April 8th, 2024

Beyond Technology, Beyond Healthcare: April Session, Day 1

Canadian immigration and integration: 'Mind the Gap,' Dr. Anna Triandafyllidou

"A good system needs to provide for all of us, not just those of us who are the strongest and the fittest."

Big picture of migration with specific focus on health and wellbeing of migrants and racialized persons; considerations of impact of Covid ('compression' then mobility), intensification of climate change, rise of global authoritarianism, democracy appearing 'fragile'; **Digital divide** during covid: 'people growing apart and not together' out of polarization from social media, challenge with universal internet access. In CAN approx. 437,000 new PRs in 2022; 471,000 in 2023; goal: stabilise to 500,000 in next 3 years; 1.5M temp residents in July 2022, 2.2M in July 2023; 1 of 3 CAN businesses owned by an immigrant; 1 of 4 healthcare workers a newcomer. Immigration and Employment: Despite media hype, over 50% of CANs disagree that there are too many immigrants. **Reversal of labour market trends** from 1M jobs vacant in 2022 to employment at capacity in 2023 – 5.8% unemployment, 50% of health professionals with foreign credentials work outside their skills' area, because international credentials not recognized (Huge **Brain Waste**); **Dual rise predicted for digital and healthcare sectors**: Investment in **Advanced Digital Technologies (ADT)** in the Canadian public sector forecasted to rise from USD $47M in 2018 to $500M by 2025; Healthcare accounted for 11.5% of Canada's GDP in 2019.

Policy Pathways and Policy Narratives for PRs – 'instrumental narrative' and 'healthy immigrant' effects (neoliberalism)

1. **Economic (60%):** those coming to work or settle; **instrumental narrative** prioritizing worker skillsets and suitability for employment over wellbeing of persons, needs to be about people and communities; **Proactive/ planned/ permanent** – secure status BUT involves deskilling; we can plan immigration but expectation of full control – impossibility, can only manage; **discrimination** in employment opportunities for immigrants and policies insufficient; **Regionalisation** – attraction & retention of people to middle and small towns a challenge; **Provincial nominee programs** – rely on 2-step migration; fuels instrumental narr- Need to go beyond this narr: now non CAN-born have higher education levels than CAN-born
2. **Family (30%):** understood as nuclear, challenge for extended members; PGP lottery and supervisa program restrictive esp. for those from the Global South; program over-subscribed, multiple entry visa, grandparents cannot work; **Moral and political dilemma in family integration** – 'if I am a citizen, why can't I bring my family here'; incorporating those into welfare system who didn't contribute? Narrative slanted to economic benefits.
3. **Humanitarian (10%):** resettlement, **criteria of vulnerability** and not skilled; 110,000 people resettled 2017-2021: PSRs (69,000), GSRs (41,000) – CAN pioneer in private sponsorship, globally recognized PSRs tend to fare better; Differences and stark contrast in programs, i.e. why special considerations for Ukrainians and not for others?

Gaps in the system: **points very high** for points system; **transition bottlenecks**: prolonged temporariness – no support for temp residents; PRs – persistent & **chronic brain waste**, **persistent discrimination**, **skills mismatch**-Canadian experience, **low uptake of services** in spite of existing settlement services (only 10% of newcomers entitled use them)

Solutions: 1) **supporting integration:** ADT for settlement service info & provision, pre- & post- arrival orientation, work with employers; 2) **facilitate transitions:** service provision for int. students & temp work permit holders, regularization mechanism for those who fall out of status; 3) **change the narrative?** We know a lot about who is coming and staying, but less about who leaves and for what reasons? 4) **De-migrantize integration**: '**whole story approach'** – account for broader transformation processes, incl. aging society, ADT, increased multi-step mobility, proliferation of crisis situations, complex health needs & complex aspirations – demographics not enough, **we need to understand complex health needs** (beyond asylum seekers, this affects everyone)

Q&A: *The role of digital health in mitigating the gap in terms of complexity of health needs and the narrative?* Health insufficiently covered by this narrative, CAN actively recruits abroad for healthcare system; we shouldn't lose opportunity brought by Covid to have broader conversations; our 'sensitive' CAN health protocols are in fact **culturally insensitive**; for tech both positive and negative – can reach remote communities, expand mental health services, telehealth, but not same as meeting in person; health info private – data stewardship needed. AI can help but unsure of its role; engineers think differently than government policy makers - amount of tech needed for quicker decisions. *Observations about tech influencing/ shaping the global flows of people?* Everyone faces uncertainty; people more proactive in searching for info and use multiple sources/ online platforms; misinformation spreading; mobilization can be positive but also negative in promoting populism, sharing inaccurate info, proliferation of hate speech; **we are globalized, but in our bubbles – how to make these bubbles speak to each other?** *Challenges of immigration policy at federal level with health policy at provincial level?* Confusing, disconnect; ON, BC, QC at the front of connecting fed to prov – healthcare sector an opportunity for connection & standardization. *GSRs and the work of settlement orgs taking on brunt of work expected of gov, but underfunded and people falling through cracks – how to bridge the gaps where there is clear need but fragmentation?* Initiatives like this conference, where research and practitioners come together to bridge the gaps; identify pros and cons; state responsible for newcomers, we are responsible too as 'the state is us.'

Presentation of AMS Research Findings, Dr. Ibukun Abejirinde

"The Social determinants of health shaped if and how newcomers experienced virtual care compassionately, but providers often lacked the resources to address these issues directly, leading to provider burnout and fatigue."

Study Objective: How can we better support virtual care (covid context for newcomers) with compassionate care? Using a health equity anchored lens to understand how immigrants can be supported with virtual care. Design: partnered with Crossroads clinic, FCJ Refugee Centre, Access Alliance; interviewed 25 patients from different migration pathways and service providers catering to them: how was their experience of virtual care? Was it compassionate? **Compassionate care** defined as ability to identify/ do what it takes to alleviate suffering; it is equity in action. **Intersectionality-Informed Data Analysis** – intersectionality to understand experiences and can explain power relations. Results - interconnected findings: **care expectations** of patients shaped by home country – CAN was first time to have virtual care, awkward; **structural factors:** temp status, persons from Africa, MENA region, Black persons have less access to virtual care; those without permanent housing or with precarious status lack postal code (documentation) needed to access services, incl SIM cards; virtual care challenging for different languages and addressing mental health issues. **Experiences and**

expectations of virtual care was linked to factors along intersecting axes of privilege and oppression. Root cause Analysis: Systemic inequities and structures; settlement organizations, healthcare providers, social workers were watering the system from the branches, we need to start watering at the roots; **4 levels of factors: structural, systemic, institutional, interpersonal**. Virtual care/ tech can be a bridge in facilitating initial contact, building trust and rapport, but also a wall in limiting patient-provider relationship; Gross inequalities even in pool of refugees & asylum seekers; Need partnership and service designs around the **whole person** (moral, ethical, social imperative). **Mapping the journey of newcomers** through different settlement pathways towards accessing healthcare showed the map was very complicated and fragmented. Challenges to integration that providers recognized as manifesting in physical and mental stressors, BUT these symptoms are determined socially. Healthcare happens down the line. Map highlighted levels of opportunity to identify gaps and barriers: individual/ institutions/ community/ policy. At **Individual level**: Language barriers, personal trauma, legal navigation, fear of deportation. **Healthy immigrant effect to healthy morality paradox:** newcomer health not prioritized due to instrumental narrative; immigrants appear to be living longer but living in worse conditions than CAN-born persons; **Centrality of social determinants of health (30-55% of healthcare outcomes related to social determinants)**: shapes/ grounds how people experience healthcare; more important than lifestyle or direct health choices; need to address housing to shift the precarity; SDH related to chronic disease, stress, mental health issues. People showed **different benchmarks of compassionate care** depending on where they were in their journey, issue of listening – some people felt they were being gas lit; for some compassion was being seen, not put in a box; also about having a choice - patients having choices to empower them. **Shared impact, shared responsibility, shared action:** poor integration evident between settlement sector and healthcare sector - Symptoms of a broken settlement and immigration system eventually manifest in health and societal issues**. Call to Action: INTEGRATED PATHWAYS.**

Q&A: *These issues are not new, so what do you think of them?* Traces back to gov and how people perceived as deserving, politics rationalizes this by excuse of not being able to do everything; more about prioritizing lives and people and who we are choosing to prioritize. Need equity & social justice lens. *People treated as a box of diseases and not actors, if healthcare providers understood SDH this would solve a part of the problem. What is the problem with the system?* Few refugee-serving orgs so people not directed to right healthcare facilities, and there is no culturally-sensitive care. **Need upstream level approach** – skip blaming; issue is not about the need for more provider training.