MIGRATION AND GLOBAL HEALTH

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AGENDA

◦ Introductions
◦ Definitions
  ◦ Migration globally
  ◦ Migration in Canada
◦ Migration as determinant of health
  ◦ One example to discuss: detention
◦ Access to health services for migrants
  ◦ One consideration: does health system financing have an impact?
◦ Conclusions/considerations
INTRODUCTIONS

◦ Who am I? And why am I talking to you about migration?
◦ Who are we in the room?
◦ Agreements
DEFINITIONS
Who is a migrant?

• “... a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students.”

IOM UN Migration
https://www.iom.int/who-is-a-migrant
Last accessed 06 October 2019
WHERE ARE MIGRANTS?

INTERNATIONAL MIGRANT STOCK (%) RANKING

- United Arab Emirates
- Qatar
- Kuwait
- Monaco
- Liechtenstein

INTERNATIONAL MIGRANTS STOCK (%) CANADA

Migration Data Portal
https://migrationdataportal.org/
Last accessed 05 October 2019
MIGRANT HEALTH DATA: CHALLENGES

GLOBALLY

IN CANADA

United Nations High Commission for Refugees
https://www.unhcr.org/figures-at-a-glance.html
Last accessed 05 October 2019

Last accessed 05 October 2019
MIGRANT HEALTH DATA: CHALLENGES

DOI: https://doi.org/10.1503/cmaj.090287

Migration and health in Canada: health in the global village

Brian D. Gushulak BSc MD, Kevin Pottie MD MCIsc, Janet Hatcher Roberts MSc, Sara Torres MSW, Marie DesMeules MSc, on behalf of the Canadian Collaboration for Immigrant and Refugee Health

ABSTRACT

Background: Immigration has been and remains an important force shaping Canadian demography and identity. Health characteristics associated with the movement of large numbers of people have current and future implications for migrants, health practitioners and health systems. This paper examines the current literature to identify demographics and health status data, health service needs, health status from population studies, and health service implications associated with migration to Canada.

Methods: We systematically searched Ovid MEDLINE (1996-2009) and other relevant web-based databases to examine immigrant selection processes, demographic statistics, health status from population studies and health service implications associated with migration to Canada. Studies and data were selected based on relevance, use of recent data and quality.

Results: Currently, immigration represents two-thirds of Canada’s population growth, and immigrants make up more than 20% of the nation’s population. Both of these metrics are expected to increase. In general, newly arriving immigrants are healthier than the Canadian population, but over time there is a decline in this healthy immigrant effect. Immigrants and children born to new immigrants represent growing cohorts; in some metropolitan regions of Canada, they represent the majority of the population. Access to health services and health conditions of some migrant populations differ from patterns among Canadian-born patients, and these disparities have implications for health services of this size has important implications for health practitioners, health systems and the health of individuals.

Health status is associated with quality of life and use of formal and informal health services. Overall, immigrants appear to be healthier than the Canadian-born population, by virtue of being capable, both physically and mentally, of successfully moving themselves, and often their families, from one country to another. However, over time, this healthy immigrant effect is lost. Health status is not equivalent across all subgroups of immigrants. Certain migrant populations experience a higher risk of infectious diseases, cancer, diabetes and heart disease, which has clinical implications for those providing care to migrant communities. The health of migrants is a product of
MIGRATION AS DETERMINANT OF HEALTH
MIGRATION AS DETERMINANT OF HEALTH

IOM UN Migration. https://www.iom.int/social-determinants-migrant-health
Last accessed 06 October 2019
MIGRATION DETERMINING HEALTH: ONE EXAMPLE

CFPC Position Statement: A call to limit the detention of immigrants
May 2019

This position statement was created by the members of the Prisons Health Program Committee of the College of Family Physicians of Canada (CFPC). The committee aims to represent the interests of all CFPC members who provide care to incarcerated men, women, and youth and to these individuals’ families and communities; for these CFPC members this care may be part of a broad scope family practice or a special interest/focused practice.

Background
While the issue of migrant detention dominated the news in 2018 due to developments in the United States, Canada also has a long history of detaining immigrants. In the federal government’s fiscal year of 2016–2017 alone Canada detained more than 6,000 migrants, including 162 minors—of whom 31 were unaccompanied.

Migrants may be detained in Canada for not providing identification deemed adequate by immigration authorities, for being at risk of not attending immigration appointments such as those prior to deportation, for being deemed a threat to public safety, or for administrative purposes, such as to complete an admission interview. The vast majority of migrants who are held in immigration detention are not suspected of having committed a serious crime.

The Canadian Border Services Agency (CBSA) is responsible for the detention of migrants. However, more than one-third (38.9 per cent) of individuals detained for immigration purposes in 2016–2017 were held in the prison system rather than in specific CBSA-managed facilities. Detention status is reviewed monthly in administrative hearings, but there is no set time limit for detention; in 2016–2017 in Canada 439 detainees were held for more than 90 days.

Both nationally and abroad, Canada has faced criticism over its immigration detention system. Given the lasting repercussions of the federal government’s separation of Indigenous families in the past, an Indigenous organization in Canada has called for a review of Canada’s migrant detention practices. Recent unexplained deaths and hunger strikes of detained migrants in custody have galvanized action regarding this situation in Canada. The Global Detention Project—a not-for-profit human rights organization based in Geneva, Switzerland—has compared Canada’s system unfavourably with those of many similar countries, and our country’s use of prisons for the detention of migrants is one source of criticism. Treatment in context with...
MIGRATION DETERMINING HEALTH: ONE EXAMPLE

Policy alternatives
The CFPC believes the federal government should end indefinite detention of immigrants, and further take steps to limit the use of detention, given the demonstrated adverse health effects of imprisonment and detention. Many European Union countries have set statutory limits to detention; for example, the limit is three months in France and Sweden and six months in Germany. After these periods of detention detainees are to be released, regardless of the respective government’s case or concerns.

Calls to action
1. The CFPC calls for the federal government to limit the use of immigration detention as a practice given the health harms associated with imprisonment and detention.

2. The CFPC recommends that Canada immediately end the indefinite detention of migrants. The CFPC suggests that Canada implement a 90-day time limit for immigrant detention, within which the government should resolve any concerns it has about a migrant.

3. The CFPC recommends against holding migrants for immigration detention purposes in provincial prison systems.

4. The CFPC calls for an end to the shackling of detainees who require care outside of detention facilities. The level of care people in detention receive should be at least equivalent to that afforded to Canadians in general, with special attention paid to their vulnerabilities.
MIGRATION DETERMINING HEALTH: ONE EXAMPLE

Supreme Court confirms right to challenge unlawful immigration detention through habeas corpus

Canadian Council for Refugees
Media release

For immediate release
10 May 2019

Supreme Court confirms right to challenge unlawful immigration detention through habeas corpus

The Canadian Council for Refugees welcomes the Supreme Court of Canada’s decision in the Chhina case which confirms that immigration detainees may challenge the lawfulness of their detention through habeas corpus.

The Court’s decision strengthens protection in Canada of the fundamental right to liberty. Detention often has devastating impacts, even when it is only for a short period, particularly for children, refugee claimants, trafficked persons and individuals suffering from mental health issues.

The CCR was an intervenor in this case, arguing that people detained under the immigration legislation do not always receive a fair hearing by an impartial decision-maker. This fact is illustrated by a recent external audit of detention reviews at the Immigration and Refugee Board. The Supreme Court cited the audit and reached a similar conclusion about the gaps in protections available to detainees under immigration legislation.

The CCR was represented in this case by Erica Olmstead, Peter Edelmann and Molly Joeck.

https://ccrweb.ca/en/media/supreme-court-detention-chhina
Last accessed 06 October 2019
ACCESS TO HEALTH SERVICES
**Migrant Access to Health: One Consideration**

<table>
<thead>
<tr>
<th>Model</th>
<th>Financing</th>
<th>Provider</th>
<th>Access</th>
<th>Example</th>
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<tr>
<td>Beveridge</td>
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<td>Universal</td>
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<td>Universal</td>
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<td>Out of pocket</td>
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**ACCESS TO HEALTH SERVICES FOR MIGRANTS**

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<th>Secondary Care</th>
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Last accessed 07 October 2019
## Access to Health Services for Migrants

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ACCESS TO HEALTH SERVICES FOR MIGRANTS

Photo: Baijayanta Mukhopadhyay.
30 September 2017.
Southbank, London, United Kingdom.
ACCESS TO HEALTH SERVICES FOR MIGRANTS

Médecins du monde Canada.
Last accessed 05 October 2019
For refugees in need of medical care, Iran health-care programme is a lifesaver

The Islamic Republic of Iran is one of only a few countries to provide comprehensive medical insurance for refugees on the same basis as its own citizens.

Despite being partially blind since birth, Ali Hashemi works as a garbage collector in a small city near the Iranian capital Tehran to provide for his wife and three children.

While Ali takes his visual impairment in his stride, the significant costs of his medical treatment placed ongoing strain on the family’s limited income. Ali sometimes waived his regular medical care in order to meet other basic needs for his children, such as transport to school and even nutritious food.

“I have to see the doctor regularly for check-ups and to get medication, but this wasn’t always possible. My family comes first for me – it will always be my obligation as a father and a husband to provide for them,” he explains.

Ali is one of close to one million Afghans and Iraqis who fled insecurity in their own countries and currently live as refugees in Iran.

Last accessed 06 October 2019
MIGRANT ACCESS TO HEALTH: ONE CONSIDERATION

From primary health care to universal health coverage—one step forward and two steps back

Primary health care (PHC), codified at the historic 1978 Alma Ata Conference, was advocated as the means to achieve health for all by the year 2000. The principles of PHC included universal access and equitable coverage; comprehensive care emphasising disease prevention and health promotion; community and individual participation in health policy, planning, and provision; intersectoral action on health determinants; and appropriate technology and cost-effective use of available resources. These principles were to inform health-care provision at all levels of the health system and the sector threatens to minimise its role in promoting other health-related SDGs such as food and nutrition (SDG 2), gender equality (SDG 5), and water and sanitation (SDG 6); and, importantly, the reduction of inequality (SDG 10), promotion of environmentally responsible consumption/production patterns (SDG 12), and mitigation of climate change (SDG 4).

Moreover, the term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme. For many LMICs, this has meant operationalising UHC through

Sanders et al., 2019. « From primary health care to universal health coverage – one step forward and two steps back. » *Lancet* 394(10199): 619-621. DOI: [https://doi.org/10.10161S1040-6736(19)31831-8](https://doi.org/10.10161S1040-6736(19)31831-8)
CONCLUSIONS – THREE THINGS TO CONSIDER

◦ Consider definitions in data carefully – who is included, and who is not.
◦ Consider definitions in policy choices carefully – what is included, and what is not.
◦ Consider the choices host societies make that have an impact on the lives of migrants – those choices can be shifted, for bad or for good!
REFERENCES/RESOURCES*

- Canadian Council for Refugees: http://ccrweb.ca
- College of Family Physicians of Canada: http://www.cfpc.ca
- Docs Not Cops: http://www-docsnotcops.co.uk
- European Union Agency for Fundamental Rights: https://fra.europa.eu
- Immigration, Refugees and Citizenship Canada: https://www.canada.ca/en/immigration-refuge-citizenship
- IOM – UN Migration: http://iom.int
- Médecins du monde Canada: http://medecinsdumonde.ca
- Migration Data Portal: https://migrationdataportal.org
- People’s Health Movement – North America: https://phm-na.org

*Please use these references/resources with a critical perspective 😊
THANK YOU

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