LINKING IMMIGRANT SETTLEMENT, HEALTH, HOUSING, AND HOMELESSNESS IN CANADA

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ABSTRACT

The literature tends to treat immigrant settlement, health, housing, and homelessness as separate agendas. Yet, given that immigrants generally experience declining health on arrival, poor health may lead to homelessness. Conversely, appropriate housing facilitates good health. For immigrants, and particularly vulnerable populations including refugees and the elderly, the risk of homelessness may be increased for those with poor health, individuals lacking social networks and who are socially excluded, or those that are settled in marginalized areas. The following considers the health status of new arrivals and access to health care before exploring the potential linkages to housing and homelessness.

If Canadians were asked to list the country's defining features, they may very well identify Canada's universal health care system and its history of immigration. For most, however, these are two separate issues. Yet, immigration (and immigrants) and where they settle are directly linked to health issues through the determinants of individual health status including sociœconomic effects such as income and education, sociodemographic effects such as age and gender, cultural effects such as the role of women in society, and through the access and use of health care facilities. How healthy, for example, are immigrants compared to native-born Canadians, and how dœs their health status change over time? Do immigrants receive equal care for equal levels of need for care? What are the broader implications of poor or declining health and dœs settlement location matter? Woven into the discussion of immigration, settlement and health is housing and homelessness, with housing facilitating good health but poor health potentially leading to homelessness. For immigrants, and particularly vulnerable populations including refugees and the elderly, poor economic conditions and low income, social exclusion (the detachment of individuals from social institutions, preventing them from full participation in society), settlement in marginalized areas, poverty, language barriers and mental health issues may combine with poor economic opportunities and limited affordable housing to restrict housing opportunities, while settlement in marginal areas may have long-term implications for both health and housing options. In both cases, the end result may be homelessness. The following discussion considers the changing health status of new arrivals and access to health care before exploring the linkages to housing and homelessness.

THE HEALTH STATUS OF NEW ARRIVALS

By definition, immigrants move from one set of health risks, behaviors and constraints, to an environment that potentially includes a very different mix, with possible adverse impacts upon health. There is strong evidence within the existing literature that the health of immigrants at the time of arrival in the host country is significantly better than the native-born population, measured through self-assessed health (How would you rate your health: excellent, very good, good, fair or poor?), chronic conditions, and mental health (Newbold and Danforth 2003), with good health reflecting screening during the application process, a process that is meant to ensure satisfactory health levels for those entering the country.

Known as the 'healthy immigrant effect', the health advantage seemingly enjoyed by new immigrants appears to deteriorate and converge toward the native-born with increasing duration of residence in the host country. Moreover, the literature suggests this transition occurs rapidly and within as few as five years after arrival in Canada. Arrival cohort (the period defining arrival in Canada) effects are also important and are intertwined, with differences in health status potentially reflecting cohort effects (Newbold 2005b; Pérez 2002). That is, recent arrivals may simply have better health when they entered the country than their counterparts did when they entered at an earlier time, although cohort-based analyses highlight similar declines in health (Newbold 2005b). Research based upon longitudinal files derived from Canada's National Population Health Survey (NPHS), for example, suggests that although all immigrants experienced declines in health status, more recent arrivals experienced particularly dramatic declines in self-reported health status compared to earlier arrival cohorts, *despite* their

younger age relative to earlier arrival cohorts and the native-born (Newbold 2005a). Other more objective measures of health status, including chronic conditions and mental health, also point to rapidly declining health amongst new arrivals. For example, the likelihood of reporting any chronic condition tends to increase with time spent in Canada, despite initially superior health relative to the Canadian-born (Newbold 2006; Pérez 2002).

Why do we observe declining health despite universal access to health care regardless of willingness or ability to pay for services, particularly in Canada where health care is nationalized? Declines in health status amongst new arrivals have often been attributed to the uptake of poor health behaviours, including poor dietary habits, smoking, and/or drinking upon settlement in the host country. Although such changes cannot be dismissed, contributions to poor health stemming from the uptake of unhealthy lifestyle choices are unlikely to manifest themselves over the short time frame typically observed within the literature.

Structural explanations provide an alternative line of reasoning. New arrivals to Canada including convention refugees, landed immigrants, and other legal entrants may be required by provincial health authorities to observe a waiting period (generally six months or less) before access to provincially funded health plans is granted. While private health insurance is typically available as a bridge in these circumstances but is a relatively costly alternative and specialized programs administered by the Federal government are directed toward refugees, costs or accessibility issues may reduce use. Low income groups and the poorly educated may be less able to deal with the health care system, particularly in the face of health care restructuring, while access to health services may be even more tenuous for those who are settled in low income or marginal areas of cities. Unease or distrust of the medical system, or a medical system that dœs not provide culturally sensitive and appropriate care may create additional barriers, while stress and poor mental health, reflecting the difficulties of the immigration process and acculturation, may ultimately impact on physical and mental health (Matuk 1996).

Immigrants may also experience other barriers to the use of health care facilities, including those created by acculturation stress, social exclusion, gender, culture, or language. For example, loss of socioœconomic status through unemployment, reduced income, and deskilling (i.e., employers failing to recognize educational credentials, with immigrants forced into lower-status jobs) has been associated with mental stress and poor health in the immigrant community (Asanin and Wilson 2008). In addition, diminished social networks, poor working conditions, and language barriers contribute to declines in health (i.e., Pottie et al. 2008). Access to health services, and ultimately overall health, may be especially limited among immigrant women whose family, job, or cultural expectations and roles may make it difficult to access and use resources. Poor access and service use may lead to a worsening of health status over time owing to the relative under-use of preventative health screening and underdiagnosis and treatment of health problems. Ultimately, such barriers may limit access to health care and contribute to observed declines in health.

THE USE OF HEALTH CARE

If health status declines after arrival, do we see evidence of a concomitant increase in the use of health care facilities? Immigrants as a whole are typically considered to be under-users of the health care system, with their lower use potentially associated with their better health status at the time of arrival (i.e., the 'healthy immigrant effect'). While it could be argued that the observed decline in health after arrival reflects less contact with the health care system than the native-born population, including contact for preventative care, there is conflicting evidence regarding immigrant health care utilization within the literature. On the one hand, Globerman (p. 22) concluded, "Over the complete life cycle, there may be little difference in health care utilization patterns, both across immigrant groups, as well as between immigrants and the native-born population". Similarly, Laroche (2001) concluded that immigrants are not a burden to the health care system, with their use of services not significantly different from the native-born population, suggesting that need for health care was (at least partially) being met. Chappell *et al*. (1997) noted similar health care utilization rates between Chinese seniors in British Columbia and Canadian seniors in general.

However, the apparent equity of use dœs not mean that need for care is adequately met. If observed declines in health are indicative of greater need for care, then immigrants are at a relative disadvantage. That is, barriers to care, including language, gender, and culture may further jeopardize health care utilization. Use of family physicians has not, for example, been observed to increase as health status declines, and hospitalization rates are significantly less for non-European immigrants than for European immigrants and the native-born given similar levels of need (Newbold 2005b). Other research suggests that immigrants tend to receive poorer quality health services than non-immigrants (Elliott and Gillie 1998). In such cases where utilization is less than that observed within the native-born community, it may be an indication of unmet health care needs within the population (Newbold 2005b).

Caught between declining health status and greater need for care, but a seemingly limited increase in the uptake of health care services, Canada's foreign born may find their poor health further entrenched, with the potential for long-term consequences including poorer individual and societal health. Poor health outcomes may be particularly troublesome for marginalized or vulnerable groups, including the elderly and refugees, both of whom have limited connections to the broader community. Amongst the elderly, barriers to health, including language and social connections, may be exacerbated, with this type of social exclusion linked to poor health outcomes. For refugees, it is generally acknowledged that they have greater health needs than most immigrant arrivals, with particular health needs shaped by the refugee experience and the resettlement process. Female refugee/asylum seekers are, for example, more likely to experience depression than either non-refugee women or male refugee/asylum seekers and are disproportionately affected by physical and sexual violence, abuse, and unequal access to asylum procedures (Lawrence and Kearns 2005).

LINKING IMMIGRANT SETTLEMENT, HEALTH, HOUSING AND HOMELESSNESS

What is the link between immigrant settlement, health, housing, and homelessness? The balance of evidence suggests that the foreign-born are relatively under-represented amongst the homeless. This is somewhat surprising, given their potentially precarious situation vis-à-vis health and income, particularly in the largest metropolitan gateways where affordable housing is already in short supply. Moreover, the correlates of poor health and homelessness, including language barriers, knowledge, income, experience and exclusion, are similar. What then, can result in homelessness? First, given that the foreign-born typically experience declining health and tend to under-utilize health care facilities, poor health may result in homelessness. Reflecting the refugee experience, the separation of family and friends, and physical and sexual violence, refugees may be particularly prone to poor health, especially poor mental health, with this vulnerability translating to limited housing options. Indeed, poor mental health has consistently been associated with homelessness (Living on Ragged Edges 2003). Conversely, the longer one is homeless, the greater the risk of suffering from mental illness and health related problems, creating a vicious cycle.

Second, initial settlement location may be linked to homelessness. Although many immigrants are initially settled in poor or temporary housing, the foreign-born tend to follow a progressive housing career, whereby homeownership rates rise over time as income increases (CMHC 2004). But not all immigrants follow the same housing trajectory and have the same experience with accessing and retaining acceptable housing over time. Some have little choice but to spend a large proportion of their income on shelter and live in crowded conditions or with family as a coping mechanism (Murdie and Teixeira 2003), with a lack of affordable housing offering few options. Individuals settled in poor housing or marginalized areas tend to stay in those areas and become increasingly marginalized (Hiebert et al. 2005). Others may suffer discrimination in the housing market (Danso and Grant 2000) or are directed into poor neighbourhoods with marginal housing stock and limited social resources. In each case, poor housing and poor neighbourhoods act as barriers to economic success, increases the likelihood of poor health, contributes to social exclusion, and ultimately raises the risk of homelessness (Access Alliance 2003; Hiebert *et al*. 2005).

Third, immigrants and refugees with limited social support in the community are more likely to experience homelessness. High rates of poverty and/or low income – both determinants of poor health on their own and common amongst new arrivals – may mean that the foreign-born rely more on social networks for housing. This shared accommodation with family and friends is a coping strategy that hints at the so-called 'hidden homelessness' within the foreign-born population (Hiebert et *al*. 2005). Not surprisingly, individuals who lack support networks of friends and family may have even fewer housing options in a crisis. Also reflecting the lack of social support, new arrivals may be hampered by lack of credit, transportation, cost and suitability of housing. Difficulties with language and understanding how the system works is compounded by uncertainties and limitations around entitlement to benefits and support limiting access to help, making it harder to access support services. Such social exclusion has also been linked to poor physical and mental health outcomes.

While the literature has only partially explored the links between immigration, settlement, health, and homelessness, and there is room for further analysis, their linkage is intuitive. Immigrants and refugees are potentially vulnerable populations that face both housing and health challenges requiring special strategies in both cases. Although anecdotal evidence would suggest that relatively few immigrants are resident in shelters, refugees may be over-represented amongst the foreign-born population, having greater disadvantages in health, housing, and labour markets. While not necessarily homeless, immigrants and refugees face difficulties in the housing market, and are somewhat more prone to homelessness than the broader population, a likelihood that is increased by poor mental health, limited social networks, poverty, and initial settlement locations in disadvantaged neighbourhoods.

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