a set of priorities and actions that connect to the WHO report's thematic areas and the findings of the literature review and jurisdictional scan.

10.3.1 Option 1: Migrant Sensitive Health Strategy

Jurisdiction: Federal – IRCC in collaboration with Health Canada

A Migrant Sensitive Health Strategy would include recommendations and guidelines related to providing culturally safe and appropriate care for all migrant groups. A strategy puts into place a foundation for all practice and policy and acts as a guiding document for present and future health strategies for migrants. Priorities and actions include:

Priority: Policy coherence between the health sector and those responsible for immigration policy

> Actions: collaboration between IRCC and Health Canada to implement a nationwide strategy that makes migrant health a priority. IRCC and Health Canada both have expertise in different areas of policy – IRCC with immigration policy and Health Canada with health policy – and therefore can have significant impact if they collaborate on a strategy.
>
> Actions: Develop standards for health service delivery, organizational management and governance that address cultural and linguistic competence, epidemiological factors, and migrant-sensitive considerations for all areas of the health care system.

Priority: Include involvement of migrants and migrant communities to ensure programme adequacy

> Actions: Migrant groups, health care providers, and communities need to be involved in all stages of the implementation of the strategy to ensure that the strategy is accurate, effective, and comprehensive.

Priority: Ensuring that human rights are fundamental components in the design, implementation and evaluation of health related policies and programmes provide the basis of a human rights approach to health. A human rights-based approach to

programming would optimize a holistic and integrated process as well as health outcomes with a focus on the goals of health promotion and disease prevention.

Actions: The strategy must include a framework that is based on an understanding of the human right to health, and this understanding is the guiding principle for why this strategy is important and how it will contribute to migrant wellbeing in Canada. The human right to health constitutes non-discriminatory care for all who seek it and requires greater thought and commitment from providers and administrators.

10.3.3 Option 2: Cultural Sensitivity Training for Health Care Professionals

Jurisdiction: Provincial – Ministries of Health in collaboration with medical schools

Migrant sensitive health systems and programmes aim to consciously and systematically incorporate the needs of migrants into all aspects of health services financing, policy, planning, implementation, and evaluation.

A lack of appropriate training for health professionals means they may not be prepared to identify and manage the variety of health issues presented by migrants, including communicable diseases, inherited conditions, chronic diseases, nutritional deficiencies, and the effects of displacement and trauma (IOM and WHO, 2010). The attitudes and values reflected in policies and practice, and displayed by leaders, affect service users of all backgrounds, who are seeking to feel welcome (Spitzer et al, 2019).

Migrant sensitive health services must include a consideration of the barriers and facilitators of health care utilization and health outcomes. As described above, these barriers and facilitators include: (1) cultural; (2) language/communication; (3) organization and quality of services; (4) health literacy; and (5) social capital (Batista et al, 2018). Cultural safety and sensitivity training for health care professionals can lead to positive health care interactions and increased health service utilization. Taking from the model created at SickKids Hospital in Toronto, a mandatory modular training would be offered to all medical and nursing students as well as current health care providers. Training can also be implemented as a continuing professional development (CPD) accreditation. CPD is offered and monitored through the various regulatory colleges of health care providers, and collaboration with the colleges can result in a larger reach across the country. In addition to the mandatory training, two secondary activities have

been identified that would contribute to migrant sensitive health services, as described in the priorities and actions:

Priority: Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way, and enforce laws and regulations that prohibit discrimination.

> Primary Action: Include migrant health in professional programs for health care providers and administrators. The training would be broadly inclusive of migrant groups, with an emphasis on regions of origin that are non-European and non-English speaking who face greater barriers to HSU. Additional modules that are focused on region-specific barriers and facilitators may be added over time.
>
> Secondary Action: Establish a migrant network for culturally sensitive care, working alongside the health care system to support learning and improve migrant-inclusive health services, through connecting to migrant communities and their representatives.

Priority: Adopt measures to improve the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable way.

> Secondary Action: As a supplement to the current model of health care delivery, patient navigators would support the navigation of immigrants through the health system. They can be placed at emergency rooms, community health centers, or requested to accompany a patient with a medical appointment.

10.3.4 Option 3: Monitoring Migrant Health

Jurisdiction: Federal – Statistics Canada, in collaboration with Health Canada and IRCC

A critical component of designing and implementing migrant sensitive health systems is having the data to monitor migrant health needs, service utilization and ongoing health status. Standardization and comparability of data on migrant health is currently lacking in Canada and is a large gap to further understanding the experience of immigrants within our health care systems.

Better understanding of the nature and origin of the HIE will also assist in the design of programme and policies to reduce some of the future health needs of migrants and to mitigate long term impact of newly arriving migrants on downstream health and medical services. Monitoring the many factors associated with the healthy migrant effect and linking this information to other social and population-based determinants of health is a goal that demands greater attention. It is not, however, an undertaking without implications. The systematic understanding of the HIE will require routine evaluation of the health status of migrants on arrival, and regular monitoring over duration of stay in Canada.

Priorities:

(1) Appropriate disaggregation and analysis of migrant health information to account for the diversity of migrant populations

(2) Improve monitoring of health seeking behaviours, access to and utilization of health services

Actions:

Identify key indicators that are acceptable and useable across provinces, and could be compared with other countries.

Make mandatory the inclusion of migration variables in existing census (CCHS), national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration.

Chapter 11.

Evaluation Framework

Assessment using a consistent set of criteria and measures supports the clear evaluation of strengths and limitations of each policy option. The primary objectives that guide the valuation of policy options include protection of the health of immigrants and equity in access to culturally appropriate health care. Secondary objectives include cost of implementation, administrative complexity, and stakeholder acceptance for the three policy options. A summary of the objectives, criteria and measures is presented in Table 11.1 and followed by a descriptive outline of each.

Table 11.1. Summary of Evaluation Framework

Objectives	**Criteria**	**Measure**	**Score**
Protection of Health	Improved immigrant self-perceived health and reduced chronic disease diagnosis	Does the option contribute to improved self-perceived health outcomes and a reduction in chronic disease diagnoses?	3 = Directly contributes 2 = Indirectly contributes 1 = Little to no contribution
Equity in Access	Equity in access to health care services for immigrants	Does the option improve access to culturally safe and appropriate care?	3 = Direct impact on access 2 = Indirect impact on access 1 = Little to no impact on access
Cost	Cost of implementation	Is the cost of implementation viable?	3 = Minimal predicted cost 2 = Some predicted cost 1 = Medium to high predicted cost
Administrative Complexity	Distribution of jurisdictional responsibility for immigrants' health	Is the distribution of jurisdictional responsibility clear?	3 = One level of government 2 = Two levels of government 1 = Government and other groups
Stakeholder Acceptance	Cooperation of involved groups	Is the option viable for support by stakeholders?	3 = Viable for all stakeholders 2 = Viable for at least two groups 1 = Viable for one or no groups

10.1 Protection

Protection of the health of immigrants must be a primary objective of all potential policy options. Analysis of a policy's potential effectiveness in protecting the health of immigrants will consider the extent to which a policy could support the improvement of two indicators most commonly used in measuring health: 1) self-perceived health and 2) chronic disease diagnoses rates. The policy option must prove to have significant impact on the health of immigrants to protect from the decline of health over the length of stay in Canada. The evaluation of this objective will be challenging to quantify; therefore, an approximate measure based on potential for impact will be used. A 'high' measure indicates the policy option can successfully contribute to the protection of immigrant health, whereas a 'low' measure indicates limited contribution to the protection of immigrant health. This criterion is double weighted to account for importance as a key objective.

10.2 Equity

The equitable health outcomes of immigrants in comparison to their Canadian-born counterparts are an important consideration of the policy options. This is measured as the capacity of each policy option to contribute to facilitating equitable health access for immigrants, and access to health care that is culturally safe and appropriate. Migrants have specific needs that apply in relation to health service utilization. Therefore, policy options need to demonstrate a contribution to supporting the specific needs of migrants. A 'high' measure would imply the policy option contributes to equitable health services for migrants, whereas a 'low' measure indicates a minimal contribution to equitable health services. This criterion is double weighted to account for importance as a key objective.

10.3 Cost

It is cost-effective to care for people before they become seriously ill, reducing the overall burden on the health system. The evaluation of cost in this issue is based on implementation costs of each policy option, and assessment of variation in short term and long term costs. A 'high' measure will imply significant cost burden to the jurisdiction implementing the option, whereas a 'low' measure would imply a minimal cost burden.

10.4 Administrative Complexity

The jurisdictional division of responsibility over the health of immigrants from the time of arrival to ten years post-arrival is the focus within this objective. Administrative complexity is deemed most complex if the distribution of responsibility is unclear and may cause tensions between federal and provincial governments (low measure), and least complex if it is clear under whose jurisdiction it falls within (high measure). The clarity of the administration of the policy options will allow for stronger results.

10.5 Stakeholder Acceptance

The involvement and participation of stakeholders in the protection of migrant health and in providing more equitable health services is of key importance. Stakeholders would include: health care professionals; governmental departments; migrant groups and the general public. As described in the literature, health care professionals are directly impacted by any health system change and must be considered as a key stakeholder group. Governmental departments, such as IRCC, HC, and Statistics Canada, as well as provincial governments, are involved in the planning and implementation of any and all policy impacting migrant groups. Therefore, government mandates and capacity for change is considered here. Migrant groups are included for the direct influence all policy considerations will have as the key receiving stakeholder. Migrant groups are often not included in consultation regarding policy that may impact them; in the policy options put forward here, migrant groups are key contributors in the development and implementation process to strengthen the outcomes. Lastly, the general population must also be considered, as policy changes are not exclusive in their impact to any one group.

The strength of any policy is in the consultation process prior to development and implementation, and sound policy is one that hears the voices of those who are impacted most. Due to absence of interviews in the methodology, stakeholder acceptance is evaluated based on literature findings and the extent to which each policy option would significantly impact each group. A ‘high’ measure indicates a prediction of acceptability among all four groups, whereas a ‘low’ measure indicates acceptability from one or no group.

10.6 Measures and Weighting

The measures used to evaluate each criterion will be doubled for the key objectives of *protection of health* and *equity in access*, and weighted equally across the secondary objectives of *cost, administrative complexity* and *stakeholder acceptance* when applied to each policy option. The key objectives address the primary concerns of the literature around the issue, with emphasis on human life and well-being. Secondary objectives are more administrative considerations for implementation. A ranking order of high (3), medium (2), and low (1) will be used to evaluate the trade-offs of each policy option. A ranking of high indicates an option is predicted to be successful in achieving the objective, a medium ranking indicates the option is satisfactory or adequate, and a low ranking indicates the option is inadequate in addressing the objective. The specified scoring for each objective is included in Table 11.1. The process of ranking will identify the policy option that will be most successful in addressing the problem.

Chapter 12.

Analysis of Policy Options

The three options are evaluated based on their potential to address the declining health of immigrants over time, using the criteria and measures listed in table 11.1. Scores and ranking for some objectives are assumptions based on limited research and actions taken to address this problem previously. As this problem is complex, the evaluated scores should only be used as a rough measure of the effectiveness of each option and is not a conclusive and refined evaluation at this early point. A summary table is below to give a snapshot of the options and where they stand in comparison to one another. Coloured boxes are associated with high (green), medium (yellow), and low (red) rankings to present a visual comparison, with the total tallied at the bottom row.

Table 12.1. Summary evaluation of policy options

Objectives	**Option 1**	**Option 2**	**Option 3**
Protection of Health (x2)	6	6	4
Equity in Access (x2)	4	6	2
Cost	2	2	3
Administrative Complexity	2	1	3
Stakeholder Acceptance	3	1	2
Total	**17**	**14**	**14**

12.1 Option 1: Migrant Sensitive Health Strategy

Protection of Health

The human right to health will be a guiding framework for the strategy. With this baseline, a holistic and integrated model will be established with a focus on health outcomes for migrants. The strategy will include considerations that would be expected to directly impact health outcomes of immigrants in both self-perceived health and chronic disease diagnoses. There is no direct example to prove the effectiveness of such a model, and that is a significant contributor to the lack of understanding and application of research to this long-known phenomenon of the declining of health of immigrants over time. This policy option would prioritize the protection of migrant health, and therefore receives a score of 3 for this criterion.

Equity in Access

Barriers in access to health care are especially pronounced for immigrants. As found in the quantitative results, immigrants are 1.35 times more likely to report barriers to attaining specialist care. The research also shows immigrant-specific barriers are prevalent in all immigrant-receiving countries. The strategy would have direct guidelines on the expectations for all pieces of the health care system to be migrant sensitive and apply considerations for how best to address inequities in access and utilization of health care services.

The involvement of migrants and experts in the field in the consultative process will seek to ensure considerations are meaningful and deliberate. However, due to the broad element of this option, it cannot be guaranteed that it will have a direct impact on equity of access to health services and is dependent on a number of other factors on the ground. Therefore, this option receives a 2 for this criterion.

Cost

The cost associated with the strategy would largely be in compensation for time spent in the consultative process of the Migrant Health Committee over a one year period, followed by monitoring post implementation to evaluate uptake of the strategy. The cost would be feasible, however the task timely, therefore the option receives a 2 under this criterion.

Administrative Complexity

The implementation of a strategy would be largely under the jurisdiction of IRCC and HC as a national strategy. The two federal departments would need to join together, by creating a Migrant Health Committee, to create the strategy within a timeframe of one year. In this process, the provincial and territorial ministries of health should be consulted to gain a better understanding of the needs across the country. The implementation would require significant collaboration; therefore this criterion receives a 2.

Stakeholder Acceptance

This policy option is expected to have support from all stakeholder groups, most strongly from migrant communities. Not being a legal document, it does not pose a burden on governments to implement. This criterion scored a 3.

12.2 Option 2: Cultural Sensitivity Training for Health Care Professionals

Protection of Health

When health care providers have an understanding of the needs of their patients, patients receive appropriate care and are more likely to adhere to the provider's recommendations. Cultural safety training that is standardized and comprehensive will contribute to improved care and support provider-patient relationships. The thorough completion and adherence to the training by providers would be difficult to monitor; however, the training includes a component of responsibility and expected practices for providers to feel accountable once they have completed the training. Therefore, this option scored a 3 for this criterion.

Equity in Access

Training contributes to a sense of responsibility and clear expectations of providers and administrators to consider the unique barriers faced by immigrants in health care utilization. The secondary activities of a migrant network and patient navigators contribute more significantly to ensuring the training is appropriate and equity in health care services are implemented. Patients can share their voices through the Migrant Network and contribute to furthering migrant-sensitive care. This option scored a 3 for this criterion.

Cost

The cost predictions for this option are higher due to the need to include numerous stakeholders and groups in its implementation, and a requirement of technical services to create the online learning modules. Therefore, this option scored a 2 for cost.

Administrative Complexity

The complexity for this option is expected to be the most complex of all other options. A collaborative effort between provincial and territorial governments, their ministries of health and individual health authorities will take considerable time and effort to coordinate. In addition, the mandate for medical schools will be an added layer of complexity due to their indirect connection to health authorities. At an initial stage, this option can be implemented in Ontario where the SickKids model comes from, and when successful the model can be applied to other provinces in their distinct health systems. This option scored a 1 for complexity.

Stakeholder Acceptance

As described in the cost criterion, there are many involved stakeholders and impacted groups. The acceptance rate from each group will differ and will require strong collaboration to ensure all are on board with this option. The option scored a 1 for this criterion.

12.3 Option 3: Monitoring Migrant Health

Protection of Health

As a critical component of understanding migrant health patterns, migrant-specific data is largely lacking in Canada. Through the identification of key indicators and inclusion of migrant and health service utilization specific variables already existing in the CCHS that are not currently mandatory, the ability to monitor migrant health can be greatly improved. Health seeking behaviours and interactions with the health care system need also to be monitored to further understanding of how best to protect the health of migrants. This option will significantly impact how we understand the various elements of this issue and will contribute to better policies and practices over time, that

in turn contribute to the protection of health. The extent to which research is applied to practice is difficult to predict, however. This option scored a 2 for this criterion.

Equity in Access

Although greater monitoring of migrant health may in the long run have significant impact on equity, this option does not directly impact health service access and utilization. The analysis and implementation of the data findings gained through this option will be a timely task and is not predicted to impact equity in the more immediate future. Therefore, this option scored a 1 for this criterion.

Cost

The cost for this policy option is predicted to be limited. CCHS already includes a number of indicators that contribute to the priorities of this option. The added cost is connected to the collaboration with IRCC and HC to develop new migrant-specific variables that would be included in the CCHS. This option is scored a 3 for this criterion.

Administrative Complexity

The complexity is limited. The jurisdiction falls only within the federal government and is mostly the role of Statistics Canada. Collaboration with HC and IRCC would not add a significant layer of complexity in comparison to the other options. This option scored a 3 for this criterion.

Stakeholder Acceptance

Stakeholder acceptance is predicted to be high, with time and resources to make changes to the CCHS being the only consideration for why Statistics Canada may oppose this option and consider it less feasible. The promotion and support of this option by the IRCC and HC is expected. This option scored a 2 for stakeholder acceptance.

Chapter 13.

Policy Recommendation

Given the strong body of evidence and the framework of the WHO report on migrant health, a comprehensive approach is the most effective way to promote the protection of immigrant health and equitable access to health care services.

The policy options defined are not mutually exclusive of one other. Each option contains specific priorities and actions to address different elements of the issue. Based on the above analysis of the policy options using the specified criteria, it is recommended to implement all three policy options as a comprehensive effort to address the issue of declining immigrant health over time.

The primary recommendation, with the highest overall score, is a Migrant Sensitive Health Strategy. This option will ask IRCC and HC to use existing research and consult with key stakeholder groups to develop a strategy for all health care providers and administrators across the country that emphasises the right to health. The considerations included in the strategy will support a shift in the health care system to become more inclusive, comprehensive, and effective in providing for all Canadians. The higher-level approach to the content of the strategy will allow for it to be applicable in all provinces and territories where immigrants reside. Within recommendations of the strategy will be the need for migrant sensitive health systems and stronger monitoring of migrant health, making options 2 and 3 a priority nationally and demanding attention to both policy directions. It is recommended that following the implementation of the Strategy, option 3 be the next priority in implementation. Having scored equally with option 2, identifying appropriate indicators to be monitored early will allow for a more timely instigation of capturing data from the immigrant population using the CCHS. Finally, option 2 of cultural sensitivity training will be the third priority. The implementation of the training requires more complexity and is removed from the jurisdiction of the federal government, unlike options 1 and 3. With the guidance from the federal government, provinces can begin to implement cultural sensitivity training for providers, administrators, and medical students, beginning with Ontario as a baseline.

Chapter 14.

Conclusion

Positive outcomes resulting from improved access to health services are not solely limited to improvements in the personal health of migrants themselves. They are also associated with social and economic benefits for the host society. Protecting the health of 23 percent of the population supports significant improvement in the economic and social wellbeing of the country as a whole. Although the HIE has been long observed in Canada, factors for declining immigrant health over time have not been well understood. It is noted in the literature and the data available, however, that immigrants are faced with a range of barriers and facilitators of health care access and utilization. This in turn results in poorer health outcomes, and signals a need to understand the interaction of immigrants with the health care system and provide comprehensive policy solutions that encompass the range of factors involved. This research project places the responsibility of immigrant health on both federal and provincial governments to address through comprehensive solutions. A migrant sensitive health strategy will prioritize this issue nationally and require all levels of government to put forward policies with considerations for migrant health.

Further research and monitoring is required to observe the impact of the policy solutions in the long term. A number of limitations and gaps were identified throughout the research that need further attention, such as the lack of causal links drawn between barriers and facilitators of HSU and the lack of longitudinal data to support migrant health strategies. This preliminary undertaking of recommending policy options to address the problem from a systemic perspective requires more focused ongoing research on the various components of this dynamic problem. As more is learned, the broad policy options can be amended accordingly.

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