DISCUSSION AND DEBATE

Authentically and Effectively Addressing Migrant Health Needs

Répondre de façon authentique et efficace aux besoins des migrants en matière de santé

AKSHAYA NEIL ARYA, BASc, MD, CCFP, FCFP, DLITT
Adjunct Professor
School of Public Health Sciences
University of Waterloo
Waterloo, ON
Assistant Clinical Professor
Family Medicine
McMaster University
Hamilton, ON

Abstract

This rejoinder proposes solutions to improve the health of newcomers, reflecting the author's clinical, teaching, research and advocacy experience. Tackling declining physical and mental migrant health requires an appreciation of varied experiences before and within Canada, necessitating a holistic approach involving the health system and beyond. Using examples of recent migration waves, the author implores policy makers to move beyond system constraints, consult with those implementing and with those affected and develop funding models to support interdisciplinary team-based specialized primary care clinics. Concurring with the importance of interpretation, the author would, however, base this in justice, and beyond training health professionals in cultural competency, asserts the need to address power, institutional responsibility and the right to health.

Résumé

Cette réplique propose des solutions pour améliorer la santé des nouveaux arrivants, en se basant sur l'expérience clinique, d'enseignement, de recherche et de plaidoyer de l'auteur. La lutte contre le déclin de la santé physique et mentale des migrants nécessite une appréciation des diverses expériences avant et après l'arrivée au Canada, ce qui demande une approche holistique concernant le système de santé, mais aussi au-delà de celui-ci. À l'aide d'exemples de vagues de migration récentes, l'auteur exhorte les décideurs politiques à aller au-delà des

contraintes du système, à consulter ceux qui le mettent en œuvre et ceux qui en sont affectés et à développer des modèles de financement pour soutenir les cliniques interdisciplinaires spécialisées dans les soins primaires. Tout en reconnaissant l'importance de l'interprétation, l'auteur fonderait toutefois cette approche sur le droit et, au-delà de la formation des professionnels de la santé en matière de compétence culturelle, il insiste sur la nécessité d'aborder les questions du pouvoir, de la responsabilité institutionnelle et du droit à la santé.

Introduction

I was asked to comment on *Breaking down barriers and solutions for newcomers* in light of my experience as a clinician running a refugee health clinic since 2008, as a global health educator and as a researcher. As such, I will be referring extensively to my own published work.

The article attempts to understand and address barriers to optimal newcomer health, addressing health system changes required to meet their needs. It recognizes that while many begin their journey with seemingly better than average health, following an initial honeymoon period, over the years, their health appears to decline.

Morton Beiser spent a career interrogating such issues, beginning by studying the "Vietnamese boat people" who arrived in the late 1970s, and recognizing the willingness of ordinary Canadians to help with newcomers, triggered Canada's private sponsorship program (Beiser 2005). Those people generally adjusted well, quickly finding employment and integrating, as had the "Ugandan Asians" who came a few years earlier. Beiser sought to develop a model to understand newcomer well-being "that takes into account both predisposition and socio-environmental factors, provides the best explanatory framework for extant findings." Any model would incorporate both stress buffers, the impact of societal attitudes, job availability, personal and social supports and the absence of these, which seemed to render some people more vulnerable to depressed mood and other mental health issues, with disillusionment and nostalgia for a lost past. Beiser recognized that understanding the reason the "boat people", and even certain child migrants who were living in poverty, did better than long-term Canadians in similar circumstances, while most other newcomers did not, must include appreciating the effects of social exclusion and discrimination on health and well-being (Beiser 2005).

Though the authors make valid points regarding primary care, screening and prevention, adherence to treatment, inappropriate mental health, emergency department, primary and specialist care services and non-evidence-based or traditional therapy use, and relate these to fear and misunderstanding, their lens as to why health might deteriorate is much narrower than Beiser's. They recognize that, given the heterogeneity of the migrant population from skilled migrants, to students, to seasonal agricultural workers, to those uniting with family, the "healthy immigrant effect" is not universal, and acknowledge that unpacking reasons behind the decline in health is rather challenging due to class, size of city and social support.

Solutions must therefore be tailored to the specific context of the patient. Furthermore, it must be noted that among refugees, each class – government-assisted, privately sponsored (largely unique to Canada) and claimants being the main ones – is entitled to different supports. "Under the table" and rejected migrants, who make up a lesser proportion in Canada than much of the rest of the Global North, receive even less assistance.

Challenges to Refugee Healthcare

To examine the impact of policies and practice, I will review surges in Canadian refugee intake during the last two decades when I have been involved as a clinician. These times perhaps acted as stress tests, identifying systemic issues impacting refugee health.

Our specialized primary care refugee clinic was formed in 2008 in response to a large influx into Kitchener-Waterloo of ethnic Karens from Myanmar, and the inability of the local reception centre assisting with settlement of government-assisted refugees (GARs) to manage the medical needs of this population. Though not funded by the federal government to deal with health, their case workers found that half of their time was related to managing medical needs. Our clinic was shown to reduce barriers to help their clients find permanent primary care providers, and seemingly to find appropriate specialist care and reduce unnecessary emergency visits (McMurray et al. 2014).

In 2015–2016, as the new federal government quickly welcomed more than 25,000 Syrians, our community and clinic were again challenged, receiving more than three times our annual number of refugees in Kitchener in just three months. Moved by the image of the doll-like, lifeless body of Alan Kurdi washed up on the Mediterranean shore, many Canadians saw this response as a welcome change from the previous government's campaign vilifying migrants, and proposals for a citizen questionnaire to ensure conformity with Canadian values and a "barbaric practices" snitch line. A few years prior, the government suggested that refugees were "queue jumpers," abusing the system at the expense of ordinary Canadians, suddenly cutting their "gold-plated healthcare," which, in reality, corresponded to that received by those on social assistance, even to the GARs that Canada had invited. It was only after a massive response from the medical community that the government backed down on these healthcare cuts (Arya et al. 2012).

While admirable in terms of goals, speed and nimbleness of management in the 2015–2016 Syrian response, the inherently disorganized approach of the new government sometimes sidelined important players. Though an attempt was made at coordinating federal and provincial responses, the conflicting jurisdictions inherent in the Canadian system sometimes resulted in disjointed work, with a lack of responsibility and accountability, ultimately relying on local responses involving the goodwill of communities and healthcare providers to develop collaboration and integration. Numerous roundtables of different government levels and of public health were held, but involvement of, consultation and communication with, those who would be administering care, was limited. Plans, in terms of whether these

migrants would be housed at a military base or in local hotels, the type of initial primary care screening and the flow of information both from overseas as well as within the country, changed on the fly. Thus, political will, cited by the authors, while critical, is, by itself, insufficient, and must be accompanied by coordination of stakeholders at all levels.

In 2021, responding to the needs of vulnerable Afghans as the Taliban overran the nation, presented new challenges. Many who had worked with the Canadian military and non-governmental organizations, and their families, suffered acute trauma and often had divergent expectations of what Canada owed them and what would be available here, triggered by promises made by their Canadian expat partners. They often found that this was lesser in terms of rapidity of access to consultation, surgical management and therapy, than available to those on military bases in Afghanistan. Furthermore, many Afghans were technically not refugees, as defined by the 1951 Refugee Convention as a person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable or, owing to such fear, is unwilling to avail [themself] of the protection of that country" (United Nations High Commissioner for Refugees n.d.), as they were rushed directly from Afghanistan, thus were not outside their borders or could not have a refugee status determination. Depending on the goodwill of the province where they resided, it could take more than a year (Government of Canada 2023) to allow them access to some healthcare services otherwise available to refugees.

A year later came a crisis caused by Russian military aggression in Ukraine. The response of Canadians, as in much of Europe, appeared relatively generous, compared to that toward previous populations. Many Canadians, particularly in western Canada, whose families fled Czarist and Communist rulers from the same region a century prior, readily identified with these newcomers' experience. While people's attitudes toward other migrants hardened, innovative new structures were developed to allow hundreds of thousands in, granting temporary status with the ability to work for three years (CLEO 2022), accessibility to social safety nets, and community and church cultural support and even one-time payment on arrival. As the conflict dragged on, the temporary status of Ukrainians became less tenable, and they too faced logistical barriers in becoming Canadian permanent residents.

At the same time in 2022–2023, African claimants in Toronto suddenly found themselves sleeping in the street lacking food, sanitation and water as shelters were overwhelmed, necessitating a response from cultural and faith-based community organizations. Claimants are more likely to have mental health issues related to more recent trauma and unresolved status than other migrants. Reports by Toronto's Ombudsman (Ombudsman Toronto 2024) and the United Way (United Way Greater Toronto 2025) found this shameful situation to be a result of a surge in claims, together with federal cuts and policies limiting beds to migrants, but underlying these, anti-Black racism was partially responsible. Such findings were quickly denied, and their recommendations dismissed by authorities.

Despite the goodwill of many, another heartbreaking lack of Canadian institutional response occurred with efforts to bring Gazan children to Canada after Israel's Operation Protective Edge in 2014. With my friend Izzeldin Abuelaish, who had himself suffered the loss of three daughters and a niece in Israel's Operation Cast Lead in 2009, I worked on mobilizing a medical response. We developed Heal100Kids (Belgraver 2014) and engaged the support of the Ontario government and ministry of health, children's hospitals, health personnel, only to be impeded by the federal government's denial of visas. Though all opposition parties had been supportive at the time, attempts to resurrect the project with the new government in 2021 following another incursion failed as it even refused attempts at dialogue. Now, in conditions considered a plausible genocide, in early 2024 by the International Court of Justice and declared by Israeli and international health, human rights, genocide and legal scholars to be the same, Canada only agreed to receive 5,000 people with ties to Canada; two years later only a trickle have been allowed in (Immigration, Refugees and Citizenship Canada 2025). Thus, absence of political will can, indeed, be important.

A major issue cited by the authors is payment models. Though for years until 2022, our clinic operated primarily with my individual fee-for-service billings, supplemented by the use of trainees and international medical grads in an academic teaching centre. Assisted by the indulgence of colleagues recognizing refugee care required relatively higher overhead, and goodwill from our local health integration network later supplying some resources for allied health professionals, ultimately this complex arrangement was untenable. To achieve sustainability, something beyond fee-for-service such as a salaried model for physician services is essential and more support for an integrated interprofessional team of providers is necessary to deal with refugee needs as they struggle to adjust to their own challenges and Canadian society.

Our 2013 article classified barriers to care into system-wide, institutional and individual elements, and these included rigidity and bureaucracy, finance and logistics, understanding of specific disease and issues, language and culture at each level (McMurray et al. 2014). Clinics across the country operate with varied models and different resources, some well-integrated and funded, while others, particularly in smaller communities, less so. Some take patients only for the first few months, and others several years, or do not discharge people at all. Some incorporate various allied health professionals, have relationships with pharmacies, diagnostic facilities, specialists and community agencies while others have very few. A University of Calgary venture, of which I am a part, has gathered more granular data as to what exists, allowing points of dialogue with decision-makers (Refugee Health YYC n.d.).

While healthcare is very important, more important determinants of refugee health are physical safety, what is happening with family (Hynie et al. 2019), both in Canada and back home, jobs, lodging, education, food security (Si et al. 2025) and so on. A point often lost are the unsung heroes in response, volunteers, interpreters, those from agencies who go far beyond roles and constraints to assist clients first, as individuals needing help.

Language

The authors highlight the importance of funding trained medical interpreters. Language discordance between the healthcare provider and migrant is certainly a major issue. In a comprehensive article (Arya et al. 2024), we captured the difference in funding across provinces, within cities and even among hospitals within the same city. We made a case for interpretation in healthcare as a human right and global responsibility, considering issues of informed consent to procedures and right not to be harmed, rights to accessibility recognized within the court and school systems and for those with disabilities and literature regarding cost benefit.

They cite the potential of new translation apps and artificial intelligence software to supplement such interpreters. New modes of interpretation certainly are a boon, particularly in more peripheral areas and with languages with few speakers in Canada. We must remember that language is not only important during the clinician-patient interaction but also with administrative staff and in written materials. In some communities with lesser integration of health records and availability of interpreting services, though less than ideal, a physical health passport may be a low-cost and easy to implement remedy to language barriers with health personnel (Martel et al. 2015).

The pandemic represented a great challenge to those dealing with newcomers, as agencies supporting them no longer provided in-person accompaniment, if they functioned at all. Providers turned to virtual care (Hynie et al. 2023) and innovations led to increased funded options, which persisted post-pandemic and as machine translation improved. Even patient information regarding COVID-19 pandemic, clinics for treatment and immunizations developed resources that could be accessed by patients' smartphones using QR codes (Arya et al. 2021).

While we, as the authors, recommended funding of medical interpretation services and compensating the added time, infrastructure and efforts for providers (Arya et al. 2024), we need to explore why, even when funded, available and remunerated, these services often are not used (Ng et al. 2023). Addressing barriers includes logistics of accessing interpretation, training of individuals and institutions in utilization and mandating such care by regulatory and professional bodies if necessary.

Training for Action

Finally, the article addresses how healthcare professionals should manage effectively within a multicultural society, when patient beliefs systems regarding the value (or inutility) of Western medicine and prevention, as opposed to spiritual and holistic options, may have them choose alternatives.

Practitioners certainly must be trained, as the authors assert, in terms of what is considered cultural competency or cultural humility (Hayhoe and Allison 2020), but must go further, learning from Indigenous Populations in terms of other world views, but also

managing intergenerational trauma and loss of traditions, and systems of support affecting mental health (Arya and Piggott 2018). Outside of formal training, an approach based on values such as humility, introspection, concern for social justice and solidarity suggested for global health settings might be useful (Pinto and Upshur 2009).

During the COVID-19 pandemic, racialized populations were at higher risk for COVID infection (Guttmann et al. 2020) and were also less likely to access vaccines (Wanigaratne et al. 2023), considered, in part, as a result of discrimination (Lin 2025). Appreciating power relationships and more purposefully seeking out priorities of such populations themselves, as we sought in our study of South Asian seniors, is critical (Arya and Tong 2023).

To fulfill the promise of Health for All, health personnel need to ascertain how interprofessional health teams can work collaboratively with our patients and their brokers. But we need to go further. As I cited in Rudolf Virchow's study of health of coal mine workers in Upper Silesia in the 1850s, we should seek out root causes, which are often in the realm of policy and intrinsically political, and advocating for measures to address these, is a medical responsibility (Arya 2013).

Correspondence may be directed to Akshaya Neil Arya by e-mail at narya@uwaterloo.ca.

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