Community-Based Perspectives on the Political Economy of Immigrant Health: A Qualitative Study

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December, 2011

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advancing urban health

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ACKNOWLEDGMENTS

The author would like to thank Bob Gardner, Nimira Lalani, Andrew Leyland, and Brenda Roche for their guidance and helpful comments. The author would also like to thank the Wellesley Institute and the Health Studies Program at the University of Toronto for thier support throughout the duration of this project.

This research was conducted as part of the Health Studies Undergraduate Program at the University of Toronto. The Health Studies Program at University College at the University of Toronto is a multidisciplinary undergraduate program of critical studies in the determinants of health and health care. The independent research study course enables upper-level undergraduate students the opportunity to work with local agencies over the course of two years to develop and conduct a pilot community-based research project.

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Executive Summary

Immigration is a prominent issue in Canada's political landscape. Clarifying the political economy of immigrant health will bring us closer to understanding why and how policy action and inaction are shaping the social inequalities in health and well-being experienced by Canada's immigrant populations.

Disparities in health outcomes between immigrants, particularly racialized immigrants, and non-immigrants in Canada have given rise to a growing body of academic, government, and community-based research investigating these inequalities. Unfortunately, this research has failed to adequately reflect on and account for the complexity of the determinants that shape population health. Specifically, it has neglected the social, political and economic environments that we know are fundamental to determining patterns of health and illness across and between societies and population groups.

This research explores community-based perspectives on the political economy of immigrant health. It seeks to examine and clarify the relationship between three bodies of knowledge: the political economy perspective on population health; the academic public health literature on the health of immigrant populations in Canada; and professional knowledge related to the provision of health and social services to immigrant communities at the level of Community Health Centres in the City of Toronto.

A review of the academic literature on immigrant health has identified several important themes, including:

- The notion of the healthy immigrant effect is often used to describe the decline in health status for immigrants after their arrival in Canada
- Access to health-care services emerges as a key issue, with a variety of social, political and economic barriers identified as contributing to difficulties in accessing health-care services.
- Culture and cultural difference are discussed in terms of cultural sensitivity, cultural competence, language barriers, and the degree of acculturation. Absent from these discussions is a strong consideration of the social, political and economic determinants of health.
- There is a noted attention to stress and mental health for immigrants. However, this is often discussed from a clinical perspective and is rarely explored from a social determinants of health framework
- Poverty, socio-economic status and unemployment are used in the literature to measure experiences of economic strain among immigrant communities in Canada.

To consider how this literature informs practice, semi-structured interviews were conducted with a small sample of service providers and executive directors from Community Health Centres in the City of Toronto. Several important themes emerged in the data:

- Community health centres employ a holistic approach to understanding immigrant health. This systems level thinking is attentive to the full range of micro, meso and macro level factors relevant to the health status of immigrant populations.
- Despite these efforts, many immigrants and their families are living with uncertainty related to immigration status. This has powerful implications, and leaves many with limited access to health care, legal services, education, social services and other basic needs.
- Neighbourhood-level features have a significant impact on the ability for immigrant communities to access transportation services, affordable food stores, good jobs, social infrastructure and quality educational institutions.
- Labour markets and adequate employment figure as particularly important determinants of immigrant health.
- Cutbacks in public services may have especially negative impacts on vulnerable communities, including immigrant communities.

This study provides recommendations to different levels of government, to community health centres and to immigrant health researchers. These recommendations strive to recognize inequalities that surface across systems and may harm the health and well-being of immigrant communities. Attention is directed towards the role that public policy can play in shaping and constraining the health and well-being of immigrant communities.

Introduction

Context and Rationale

The field of public health in Canada is approaching a critical impasse: mounting evidence has drawn attention to asymmetries in health outcomes across Canadian society (Kirkpatrick & McIntyre, 2009; Raphael, 2004). Research on the health of immigrant populations has not been immune to this development, and inequalities between immigrants and their non-immigrant counterparts can no longer be ignored. We do, however, require a conceptual framework that can explain these inequalities and inform the public health interventions needed in order to address them. As with health outcomes more generally, increasing attention has been awarded to studying inequalities in health through a *social determinants of health* lens.

The social determinants of health are the social, political, and economic conditions that impact the health and well-being of individuals and populations. Rather than focus on the proximal causes of illness — which is the emphasis of most research on immigrant health — research on the social determinants of health instead highlights the larger political economy that structures the social production, distribution, and treatment of health and illness (Navarro, 2000; Navarro & Muntaner, 2004; Raphael, 2004). Locating the seeds of illness in this larger political economy, the social determinants of health perspective, by extension, frames efforts to improve it in these terms. The political economy orientation "offers a window into both the micro-level processes by which social structures lead to individual health or illness and the macro-level processes by which power relationships and political ideology shape the quality of these social structures" (Raphael, Bryant & Rioux, 2006, p. 132). Applied to the question of immigrant health, it highlights the formative role played by power and politics in shaping the social conditions of life, and thus the well-being, of immigrant communities. Examining this political economy can help us address the health and social inequalities that exist across Canadian society, including those afflicting its immigrant population. Lack of attention to these socio-political forces that shape the conditions of life has been identified as a gap in the literature on immigrant health (Vissandjée et al., 2004).

Immigration remains a prominent issue in Canada's political landscape. Currently accounting for more than one fifth of the population, immigrant communities represent an increasing proportion of Canadian demographics. It is not surprising, then, that the public health of Canada's immigrant population has been the subject of much academic, community-based and government research.

Immigrants tend to arrive to Canada in better health than the general population. Despite this fact, research on immigrant health has demonstrated quite clearly that the health of individual immigrants deteriorates significantly after settlement and over time (Kinnon, 1999). At the population-level, this has manifested clear gradients (i.e. inequalities) in health outcomes between immigrants and their non-immigrant counterparts. These inequalities and the decline in the health of immigrants more generally have, in some instances, been attributed to shortcomings in public policy (Beiser, 2005). More often, however, research on the health and well-being of Canada's immigrant communities suffers from a narrow focus on individual-level behavioural determinants of health

that do little in terms of accounting for public policy (De Maio, 2010). In addition, this research has tended to over-emphasize the role of "culture" — a term that, unsurprisingly, is rarely explained — in determining the health of immigrant communities (Thurston et al., 2006). In these scenarios, inequalities in health are framed solely in terms of individual, behavioural, or cultural difference, masking the occurrence of barriers that exist before they are experienced by an individual, their behaviours, and their "culture." These shortcomings in the study of inequalities affecting immigrant communities have implications for public health practice: "explanations reduced to the level of univariate individual level measures are insufficient to guide policy" (Thurston et al., 2006, p. 2). To the degree that the orientation of most research on immigrant health has avoided addressing crucial questions of public policies, the conclusions and recommendations that emerge from this body of work have been limited in their ability to promote and protect the well-being of immigrant communities. Overall, immigrant health research has failed to adequately reflect on the complexity of the determinants that shape population health; specifically, it has neglected the social, political, and economic environments that have been demonstrated as being fundamental to determining patterns of health and illness across and between societies.

Without being prompted, immigrants identify the social determinants of health as having an impact on their quality of life (Haque et al., 2010; Thurston et al., 2006). Income, employment, housing, and the quality of neighbourhoods are among some of the elements cited. Despite these findings and a growing social determinants of health tradition that highlights the importance of social, political, and economic environments for explaining population health, a review of academic public health literature on the health of Canada's immigrant communities reveals that the political economy of immigrant health has gone relatively unexamined. Thus, a conceptual disparity has emerged, largely as a result of a failure to adequately apply the social determinants of health lens to discussions on, and the study of, immigrant health. Instead, this research opts to rely on more traditional frameworks that emphasize a range of biomedical, behavioural or cultural, psychosocial and, in exceptional circumstances, individual-level socio-economic factors. While these may contribute to poor health, they are not the major causes of the inequalities that persist between immigrants and their non-immigrant counterparts: these are more fundamentally determined by political economy and the organization of society (Raphael, Bryant & Rioux, 2006).

This research explores community-based perspectives on the political economy of immigrant health. It interrogates the relationship between three bodies of knowledge: (i) political economy perspectives on population health; (ii) academic public health literature on the health of immigrant populations in Canada; and (iii) professional-based knowledge related to the provision of health and social services to immigrant communities at the level of Community Health Centres in the City of Toronto. Specifically, this research begins to explore the gaps between these bodies of knowledge by way of qualitative inquiry: first, a partial and critical review of the academic literature on immigrant health; and second, the use of semi-structured interviews with a small sample of service providers and executive directors from Community Health Centres in the City of Toronto. Clarifying the political economy of immigrant health will bring us one step closer to understanding why and how policy action and inaction are responsible for the well-being of Canada's immigrant populations and the inequalities from which they suffer.

Literature Review

A review of the literature identifies several recurring themes:

a) The healthy immigrant effect;
b) Access to health care services;
c) Culture and cultural difference;
d) Mental health; and
e) Poverty and social status.

(A) HEALTHY IMMIGRANT EFFECT

Upon their arrival to Canada, immigrants are in better health when compared to the general population. This is attributed to two factors (Beiser, 2005; Dunn & Dyck, 2000; Kinnon, 1999). First, those in good health and with greater access to social and economic resources are more likely to be able to emigrate. Second, Canada's immigration screening process has a selection bias for the healthiest applicants. However, this health advantage is lost over time. This "healthy immigrant effect" reflects the poor and declining health status of migrant communities in Canada (Kinnon, 1999; McDonald & Kennedy, 2004; Ng et al., 2005; Perez, 2002).

The significant decline in the health of immigrants is not unique to the Canadian context. The precise mechanisms through which this decline occurs, however, are still unclear. Some have attributed the decline to the uptake of unhealthy lifestyles (Elliot & Gillie, 1998). Alternatively, it can be explained by the decline in the socio-economic and social class status of immigrants after settlement (Newbold, 2005). Migration can cause changes in income, health behaviours, social support and social networks, levels of stress, and patterns in the use of health services (Hyman, 2004). In other words, the decline in the health status of immigrant populations is most likely the result of a combination of social, political, economic, physical, and cultural factors (Newbold & Danforth, 2003). Nevertheless, cultural and behavioural factors are unlikely to be significant contributors to this decline (Raphael, 2004; Fuller-Thomson, Noack & George, 2011).

There exists competing discourses on the "healthy immigrant effect." Convergence theories suggest a semi-linear decline in immigrant health status toward convergence with the population average. However, the health status of the immigrant population does not always deteriorate to a level mirroring that of the general population. Contrary to convergence theories, the "immigrant overshoot" perspective suggests that the immigrant health status declines to the point where it falls below that of the general population (Beiser, 2005; Jolly, Pais & Rihal, 1996; Newbold & Danforth, 2003). Research on immigrant health is less likely to employ this latter framework.

Investigations of the "healthy immigrant effect" in the published literature are most often reduced to questions of health care access, culture, and behaviours, despite evidence that individual-level variables, such as lifestyle behaviours, contribute little to health over the life course. The social inequalities that are largely responsible for differential exposure to and accumulation of harm and illness are awarded limited attention in attempts to explain this significant decline in the health of immigrants.

(B) ACCESS TO HEALTH CARE SERVICES

Provisions exist in the 1984 *Canada Health Act* to ensure the equitable distribution of health care services across the entire population. Nevertheless, disparities in access to health care services are

reported and Canada is not immune to the "inverse care law" that characterizes its distribution: the presence of quality health care services tends to vary inversely with the need for it at the population-level (Eyles, Birch & Bruce, 1995).

Research on health care utilization by Canadian immigrants has been inconsistent. Evidence exists demonstrating that while immigrants living in Canada are more likely to fall ill, they are still less likely than their non-immigrant counterparts to make use of health care services available to them (Des Meules et al., 2004; Newbold, 2009; Newbold & Danforth, 2003; Simich et al., 2007).

By contrast, the results of earlier surveys show that the utilization rates of health care services do not vary between these populations (LaRoche, 2000). Other research has demonstrated that, despite being less likely to make use of health care services, immigrants do not report a greater degree of unmet health care needs than the general population, though differences in care-seeking behaviours help to account for this pattern (Dunn & Dyck, 2000; Wu, Penning & Schimmele, 2005). Moreover, those health care services that immigrants do access tend to be of poorer quality (Chen, Ng & Wilkins, 1996). Additionally, similar rates of utilization do not seem to be sufficient enough to offset the declines in health observed in immigrant populations (Newbold, 2005). Furthermore, disparities in health care use have been noted between European and non-European immigrants (Dunn & Dyck, 2000; Ng et al., 2005).

Despite the assumed universality and accessibility of Canada's health care services, there exist a number of social, political, and economic barriers associated with health care use in the Canadian context. Some of these barriers include income, employment, gender, and place (Fuller-Thomson, Noack & George, 2011). While these are not subject to comprehensive description here, research has demonstrated that immigrant populations are more likely to be susceptible to these socio-economic barriers than non-immigrants (Dunn & Dyck, 2000).

In addition to these socio-economic barriers, variables such as inappropriate care, lack of information, unfamiliarity with the Canadian health care system, and language barriers are often used to examine the quality of access to health care services between these two populations (McDonald & Kennedy, 2004; Wu, Penning & Schimmele, 2005).

Despite being a signatory to the Universal Declaration of Human Rights, Canada does not guarantee the right to basic health care services to undocumented migrants or migrants without full immigration status. This point is particularly relevant to urban cities like Toronto where there exist high concentrations of such populations who do not benefit from the purported universality and accessibility of Canadian health care services. Fear of deportation and fear of costs accompanies the decision to access health care services for these populations (Magalhaes, Carrasco & Gastaldo, 2009). The assumption that all "Canadians" are publicly insured glosses over the fact that hundreds of thousands of people residing in Canada lack insurance. Research on immigrant health has paid inadequate attention to this question of insurance liminality. (Initiatives such as the Women's College Hospital Network on Uninsured Clients are attempting to fill these gaps.)

Structural features of the Canadian health care system — such as the restructuring of health care services and the limited availability of funds — have received little empirical attention (one exception is Steele et al., 2002). There is reason to believe, however, that it is precisely these structural features that are responsible for growing inequalities between the health status of immigrants and non-immigrants (Newbold, 2009; Vissandjé et al., 2001).

> "Changes to the health care system in the 1990s made an increasing proportion of care non-insured. In an era of cost containment, the impact within the Canadian health system has not been equal across the population, with low-income groups and the poorly educated less able to deal with system restructuring, even within the publicly financed system" (Newbold & Filice, 2006, p. 313).

Access to health care services has taken up a central place in research on immigrant health. Consequently, little attention has been awarded to the study of the impact of access to broader social services, including community-based services offered at the level of community health centres (Steele et al., 2002).

Despite the focus on access, health care plays a limited role in shaping population health, including the health of immigrants.

(C) CULTURE AND CULTURAL DIFFERENCE

Along with the study of access to health care services, cultural barriers and their effects on the health status of immigrant populations have drawn significant attention in the Canadian literature (Magalhaes, Carrasco, & Gastaldo, 2010; Newbold, 2009). Recurring variables include cultural sensitivity (Azad et al., 2002), cultural competence (Vissandjée, 2001; Thurston et al., 2006), language barriers (Ali, McDermott & Gravel, 2004; Newbold, 2009), and the degree of acculturation (Salehi, 2010; Newbold, 2005). While the benefits of culturally competent care have been documented, it has not been adequately implemented in practice (Gastaldo, Andrews & Khanlou, 2004; Vissandjée et al., 2001). Furthermore, it is unclear the ways in which culture and cultural difference contribute to the health status of immigrant populations, and in what direction. While some suggest there are benefits to acculturation, others argue it is associated with the up-take of harmful behaviours (Newbold, 2009).

The effects of culture as determinants of health are receiving the attention of a growing body of research. Nevertheless, this remains a highly contested body of literature (Salant & Lauderdale, 2003). "Culture" is rarely, if ever, defined; it is often conflated with the variables of race and ethnicity. This raises serious questions about the analytical value of these variables, especially in the context of their regular appearance in published literature.

The acculturation literature suffers from the tendency of treating immigrant communities as homogenous (Simich et al., 2005). Similarly, the focus on "risk" as opposed to the positive strategies that immigrant communities develop in response to their marginalization also paints these communities as passive victims of these processes (Salehi, 2010). Arguments have been made against simplistic conceptualizations of culture and ethnicity (Elliot & Gillie, 1998). Salehi (2010) notes a major problem associated with "measuring" culture: acculturation and cultural barriers are easily confounded by various other factors that are playing a role in shaping the health of immigrants.

These other factors that emerge from the social, political, and economic environment are likely to present more pressing concerns than culture and cultural difference (Gastaldo et al., 1999). The decision to attribute health inequalities between immigrants and their non-immigrant counterparts amounts to "culturalization" – it is worth quoting Thurston and her colleagues at length, here:

> Cultural differences [are] identified as explanations of, rather than signposts for, the occurrence of social oppression. The assumption underlying culturalization is cultural

> inferiority, and the solutions proposed usually involve efforts to improve individual level integration and adaptation to the dominant culture without paying attention to the barriers erected by that culture. [...] The issue of who established the norm against which others are judged and what purpose the norm serves remains unexamined; the idea that others have culture is perpetuated. (Thurston et al., 2006, p. 4)

The attention received by questions of culture (and health care) is awarded at the expense of the salient and structural barriers erected against immigrant communities. This does not mean that cultural barriers are not important, only that the health status of immigrant communities cannot be explained, a priori, in "cultural" terms — a tendency that characterizes much published literature on immigrant health. The experience of health is not entirely, or even significantly, a "cultural" experience — it is, rather, a deeply social one. The health status of immigrant populations thus requires social explanation.

(D) MENTAL HEALTH

In addition to the study of health care access and cultural barriers, a significant portion of the immigrant health-related research is dedicated to examining the mental health of immigrants (Gastaldo, Andrews & Khanlou, 2004; Tousignant, 1997). This research tends to show that immigrant populations experience mental health profiles and outcomes to similar to those of their non-immigrant counterparts.

Within this body of literature, the relationship between stress and mental health is given the greatest amount of attention (Ali, McDermott & Gravel, 2004; Hyman, Beiser & Vu, 1996). Common themes that emerge include the lower rates of mental health service use reported among immigrants and refugees, disruptions in family processes, and the ways in which variable levels of exclusion or inclusion may be experienced by immigrants depending on their degree of acculturation (Ali, McDermott & Gravel, 2004; Beiser et al., 2002; Beiser & Edwards, 1994; Fenta, Hyman & Noh, 2007; Hicks, Lalonde & Pepler, 1993). The concept of resilience also appears in this body of work and is used to account for the ability for individual immigrants to confront and overcome risk and harm (Bernhard et al., 2007; Magalhaes, Carrasco, & Gastaldo, 2010).

The stress and mental health literature is rarely placed in a "determinants of health" framework that can fully account for the complexity of immigrant health. Instead, this literature is dominated by clinical explanation (Beiser et al., 2002). Exceptions include Simich et al. (2005) and Thurston et al. (2006), who give attention to variables such as social support and social cohesion when discussing the mental health of immigrant communities.

Interestingly, Gastaldo, Gooden and Massaquoi (2005) have begun to investigate the ways in which the migration experience itself can cause stress and have implications for the mental health of immigrants.

(E) POVERTY AND SOCIAL STATUS

Given the limited role that individual-level variables — including access to health care, culture, and lifestyle behaviors — play in shaping the health of populations, the published literature has slowly begun to give attention to the social and economic dimensions of immigrant health.

Immigrants in Canada experience disproportionately higher levels of poverty compared to their Canadian-born counterparts (Hyman, 2004). Beiser et al. (2002) report that a third of immigrant chil-

dren in Canada live in deep poverty. In addition, recent immigrants are twice as likely to be poor than the general population (Beiser et al., 1997). The relationship between income and health has been well documented, and while socio-economic factors such as income are important in determining the health status of immigrants and non-immigrants alike, their consequences are more salient for immigrants and other marginalized communities who are more likely to find themselves suffering from poor socio-economic conditions, including inadequate income (Dunn & Dyck, 2000).

Un- and under-employment are the most common variables used to measure economic strain among migrant communities in Canada (Ali, McDermott & Gravel, 2004; Thurston et al., 2006). Immigrants are finding it increasingly difficult to secure permanent, full-time employment in Canada's increasingly racialized labour market; in the case that employment is secured, immigrants are found to earn lower wages than their non-immigrant counterparts (Badets and Howatson-Leo, 1999; Daenzer, 1991; Hou and Balakrishnan, 1996; Hyman, 2009).

Overall, the public health literature pays little attention to the increasingly serious economic burdens faced by immigrant communities in Canada, despite the attention this has received by other disciplines (Caulford & Vali, 2006). This may be a consequence of the fact that little analysis in general has been conducted on poverty among immigrant communities in general (Kinnon, 1999; for a recent review, see Block & Galabuzi, 2011). This comes as a surprise, given the formative role that poverty, employment and income play in determining population health.

Little empirical analysis exists in the published academic literature on discrimination against immigrant populations. While 75 percent of immigrants belong to racialized groups, it is not uncommon for research on immigrant health to exclude any mention of racism. This comes as a surprise, given the fact that racism and xenophobia have been identified as determinants of immigrant health (Hyman, 2009). By contrast, the intersections of race, immigration, poverty, and health have been well explored at the community-based level (Access Alliance, 2005; Colour of Poverty, 2008).

Though research on immigrant health is increasingly attentive to the broader social and economic determinants of health, this trend has been limited in scope and scale. Published literature on the subject of immigrant health is still dominated heavily by concerns with health care access, culture, and behavioural factors.

Research Questions

Despite representing a range of biomedical, behavioural, psychosocial and socio-economic determinants of health, a review of academic public health literature in Canada demonstrates that research on immigrant health falls short when it comes to examining the "causes of the causes." This lack of attention to the upstream determinants of immigrant health has limited the ability for this body of work to frame health outcomes properly in the context of the broader social, political, and economic forces that shape and constrain them.

Front-line community-based workers are familiar with these forces: they are exposed to their reality by way of their direct and reciprocal engagement with immigrant populations accessing community-based services. This research explores the degree to which practice-based knowledge embodied in the front-line provision of services to immigrant communities can treat some of the theoretical and conceptual problems associated the published literature reviewed here.

In conducting interviews with a small sample of community-based front-line workers, this project explores the relationship between theory and practice. By theory, we mean the political econ-

omy perspectives on population health described in the Context and Rationale section as well as the conceptual assumptions that underlie the published academic literature on immigrant health in Canada reviewed in the Literature Review section. By practice, we mean the specific knowledge that service providers acquire as a result of their experience providing health and social services to immigrant communities at the level of Community Health Centres in the City of Toronto.

More specifically, the intention is to highlight instances of dissonance or consonance between theory and practice as they relate to the health of Canadian immigrants, with the ultimate objective of clarifying front-line, community-based perspectives on the political economy of immigrant health.

The research questions are as follows:

1. Have the theoretical and conceptual shortcomings that characterize the published academic literature on immigrant health translated into similar problems on the front-lines?
2. What are the macro-social determinants of immigrant health identified by front-line community-based service providers?
3. How and to what degree do these begin to treat the theoretical and conceptual problems that characterize the study of immigrant health?

Methodology

(A) DESIGN

Seven community-based front-line workers were invited to participate in the research project. Each was affiliated with one or more community health centre in the City of Toronto: three were executive directors; four were direct service-providers. Key informants were approached based on their experience working at community health centres that either have catchment areas that include a significant immigrant population, or provide immigrant-, refugee-, or newcomer-specific services. Three of the seven front-line workers invited to participate did not respond.

Initial contact was made with each of the seven invitees via email contact. The motivation and scope of the project was described to them using the following text.

> *The goal of these interviews is to investigate the relationship between the public health literature (theory) and the provision of health and social services (practice) to immigrant communities, and, in particular, to highlight instances of dissonance or consonance between these two bodies of knowledge. Interview questions will relate to your perspective on the health priorities of Toronto's immigrant communities, as well as the barriers and facilitators affecting their access to community-based health and social services.*

At the start of each interview, participants were provided with a quick overview of the social determinants of health framework guiding the research.

In total, four semi-structured interviews were conducted between December of 2010 and January of 2011. These were conducted with a combination of two executive directors and two direct service-providers. No two participants were directly affiliated with the same community health centre in order to ensure adequate breadth of content. These interviews lasted between 35 minutes and 65 minutes.

The research protocol was reviewed and approved by the Office of Research Ethics at the Univer-

sity of Toronto. Because all study participants were front-line service-providers or executive directors from community health centres, this review confirmed that the risk posed to informants was minimal. Nevertheless, the identity of interviewees and their affiliated agencies will remain anonymous throughout this report.

(B) DATA ANALYSIS

Each of the four interviews was digitally recorded. The contents of these interviews were transcribed for qualitative analysis. After reading them several times, the primary investigator developed a list of preliminary codes reflecting the themes that seemed to be emerging. This first layer of coding was stratified according to five codes:

Behavioural-cultural determinants of health; this node denoted any content addressing behavioural or cultural determinants of immigrant health.

Psychosocial determinants of health; this node denoted any content addressing the relationship between immigrant health and the psychosocial environment (e.g. the availability of social capital or immigrants' perceived control over life circumstances).

Political Economy determinants of health; this node denoted any content addressing the impact of politics, public policies, or social inequalities on the health status of immigrant populations.

Community health centre; this node denoted any content addressing the role that community health centres play in promoting and protecting the health of immigrant communities accessing their services.

Advocacy and community action; this node denoted any content connecting immigrant health to advocacy, lobbying, community-building, or social movements.

This first round of thematic coding facilitated a second layer of analysis and the identification of more specific themes and sub-themes. These were included in or excluded from further qualitative analysis on the basis of whether or not they contributed to the research questions listed above. In other words, only those themes clarifying community-based perspectives on the political economy of immigrant health were included for further analysis. These are discussed in the subsequent section.

(C) LIMITATIONS

There are several limitations to this study.

(i) The sample size of those interviewed was small. It is highly unlikely that saturation was met. At the same time, the exploratory nature of this research meant that the project still stood to benefit greatly from even this small sample size of front-line community-based workers.

(ii) The generalizability of the interview contents is further limited by the context-specific nature of some of the observations. These include observations about national policies (e.g. immigration policy), provincial policies (e.g. three-month wait period; health care policy), and municipal policies (e.g. housing policy) that cannot necessarily be generalized beyond their specific contexts. Similarly,

a number of observations are specific to community health centres and the *community*-based provision of health and social services. This does not, however, take away from the analytical value of these observations and their contributions to clarifying the political economy of immigrant health.

(iii) Finally, a serious shortcoming of this project lies in the fact that those interviewed were not necessarily members of the affected communities under study. Future research will no doubt have to account for the perspectives of immigrants themselves, and in a manner that is safe, participatory, and action-oriented.

Findings

The thematic analysis of interview data resulted in the identification of several recurring themes:

a) Systems-level thinking;
b) Immigration systems;
c) Neighbourhood-level impacts;
d) Labour markets and employment; and
e) Retrenchment in the provision of public services.

(A) SYSTEMS-LEVEL THINKING

> *"Health centres are determinants of health focused…we look at individual needs and issues… and then also the broad, systemic issues."*

> *"Our work is premised on understanding the determinants of health. We use that as a lens… we approach any given situation knowing that it's more than your headache. It's more than your immigration status. That all of these are interrelated."*

> *"It is the macro basically because its the policy [doing the] determining."*

> *"We do lots of advocacy for newcomers. But there is a systemic problem here."*

Our interviews confirm the significance of systemic, or macro-social, determinants of immigrant health.

As our review has demonstrated, the tendency has been for research to focus on individual-level variables. In neglecting more contextual factors, this perspective has been limited in its scope of study and thus in the prescriptions it has been able to offer. By contrast, as interviewees noted, community health centres employ a "holistic approach" in their attempts to address the health of immigrant communities accessing their services.

In fact, all informants emphasized the importance of systems-level thinking when approaching questions of immigrant health. This shows that analysis must be attentive to a range of micro-, meso-, and macro-level factors in order to adequately explain the health status of immigrant populations accessing community-based services. The political economy of health lens highlights the form and degree to which these various processes interact and work together to manifest broader, population-level patterns of health.

The particular health promotion model utilized by community health centres acknowledges that, while service-providers are working primarily with individuals, there is nevertheless a need to address the systemic barriers faced by newcomers and the impact these have at the level of commun-

ities. This "determinants of health" model recognizes the mutually constitutive role played by direct service provision, community-level capacity building, and systemic action and change. No single-level of intervention is prioritized over the others. Rather, efforts to address the entire system at every level are seen as necessary in order to overcome the barriers faced by the immigrant population.

(B) IMMIGRATION SYSTEMS

"It really depends mainly on the immigration status. So people who are non-status, they just don't get anything at all."

"…immigration status has an impact on their health."

"…large numbers [of immigrants] are non-insured. Non-insured for a whole bunch of reasons."

Our findings highlight the importance of immigration status and immigration policy as determinants of health.

Approximately 500 000 non-status migrants currently reside in Canada (PCNC, 2009). Half of them are thought to live within the Greater Toronto Area. Lack of status leaves these individuals and their families with little to no access to health care, legal rights, education, social services and other basic needs that play a role in promoting and protecting population health and well-being (Magalhaes, Carrasco, & Gastaldo, 2010).

"…if they're still within their three month wait…the hospital fee can be very expensive."

"…people [are] afraid on a number of levels of entering a system, a realm, where they may be confronted with…things…like [user] fees and stuff like that."

"The clinicians within the hospital wanted to serve him [a non-status immigrant], provide the care, and their administration would not allow it."

Those without full immigration status — including landed immigrants subjected to a three-month waiting period — are unable to access health care through provincial public health insurance. In order to access health care services, they must either purchase private insurance or pay for these services out of their own pockets. Due to the fact that both of these options are expensive and that a large number of immigrants are unlikely to be able to afford the associated costs, non-insurance proves, in many cases, to be an insurmountable barrier for many non-status immigrants. As one informant put it, even the fear of having to face a user-fee can keep immigrants from considering entering the doors of a hospital or clinic.

Our findings also stress that precarious immigration status is associated with significant burdens in the realm of education, housing, employment, and other social determinants of health. Thus, the burden of being without status lies beyond simply the lack of health insurance. The precariousness of status contributes to the poor health status of many immigrants in various and intersecting ways, cutting through a range of social determinants of health (Bernhard et al., 2007). For instance, the inability for non-status immigrants to work within the formal economy leaves many of them with little recourse beyond informal or underground economies that are often characterized by low

wages and insecure and unsafe work arrangements (Papademetriou, O'Neil, & Jachimowicz, 2004). Overall, the immigration status of those accessing community-based services was reported to hold significant consequence for their health status.

> *"We do have people, we call them non-insured, people who don't have an OHIP number…We give those kinds of services here."*

> *"…there is only so much we can do [to address non-insurance], within the limited resources."*

A number of community health centres in the City of Toronto are equipped with funds specifically meant to facilitate the provision of services to those with precarious immigration status. As participants in the study noted, however, immigrants often face difficulties navigating complex and convoluted intersections between Canada's immigration, health care, and legal systems. A great deal of difficulty accompanies efforts to determine what services one is eligible to access. This has no doubt led to a significant degree of unmet needs. In fact, in a recent publication, community health centres in the city have reported that only a small fraction of non-status persons — approximately 12, 000 — are suspected of actually accessing these services, which are often the only ones available to this vulnerable population (Community Health Centres of Greater Toronto, 2009). In addition, interviewees confirmed that this form of community-based, ad-hoc provision of services to non-status populations is unsustainable, with funds available never meeting the demands faced.

> *"We don't…share information with the CIC [Citizenship and Immigration Canada] because there is always the fear in terms of deportation. There are…mechanisms in place to ensure that they can have access without any kind of fear."*

> *"A couple of stories always stand out for me around the experiences of disclosure and people being afraid on a number of levels."*

Though navigation of the system of health and social services in the city can prove difficult, participants also highlighted the fear of deportation as a reason for unmet needs. Much like the fear associated with out-of-pocket costs, the fear of deportation can keep immigrants from accessing vital services, including those provided by hospitals and community health centres.

> *"Communities have to…understand these [legislative] bills better and how [these have] impacts in terms of legal remedies, in terms of family reunification strategies."*

> *"So in terms of the [immigration] policy, this has really put a big barrier on them."*

> *"We do have case workers who try to support people who have immigration issues…But when I look at the problem, it is big and it's bigger than just the community health centre…there is a systemic problem here."*

Participants identified the immigration system itself as a determinant of health. They attributed some of the barriers to health and well-being experienced by immigrant communities to immigration policies. In particular, informants described recent and on-going changes to immigration laws and regulations as being responsible for the growing population of immigrants with temporary or precarious status. Among the changes highlighted were recent restrictions placed on family reunification and spousal sponsorship application processes and eligibility.

In recent years, the number of temporary work visas granted by the Canadian government has exceeded the number of successful applications for permanent residency. Changes to Canada's political economy are pushing more and more newcomers into states of precarious and temporary immigration. This context of institutionalized precariousness will mean that larger and larger portions of the immigrant population will come face-to-face with the consequences associated with this precarity: little to no access to health insurance, meaningful and safe employment, legal rights, and other basic needs.

Interviewees highlighted some of the ways that immigration policies can worsen the conditions of life in which immigrants find themselves. These findings confirm that immigration systems are determinants of the health status of the immigrant population.

"We work with non-status populations, but we don't work with people who are on temporary work visas…they are not eligible based on our criteria."

In the context of community health centres, the reality of an increasingly "temporary" immigrant population is especially troubling. Community health centres are not equipped with the mandate or the funds to provide services to those in Canada on temporary visas. One informant did, however, note the fact that the changing make-up of Canada's immigrant population will force community health centres to review their eligibility criteria and delivery methods.

(C) NEIGHBOURHOOD-LEVEL IMPACTS

The impact of neighbourhood contexts on the health of immigrants was raised by three of the four participants.

"Most of the time, the immigrant populations, when they land, it's where? It's a low-income area."

"…where do they live when they arrive? Neighbourhood-level impact, you know?"

People are not randomly distributed across the city's different neighbourhoods. Likewise, the quality of life between these neighbourhoods takes a similarly uneven, spatial form. Identifying that there are inequalities inherent to the way in which the city is organized, interviewees noted, first and foremost, that immigrants accessing community-based services were more likely to settle down in low-income neighbourhoods and to be living in poorly maintained social housing units. Insight was provided as to some of the implications that the neighbourhood-level context can have on the social determinants of health.

"Well, I mean, the thing is, Rob Ford says 'No more Transit City.' What does that mean for the city? What does that mean for the health of the population in general, and in particular people who are already disadvantaged?"

"Here, the closest food store … is really expensive. To go [find] more affordable food, you have to take a bus. And if you are a parent of five children and you don't have your own vehicle, it's not cheap. It's not practical."

"The city has to invest money – in the schools for example. When you look, there are disparities between different neighbourhoods' schools…when you look at the schools, they're not well equipped. When you look at schools around here…there are high drop-out rates. I don't think it's because of the students. I think when you look at the schools they are not well-equipped."

As demonstrated by the above interview excerpts, there is more to neighbourhood-level contexts than the quality of housing. Access to transportation, affordable food stores, and the availability and quality of educational institutions are also determined by this neighbourhood-level context. All three examples point to the upstream determinants of health — the conditions of life in these neighbourhoods — that lie beyond the agency of any individual.

Without adequate opportunities for meaningful employment and income generation, immigrants and immigrant families are more likely to settle in neighbourhoods where housing is more affordable, and consequently very often of poorer quality. The problem does not lie simply in the quality and affordability of housing, however. As participants pointed out above, this burden is amplified by the fact that there is, in turn, little social infrastructure within these neighbourhoods to support other broad determinants of population health.

"Enough talk about priority neighbourhoods."

"They divided the priority neighbourhoods and tried to give them money, but how much of an impact did this have?"

City authorities acknowledge that there are, in fact, "priority neighbourhoods" characterized by low standards of living. In assigning "priority" to neighbourhoods, they also reveal that polarizing standards of living are largely a result of poor policy action and inaction that require redress. However, as noted in the above interview excerpts, these "priorities" do not exist very much beyond rhetoric. In fact, there is evidence that socio-economic polarization at the level of the city is increasing (Hulchanski, 2010).

Neighbourhood-level disparities give rise to inequalities in people's quality of life. That is to say, the life chances of the city's residents are stratified according to a distinctly spatial hierarchy. Vulnerable and marginalized populations, including immigrants and refugees, are more likely than their non-immigrant counterparts to find themselves in neighbourhoods on the lower end of this hierarchy, resulting in a number of negative consequences for their health and well-being.

(D) LABOUR MARKETS AND EMPLOYMENT

"It's a big issue, when you're unemployed or underemployed. And that's why people are coming here [to Community Health Centres]."

If you are unemployed or underemployed – it affects your health. When you don't have sustainable income, that affects your health."

All four interviewees highlighted the importance of access to employment as a determinant of health. One interviewee described employment as the "number one" issue facing immigrant communities.

The association between employment and health, as well as the harmful affects of un- and under-employment on quality of life, has been well documented (Benach et al., 2000). Little attention, however, has been paid specifically to the employment-related health outcomes of the immigrant population. This is despite the fact that immigrants are more likely to find themselves without, with too little, or with insecure and unsafe employment.

"We support people to get the skills that are necessary to do a job that is actually meaningful, will generate some income…People need an income. Most people want that."

Our findings suggest that employment takes up a unique position as a determinant of health. This is because income is a necessary pre-condition for securing access to a number of other social determinants of health, including education, quality housing, and adequate and healthy food. These latter variables depend on the availability of work and income. Without employment, income is not generated and basic needs cannot be met.

Interviewees noted in several instances that community health centres play an important role in providing training in employable skills in order to facilitate the integration of newcomers into the labour market. In addition, these services were highlighted as being some of the most important for the immigrants seeking support from community health centres, underlining the vital role that employment plays as a determinant of health.

"It's about discrimination, it's about oppression, it's about non-recognition of foreign credentials, its' about poverty, it's about racialization of poverty."

"There are lots of foreign trained immigrants. [But] because they have foreign trained degrees, they aren't recognized here. So they have difficult times finding jobs."

"They come here to find out that they can't find a job in professions they may be trained in."

Even though one in two immigrants enter Canada as a skilled worker, immigrants are less likely to be employed, and more likely to be poor because of it. This is in part due to the devaluation of foreign credentials. Participants emphasized how the failure to recognize foreign credentials presents a critical mechanism connecting employment to the health status of the immigrant population.

"When I say employment, I mean full employment."

Not all employment is equal. This is reflected well in the tendency for contemporary labour markets to move toward increasingly flexible and insecure forms of employment, wherein atypical employment has replaced the standard of full-time, permanent jobs.

In the same way that not all employment is equal, not all persons are affected equally by the trend toward atypical work arrangements. Immigrants are more likely than their non-immigrant counterparts to find themselves precariously employed. This precarity manifests a range of material and psychosocial health-related consequences.

"The racialization of poverty…is the result of any number of policies."

One participant highlighted the intersections between racism and access to quality employment. Up to 75 percent of immigrants are racialized (Hyman, 2009). Our interviews confirm that the work of racialized immigrants is devalued. In the context of "color-coded" labour markets, they are more likely than their non-racialized counterparts to face un- or under-employment. Similarly, when immigrants of color manage to find employment, their work is more likely to be insecure, temporary, and offer less in wages.

"[And] what if they get jobs? Do they know about their rights as a worker?"

"…sometimes, the employer will exploit them. Like [by] not paying them overtime…The onus is put on the newcomer…to find out their right as a worker."

One informant stressed how immigrants are often denied the privileges associated with standard labour laws and regulations. Even when these apply to them, they are often not respected. The participant noted that in some instances, immigrants are simply unaware of their rights as workers. However, even in the scenario where they recognize that violations are taking place, there is still a chance that they will not assert their rights out of fear of losing their jobs. This fear is not only perceived, but emerges in response to the reality of employment insecurity to which these findings have alluded.

As immigration becomes increasingly precarious and temporary, immigrants are going to be more and more likely to have to engage in equally precarious forms of work: part-time, temporary, casual etc. This work is more likely to be characterized by unsafe physical and psychosocial work conditions, poor wages, and little to no access to employment benefits. This dual burden of precarious employment and immigration status will hold serious consequences for the health status of the immigrant population.

Employment presents an interesting example of the political economy of immigrant health, wherein macroeconomic processes, country-level and regional variables, individual contexts, and health interact.

(E) RETRENCHMENT IN THE PROVISION OF PUBLIC SERVICES

All four interviewees made reference to austerity, defined as retrenchments in the public provision of social services.

"[These] funding cuts are going to create a negative impact on people's health. Especially immigrants."

"There was a big threat that the cuts would be really deep this year."

"We have to proactively be more creative and look at alternative sources of funding."

Participants noted that settlement service organizations have recently been subject to $53 million in funding cuts, with promises by the current government for deeper cuts in the future. These cuts not only pose a threat to the operations of these organizations and their ability to provide crucial services to newcomer and refugee populations, but simultaneously endanger the well-being of these populations that depend on the provision of these services. Cuts to English as a Second Language

programs, for example, will exacerbate the hardships immigrants experience when attempting to enter labour markets and access employment. These research findings also suggest that, in addition to the initial shock associated with the loss of funding, these service organizations begin to place limits on their programing in order to safeguard what little capacity remains.

Community health centres have largely been immune to this trend toward austerity and retrenchment. One informant noted that they secure funding from a multitude of sources, precisely in order to minimize the risk associated with any single source of funding.

An environment of fiscal conservatism has forced service-based agencies such as community health centres and settlement organizations to make clear and evident the impact of the funding they continue to receive. Nevertheless, this process has required a "rethinking of evaluation frameworks" in order to more readily appeal to the interests of those providing the funding. For those interviewed, this raised questions about how success and the impact of funding should be measured, and to whom agencies should be accountable.

"We've seen this before, in terms of cuts. We're still feeling the impact of those earlier cuts."

Reflecting on current politics of austerity, participants were reminded of earlier eras of welfare retrenchment whose consequences to population health and well-being were deep and lasting. Concerns were raised in the interviews about the possibility of "a deep freeze" establishing itself over the public sector and lasting for years. Informants recognized that commitments to fiscal conservatism translate into cuts to welfare, health, education, pensions, and other social programs on which populations such as those accessing community-based health and social services depend.

As informants pointed out, austerity has not been limited to the settlement services sector, despite it being subject to disproportionate targeting. The climate of retrenchment has meant the termination of Transit City and increases in the cost of public transit, cuts to welfare provisions like the Special Diet Allowance, and the privatization of public housing. As vulnerable populations that are more likely to have to rely on such provisions as the Special Diet or the affordability of public housing, immigrant communities are disproportionately impacted by these changes.

"...marginalized communities are always at the bottom of the barrel."

"Funding [is] sometimes cut [to] immigrant service, and settlement services, and support services...The impact of those cuts becomes so invisible because the people affected by the cuts are invisible."

Shifting and uneven priorities have meant that certain communities have had to bear the brunt of funding cuts. Making reference to a growing environment of xenophobia, participants suggested that the burden of these cuts, and of the economic crisis more generally, has fallen upon immigrants and other marginalized communities, that is to say, upon the shoulders of precisely those communities least able to afford it.

"Whenever they talk about budgets...it's a numbers game. It really depends on...how you want to present it to the public..."

"The city has to invest money...We need to advocate to have more money."

The economic crisis of 2008 has taken its toll on standards of living. Not surprisingly, it is a generally accepted principle in the public health literature that particularly strong public provisions are required in order to protect the health of populations from the harmful effects of this crisis and the turbulence it causes in the people's daily lives. The cost of delaying these social provisions greatly outweighs the cost of the initial investments they require (King, 2009). In addition, as our findings demonstrate, a human cost can be attributed to the decision not to invest in these social determinants of health. Nevertheless, elected officials have failed to put the necessary protective measures in place. In fact, it is precisely these budget lines — public services, pensions, wages, welfare allowances — that have been subject to the greatest cuts. This reversal of public health logic highlighted by participants reveals that ideology and political must be recognized as barriers to healthy public policy change.

The social determinants of health have become the target of the new politics of austerity. The implications of this politics and its retrenchment polices will have a lasting impact on population health, and on the health of marginalized populations in particular.

Conclusion

The findings of this qualitative study begin to delineate some of the macro-social determinants The findings of this qualitative study begin to delineate some of the macro-social determinants that define the political economy of immigrant health. The front-line service providers interviewed for this study very clearly identified that this political economy plays a formative role in shaping immigrant health. In addition to a broad, systems-level orientation, this research has highlighted four elements of this larger political economy and their implications for the health and well-being of Canada's immigrant population: the immigration system; labour market policies; welfare retrenchment; and the neighbourhood-level context. The significance of these findings rests primarily in the fact that this political economy of immigrant health lies beyond the agency of individual immigrants and, in most cases, even communities at large. Rather, this political economy is largely the result of public policies and the logics that govern them.

Without being prompted, immigrants as well as those who are directly providing services to them identify this political economy as having a determinative effect on their standards of living and well-being. Nevertheless, because of the conceptual, methodological, and political obstacles associated with the study of these broad determinants of health, they have been awarded inadequate attention by public health researchers and practitioners. Clarifying the political economy of immigrant health will help rectify the problems associated with the myopic and reductionist assumptions that have hitherto characterized much of the research on immigrant health. This study has solicited front-line, community-based perspectives on the political economy of immigrant health as a critical first step toward treating these problems and the barriers they pose to the health and well-being of immigrant populations.

Recommendations

FEDERAL, PROVINCIAL AND MUNICIPAL GOVERNMENTS

1. All levels — Strengthen public investment in social services and programs.

2. Federal — Reverse all cuts to settlement services.

3. Federal and Municipal — Ensure access without fear, prohibit the presence of the Canadian Border Services Agency from all spaces that provide health and social services.

4. Federal — Ensure equitable access to health and social services by implementing a comprehensive, inclusive and on-going regularization program that provides full legal status to all persons living in Canada.

5. Federal — Prioritize permanent immigration over temporary work programs.

6. All levels — Facilitate access to safe and meaningful employment for all newcomers.

7. Provincial and Municipal — Build on the potential of community health centres. Invest further in the community sector.

8. Provincial — Eliminate the three-month wait period for access to Ontario Health Insurance Plan (OHIP).

COMMUNITY HEALTH CENTRES

9. Support the mutually constitutive roles played by direct service provision, community-level capacity building, and systemic action for change.

10. Recognize the role that grassroots movements play in systemic change.

11. Combat trends toward fiscal conservatism that limit the capacities of services-based agencies such as community health centres.

RESEARCH ON IMMIGRANT HEALTH

12. Develop a formal research agenda to address the social, political, and economic determinants of immigrant well-being.

13. Recognize the limitations to perspectives that frame immigrant well-being in behavioural or "cultural" terms.

14. Respect the insights of front-line perspectives and their potential contributions at all levels of the research process.

15. Incorporate analysis of the intersections of immigration with class, race, and gender.

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