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How immigration shapes health disadvantages and what healthcare organizations can do to deliver more equitable care

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Abstract

That immigration is a determinant of health and that immigration systems themselves contribute to structural disadvantage remains under-addressed within healthcare in Canada. This article offers context for how immigration shapes health, and recommendations for how health systems can be better prepared to respond to the diverse needs of immigrants and migrants (together referred to as im/migrants), based on a community-based research project in British Columbia. Findings call attention to the varied and intersecting ways in which immigration status, access to health insurance, language, experiences of trauma and discrimination, lack of support for health system limits access to healthcare, and the roles community-based organizations play in supporting access. Recommendations are intended to help make sure that all health services are accessible to everyone, and move beyond a homogenizing category of "newcomers" into practical, meaningful strategies that attend to diverse and intersecting community needs.

Introduction

In Canada, over 23% of residents are immigrants,[1] but within this category people have varied experiences and circumstances. While people with precarious status, such as refugee claimants, temporary workers, and undocumented persons, experience particularly pronounced barriers to healthcare,[2,3] healthcare inequities have been observed among many immigrant groups.[4-7] That immigration is a determinant of health[8] and that immigration systems themselves contribute to structural disadvantage remains under-addressed within healthcare in Canada.[9,10] Structural determinants—that is, political, economic, and social arrangements that distribute social determinants of health[11]—create disadvantages among immigrants including social isolation, discrimination, un/underemployment, cultural dissonance, and poverty that strongly shape healthcare access and outcomes.[2,4,12] This article offers context for how immigration and immigration systems shape health, and how healthcare systems can be better prepared to respond to the diverse needs of immigrants and migrants (together referred to as im/migrants), based on a community-based research project in British Columbia (BC).

Immigration systems and health

The federal ministry Immigration Refugees and Citizenship Canada (IRCC) regulates immigration policies and movement across Canada's borders, with enforcement delegated to the Canadian Border Services Agency. These borders circumscribe the lands of more than 600 Indigenous nations through resisted historical and ongoing colonial processes.[13] As immigration policy controls who can cross borders and what rights they have in Canada, it inherently creates disadvantaged groups based on immigration status, in addition to circumstances of disadvantage that may prompt the need to migrate.

Im/migrants include people with permanent, temporary, precarious, or no legal status in Canada. Permanent residency is granted to people who have applied and been accepted through economic, family, and business classes, as well as resettled refugees and protected persons. People with permanent residency must maintain physical residency terms, but have access to most of the benefits available to Canadian citizens, including provincial healthcare coverage, and ability to travel and work in Canada. People with temporary status are authorized to be in Canada for a temporary period, including international students, temporary workers, visitors, refugee claimants, and sponsored family members. Undocumented people are often people who live and work in Canada beyond the expiration of temporary documentation.

For people with temporary status and undocumented migrants, access to health and social services is variable and dependent on provincial and municipal policies, as well as individual circumstances. For example, some students and temporary workers are eligible for provincial health insurance, refugee claimants are eligible for federal health insurance, and visitors of higher socioeconomic status often hold private insurance

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or pay out-of-pocket for health services. Local community-organized supports, along with Community Health Centres and specialized clinics in some municipalities provide healthcare to people regardless of immigration status, though options for undocumented people remain extremely limited.[14]

Discussions of immigration and health often start with the observation that, on average, recent immigrants to Canada appear to be "healthier" than people born in Canada. This "healthy immigrant effect" is shaped by immigration system requirements, including medical eligibility criteria,[15,16] with people potentially being denied admission because of pre-existing conditions.[17] It can obscure serious immigration-related barriers to healthcare access[18,19] and mask the ways that social determinants among people who migrate (either by force or by choice) contribute to adverse health outcomes.[8]

Health systems and immigration

Disadvantages associated with immigration and reinforced by immigration systems should not be replicated within health systems. Provincial health insurance is contingent on immigration status in all Canadian provinces, and im/migrants face specific barriers to accessing quality and timely healthcare, illustrating how immigration and health systems are closely coupled. That Canada is in clear violation of commitments to recognizing health as a fundamental right independent of immigration status has been repeatedly observed but remains unaddressed.[20,21]

Within health services planning, there is often consideration of broadly defined "newcomers"[22] as well as responses to the specific and important needs of refugees.[7,23-25] In addition to the important role that focused "newcomer" or refugee services can play, it is essential to consider how all health services can be better prepared to meet the needs of people across broader categories of im/migration, including undocumented and temporary im/migrants. This community-based research project in British Columbia applied a mixed-methods approach to understand healthcare use and experiences with the goal of informing how health systems can meet the varied needs of im/migrants.[26]

Approach

Community-based research

The Evaluating Inequities in Refugee and Immigrant Health Access (IRIS) project was built in collaboration with im/migrant community members in the lower mainland of BC; community-serving organizations including Watari, Sanctuary Health, MOSAIC, and Pacific Immigrant Resource Society (PIRS); community advisory board members; and research team members with diverse immigration experiences.

Between 2018 and 2023, we conducted three initial focus groups, 112 baseline, and 18 follow-up interviews with people aged 17 to 50 residing in the lower mainland of BC and who have immigrated to Canada through an international border, with focused efforts to recruit participants with experience of temporary or no legal immigration status. Interviews were conducted in four languages (English, Farsi, Spanish, and Tigrinya). We also analyzed linked health and immigration administrative data to understand patterns of service use.

Collaboration exists in all stages of research (study design, data collection, participatory analysis, and reporting) and is guided by shared values of respect, collaboration, and relationship building.[27] Detailed findings from individual qualitative and quantitative analyses are reported elsewhere.[20,26,28-30]

Study context

In BC, as in other provinces, eligibility for provincial health insurance includes Canadian citizens, permanent residents, and certain individuals with temporary immigration status who meet specific requirements.[31-36] Newly eligible people must wait three months before they can obtain health insurance coverage (as in Manitoba and Quebec systems).[28] People with other forms of temporary immigration status or no status, including expired temporary permits, are not eligible.[20] Though based in BC, findings and recommendations may transfer to other jurisdictions, particularly as immigration applications are under federal jurisdiction.

Generating recommendations

The recommendations for service planning and delivery reported here were prepared by all named authors, who comprise the knowledge exchange group within the broader project team. Authors include people with expertise in both the qualitative and quantitative analysis, people who supported community advisory boards in multiple languages (Spanish, Tigrinya, Farsi, and English) and people who themselves have varied experiences of immigration, including different immigration pathways and tenure in Canada.

These recommendations were generated through a team-based process in which authors reviewed all qualitative and quantitative research findings generated by the study (published and under review), identified cross-cutting themes within findings, and formulated associated recommendations. For recommendations relevant to service planning and delivery, we drafted associated self-assessment questions organizations can use to guide how recommendations can be put into practice. We shared draft themes, recommendations, and questions with community-serving organizations and community advisory board members for feedback. This helped us consolidate and confirm results reported here.

Findings and recommendations

This research highlighted that current immigration status and associated access to health insurance, past immigration experiences, language, culture, community connections, and intersecting social and economic characteristics crucially shape access to and experiences of healthcare. Cross-cutting findings and associated recommendations highlight opportunities to better design care that meets the needs of specific im/migrant groups, while ensuring all services are accessible to im/migrants broadly. Below we describe findings and recommendations and suggest

self-assessment questions service delivery organizations can use to improve the quality and equity of their own care for im/migrants (Box 1).

Box 1. Self-assessment questions for organizations to consider in planning services that meet the needs of im/migrants

Immigration status

- Is your organization aware of Sanctuary principles and have you developed policies to apply these principles in your services?[47]
- Are these policies communicated to clients so they know that they can access care without fear of being reported to immigration authorities?
- Have you ensured that all staff are aware that they have an obligation to protect patients' information, including from the Canada Border Services and other law enforcement agencies?*

Health insurance

- Does your organization clearly understand the different types of health coverage that people using your services may have?
- Do you have ways of supporting access for all coverage types (e.g., provincial, Interim Federal Health Program, private insurance, and people with no insurance)?

Diverse and intersecting community needs

- Are you aware of different pathways of immigration and the specific landscape of immigration in your community?
- Are you aware of different cultural communities that may access services you provide? Do you provide training to your staff about communities served?
- Do you prioritize hiring people with relevant lived experience to provide services to these communities?
- Have you reviewed the services you offer and developed policies that ensure the implementation of culturally responsive care across all services? For example, how can preferences for gender-concordant care be respectfully navigated?
- Have you provided training and resources for staff to implement policies?

Language

- Have you ensured interpretation resources are available?
- Are staff aware of all interpretation resources available, and do they know when and how to use them?
- Have you communicated rights and availability of interpretation to clients (e.g., posters in relevant languages)?

Experiences of trauma and discrimination

- Do you know what trauma-informed services look like?[48,49] Have you reviewed the services you offer and developed policies that ensure meaningful, ongoing implementation of trauma-informed care across all services? Have you set aside time and resources to support this implementation?
- Have you developed policies that ensure your care is free from discrimination? Do you have evaluation mechanisms to ensure this is practiced?**
- Have you provided adequate training and support for staff to implement policies, including <u>all</u> staff (from frontline clinic staff to back office leadership) in training?

Health system navigation

- Are pathways to access your service or program clearly communicated?
- Are your services described in multiple languages or on a website that can be used with on-line translation (i.e., not as a pdf)?
- Is it clear who is eligible to use your services? Are any associated costs (e.g., for people who do not have provincial health insurance) transparently communicated?
- Have you thought through who may need your services but have not made it through the door?

Community-based organizations

- Do you know immigrant-serving organizations in your community and do they know you?
- Do you have relationships with groups or organizations within cultural communities that may access your services (e.g., religious organizations and advocacy groups)?

*This is separate from health worker regulatory college requirements on duty to report.

**Note: any evaluation mechanism that engages with patients or communities should carefully communicate that any feedback is welcome and will not impact access to or quality of care for the participant(s).

Immigration status

Insensitive practices pertaining to determining health insurance coverage accompanied by unnecessary questioning about immigration status in healthcare settings contributed to uncertainty, fear, and not getting needed care among participants. According to the UN Human Rights Office of the High Commissioner, all people in Canada should have access to essential healthcare regardless of immigration status.[21] Fear of health personnel contacting the Canadian Border Services Agency or other law enforcement was prevalent among people with undocumented or precarious immigration status, despite this being a violation of privacy protection acts.[37] Where health insurance information is needed to guide service provision, questions should be framed sensitively, articulating the assurance of care regardless of status and obligation to protection of data from enforcement agencies. To ensure safety and inclusion of all im/migrants in healthcare settings, it is imperative for all staff and providers to be trained to avoid questioning of patients in ways that could be construed as "status-checking" or declining access to care dependent on immigration status.

Health insurance

Confusion over what and who are covered by public insurance limits access to necessary services, and contributes to uncertainty and fear, even for participants with coverage. People need clear information about where they can access care regardless of insurance status, and access to health services should be determined by need and not health insurance coverage. Healthcare providers need to be aware of the Interim Federal Health Program, third-party insurance for workers, and local options for people who do not have provincial health insurance.

Diverse and intersecting community needs

Immigrant communities are diverse and have varied cultural backgrounds and experiences of health and healthcare in Canada. Health systems need to be prepared to meet the diverse needs of im/migrants in their interactions with the healthcare system. This includes adequate training for clinicians to deliver culturally safer care and to communicate effectively. Culturally safer care is grounded in cultural humility, an approach that can be applied with any community, and is especially relevant for Indigenous people and im/migrants in Canada.[38] Cultural humility can be learnt and integrated at every level of service design, from on the ground providers through health system administration.

Im/migrants also experience intersecting determinants of health, including race and gender. Gender intersects with experiences of immigration, discrimination, and trauma.[2] For many participants the gender concordance of their clinicians was fundamental to feeling comfortable receiving care, particularly sexual and reproductive healthcare. Flexibility is needed to be able to support gender concordance between patients and clinicians when this is important to patients. This can be challenging in urgent care situations but can be approached with humility and sensitivity in order to meet peoples' needs.

Language

Inconsistent support for quality, professional interpretation, or access to services in preferred languages contributed to unmet healthcare needs and poorer health outcomes among participants. Requiring people to supply their own interpreters or using friends and family members can be harmful (e.g., increasing medication errors, supporting abusive partners, and miscommunication). Communication is a core competency for any clinician and the basis of safe and high-quality care.[39] Language discordance can be meaningfully mitigated through a variety of widely available and appropriate options in Canadian healthcare settings. These include professional interpretation via phone, videoconference, or in person through trained agency interpreters or Community Health Workers (such as Cross Cultural Health Brokers).[40] These interpretation options can be integrated into health service design to support and normalize consistent, competent use whenever needed in patient interactions. Providing appropriate interpretation is nuanced and changes with interpersonal dynamics, gender, community norms, and size of community in Canada.[41] There is an urgent need for more widespread access to high-quality, trained, and culturally competent interpretation within care delivery settings, and also for more multilingual information on health promotion, health services and system navigation.

Experiences of trauma and discrimination

Many im/migrants come to Canada with experiences of trauma. Participants described how these experiences influence interactions with care. When care is not trauma-informed, im/imgrants' interactions with healthcare can be retraumatizing and they may avoid future visits or types of care that they need.[42] Discrimination is embedded in the provision and quality of care through assumptions made about race, age, im/migration status, gender (e.g., if and how contraception is offered),[2] and where multiple axes of discrimination are present, im/migrants experiences of care are uniquely degraded.[12] Discrimination and prior trauma together undermine equitable healthcare provision; however, these can be overcome with organizational interventions that include trauma-informed and equity-oriented approaches.[43] Interactions with frontline and administrative staff shape trust and experiences of care, so organizational training and approaches must be continuous, include all staff, and consider physical design.

Health system navigation

Participants described receiving little information about their rights, how the health system operates, and how they can access care. Im/migrants need clearer information about how to

navigate the system and access care they need, in multiple languages. Orientations to the health system should be offered as a routine part of arriving in Canada,[44] for example, through peer-led or community-based organizations, or partnerships between settlement and healthcare agencies, or public health.

Community-based organizations

Community-based organizations played crucial roles in supporting access to healthcare for participants. They are often filling gaps created by political and economic structures that marginalize im/migrants, especially refugees and people with no or precarious immigration status; they can sometimes provide life-sustaining support. Yet, they are under-resourced and sometimes limited by their funders in who they can serve, for how long, and the scope of their services. They often know the specific vulnerabilities and barriers constructed for diverse im/migrant communities, and have insight into meaningful and effective strategies to mitigate these. Community-based organizations need to be adequately resourced for immigrants with any status and connected to health services planning.[20]

Discussion

These findings, recommendations, and questions are intended to help people planning or delivering health services to address inequities in health related to immigration. A key feature of these recommendations is that they are intended to reduce barriers to access across all service delivery contexts, and for all im/migrant populations—with attention to those with the most structural disadvantage. In addition, the recommendations proposed improve accessibility and strengthen system capacity broadly, applicable for any populations with intersecting health barriers including racism, discrimination, and trauma.

We recognize these recommendations come as health systems are under intense strain. Putting them into practice requires staff time for information gathering, training, reflection, and policy development which we recognize is in short supply. We also observe that many organizational and payment models do not facilitate needed teamwork and collaboration. While many health systems have released equity, inclusion, diversity, accessibility, and/or anti-racism strategies and frameworks, these must come with practical investments in implementation including protected time for the processes needed to bring principles to practice.

Efforts to more comprehensively meet the needs of people who have immigrated must be a priority, and these efforts work in synergy with efforts to strengthen health systems more broadly. People who have immigrated play outsized roles in supporting the health system as health workers and as taxpayers relative to the services they use.[45] This is such a necessary influx of personnel that in June 2023, IRCC announced a new immigration stream specifically for healthcare workers.[46]

In addition to these recommendations specific to service planning, broader health insurance and immigration reforms are also needed. Within provincial health systems, wait periods for provincial health insurance must be eliminated. Making people wait for health insurance is inefficient and leads to worse outcomes. Within federal immigration systems, exploitative immigration programs that create precarity through temporary status must be redesigned, so that everyone living in Canada has permanent legal status and access to insurance.

Conclusion

Collective and coordinated action is needed to achieve equitable health for all immigrants and migrants in Canada. These recommendations are intended to help make sure that all health services are accessible to everyone, and move beyond a homogenizing category of "newcomers" into practical, meaningful strategies that attend to diverse and intersecting community needs.

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Ethical approval

This project holds ethical approval from the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards.

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