SciMedCentral

Journal of Family Medicine & Community Health

Research Article

Access to Primary Health Care by New and Established Immigrants in Canada

Higginbottom GMA[1]* and Safipour J[2]

[1]*Department of Ethnicity and Community Health School of Health Science, University of Nottingham, England*

[2]*Department of Health and Caring Sciences, Linnaeus University, Sweden*

***Corresponding author**

Gina Awoko Higginbottom, Mary Seacole Professor of Ethnicity and Community Health School of Health Sciences, University of Nottingham, Rm 1976, A Floor, South Block Link Queen's Medical Centre Nottingham, NG7 2HA, England, Tel: 44-0-115-82-30991; Fax: 44-0-115-82-31208; Email: Gina.Higginbottom@nottingham.ac.uk

Submitted: 29 June 2015

Accepted: 11 August 2015

Published: 13 August 2015

Keywords

- Immigrants
- Primary health care
- Access to health care
- Ethnography
- Canada

Abstract

Aim: To investigate barriers related to access to primary health care by new and established immigrants in a western Canadian province.

Background: The immigrant population continues to rise in Canada; but impediments to the access of immigrants to primary health care may be threatening their health and well-being.

Methods: In total, 12 new and established immigrants participated in our focused ethnographic study. Data obtained from semi-structured interviews was analysed using the framework of Roper and Shapira assisted by the use of ATLAS.ti the qualitative analysis software package.

Findings: We identified four main factors that create barriers to access of primary health care services: (1) information barriers that impede navigation of the health care system by immigrants; (2) communication barriers arising from language difficulties and cultural differences; (3) socioeconomic barriers that make medical expenses unaffordable and the provision of services inequitable; and (4) negative prior experiences that discourage further use of services. We reveal that Canadian primary health care, although universally available, does not necessarily provide equitable care to new and established immigrants because they face considerable barriers in accessing and navigating these services.

ABBREVIATIONS

PHC: Primary Health Care

INTRODUCTION

The number of immigrants in Canada continues to rise [1-3]. Although immigration can help the country reach its strategic demographic, economic, social, humanitarian and security goals [4,5], negative health consequences may result for the immigrants [6,7]. Statistics Canada [13], defines an immigrant as someone who was born outside Canada but who now has permanent residency in Canada. This definition can also include other new comers such as refugees, all of which are considered immigrants in this article.

In addition, global migration and the formation of multicultural societies create challenges for practitioners of primary health care (PHC) and for the configuration of PHC services [8-12]. 'Primary health care' is the first-point-of-contact services (by family or emergency physicians, for examples [14]. The practice of PHC is unreservedly informed by principles of social justice [15]. This broad definition of PHC embraces primary care (access to and the first encounter with primary medical services) as well as activities focused on population and community health.

Access to PHC may be challenging for immigrants, and barriers to such access may threaten their health status. Many immigrants experience triple jeopardy-they are newcomers; they suffer chronic ill health; and they speak English as an additional language, which itself creates significant challenges in accessing and navigating PHC services [16-18]. Furthermore, new immigrants frequently encounter significant obstacles to securing employment and establishing livelihoods [17,19-21]. Though immigrants are welcomed into the country, they may find themselves actively and passively excluded from opportunities to participate fully in Canadian society and disadvantaged in their navigation of social and health care services. Supporting evidence gathered over several decades has established a significant linkage between socioeconomic status and the health of immigrant populations [22,23].

Although many immigrants have quite good health status upon arrival, particularly those who enter Canada as economic immigrants or 'skilled workers', they can fall prey to the

'healthy immigrant effect' where by their health status declines and converges towards the Canadian average over a period of approximately ten years [24,22,25,26].A number of explanations have been postulated for this phenomenon [27]. 'Good health' is a factor in admission to Canada, but this effect may be offset by the impact of migration [28]; acculturation and the stress of relocation may erode the initial health advantage, as may a preference for traditional health care providers [29] and a distrust of Western medicine [29,18].

Even though commonalities exist among all immigrants in terms of their experiences of migration, cultural adaptation and acculturation, a factor that can variably affect their health and well-being is quality of access to appropriate and timely PHC. Some studies have demonstrated under utilization of PHC by immigrant populations [30,16]. Other studies have demonstrated over utilization, possibly because of language barriers that engendered poor-quality health care interactions and caused health issues to be left unaddressed until they became serious[31,12]. PHC services are the 'first port of call' for individuals, families and communities in addressing their immediate health needs and concerns, yet many new immigrants have little or limited knowledge of Western models of PHC and face challenges in access and negotiation of PHC services [32,18]. Immigrants may strongly adhere to the traditional systems of medicine of their birth countries, and lay health beliefs may have become deeply embedded within them via socialization processes. These beliefs can be dissonant with Western biomedical interpretations of health and illness [18]. Other factors associated with access to PHC are (a) length of residence in the host community [12]; (b) level of education [33]; (c) racial discrimination [31,34]; (d) marital status and country of origin [30,35]; and (e) lack of acknowledgment by healthcare professionals of cultural or religious beliefs [18]. Knowledge and understanding of PHC services and the ability of immigrants to navigate the system may also play a role.

Although some of the barriers to health care access have been identified, additional investigation is needed, there is a paucity of research in Canada focused on primary health care and therefore our study adds considerably to the knowledge base therefore, our aim with this study was to investigate access to PHC by new and established immigrants in Alberta, Canada, and to contribute to the ongoing development of PHC in Canada. Our main research question was to identify the challenges facing new and established immigrants in accessing PHC and the differences that may exist between the two cohorts.

MATERIALS AND METHODS

We utilized a qualitative design with an applied ethnographic approach, as appropriate for the study of diverse communities [36-38]. Specifically, we conducted a focused ethnography, which is suitable for studying a limited number of participants with shared socioeconomic and cultural characteristics [39-41]. Focused ethnography is an appropriate methodological approach to use in PHC and nursing research because it can capture specific information for the development of more efficient care practices [42,40,18]. Classical or anthropological ethnographers require immersion in the field for a considerable length of time. In contemporary health care research finite budgets and limited resources require expedite methodological research approaches. The focused ethnographic approach is less time-consuming and offers the opportunity to answer more specific research questions . In this study, we gathered perspectives from a population of immigrants who had a shared experience regarding their use of PHC services in Canada.

Sampling and Recruitment

In ethnographic research, the study sample comprises the members of a community or culture under investigation who demonstrate the specific characteristics under study [40,18]. Therefore, we generated a non-probability purposive sample [38,40,18], with subgroups of new and established immigrants residing in Edmonton, Alberta, Canada. We asked the respondents to categorize themselves into one of the two subgroups—whether they had resided in Canada for less than 10 years or 10 or more years—because this categorization had been identified as a key variable in previous research on access to primary care [12] .

Participants were recruited via an immigrant-serving health centre and other immigrant support agencies . These agencies were selected because they had frequent contact with our potential study sample. The organisations offer a universal service providing services for all classes of immigrant populations making no distinction between economic migrants, refugees or other classes of immigrants. Representatives of these organizations provided assistance as collaborators and key informants. A multifaceted strategy was used to recruit participants from communities that were considered quite marginalized . Information concerning our study was available to all users of the services. The key informants acted as conduits by distributing a written summary of the study. We also provided envelopes with postage to allow immigrants to express their interest in participating (in their own languages). Members of the research team then contacted potential participants to explain the study and gain informed consent. We also provided details of the study at the immigrant support agencies on several occasions.

This project received ethical approval from Panel B of the Health Research Ethics Board (University of Alberta). The principles of informed consent, confidentiality and anonymity were observed at all times, including regarding the storage of study documents. Participants were aware of their right to withdraw at any time.

Data Collection

Semi-structured interviews are one of the fundamental tools for data gathering in focused ethnography [40,18]. In the focused ethnographic approach observation may or may not be a feature, in this study observation did not occur . All of the data about barriers in access to PHC for new and established immigrants were gathered using such interviews . All interviews were taped recorded (with the participants' permission) and transcribed verbatim for the purpose of analysis. All identifying information was removed during transcription.

Data Analysis

Following translation of the interviews into English and their subsequent transcription, the co-investigators reviewed

the transcripts and provided preliminary interpretations. Data was analysed with the aid ATLAS.ti qualitative data management software (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), however the interpretation of the data was wholly dependent on the cognitive skills of the researchers. We used the framework of Roper and Shapira [42], for the analysis of ethnographic data. This framework includes the following t analytical steps included coding for descriptive labels, sorting for patterns, identifying outliers, memoing and recording reflective remarks, and constructing narratives.

RESULTS AND DISCUSSION

Results

In total, 12 people (five new and seven established immigrants) participated in this study. We categorized the study findings into four main themes summarizing the factors that influenced our participants' access to PHC: (a) information barriers, (b) communication barriers, (c) socioeconomic barriers, and (d) negative prior experiences that discouraged utilization of services. A network view of the overall findings (Figure 1) was generated using ATLAS.ti. A generic observation that we made about the findings was that participants often felt more comfortable sharing anecdotal information about others in their social network, than their own personal experiences.

Information Barriers

This theme refers to the importance of having adequate information for the navigation of health care services. Our findings suggest that many new immigrants were not familiar with the health care system in Canada. This theme is divided into three parts: complexity and lack of information, language barriers, and incorrect information.

Complexity and lack of information: Many participants found the Canadian PHC system to be complex and difficult to navigate. Both established and new immigrants pointed out that utilizing PHC services can be confusing for them. One new immigrant mentioned that *'Sometimes when you need the doctor that you know, the access is different and they hard to catch, it's kind of you know, things are not easy to understand and you know to ge t access.'* Established immigrants seemed to have fewer problems, although they still encountered difficulties related to the system's complexity: *'if some of them have been here a long time, it is confusing, you know, the hospital or the health care system is so - it's big, right? . . . sometimes it gets very hard.'*

Lack of information about the health care system and how one should navigate it increased the dilemma. This problem seemed to be a more pronounced for the new immigrants, but established immigrants also reflected on difficulties they experienced during the time of their arrival. One new immigrant stated that *'Some people, they are eligible to access the healthcare, but they don't know where they can get, uh, this information, and where they can access the healthcare.'* Some participants recommended that an informational package be provided for new immigrants in the time of arrival: *'I think that will be very helpful. A small package to say, if they are, for example, a South Asian community or they are from Somalia, so something in their own language. They have that welcome kit sort of saying about the most important numbers like 911, the medical care'* (established immigrant).

The health care services offered by the country of origin of the immigrant may differ significantly from those of the receiving country. In the absence of correct information, these differences may lead to unrealistic expectations. Moreover, the information received prior to arrival may conflict with that learned or perceived afterwards, and misleading information can influence their use of PHC. One established immigrant pointed out, *'If you come to Canada, you, you can be very, very happy. They have that, expectation, nothing you do going to, you don't have any problems with, money or anything . . . They say everything is going to be easy for you there, they going to the better life in your country.'*

Communication Barriers

This theme refers to the communication difficulties specifically within the PHC setting between immigrants and health care providers. We found that communication interactions were limited by not only language fluency but also cultural differences in the interpretation of verbal and non-verbal communication. Although established immigrants appeared to have fewer problems than new immigrants, language barriers were still the main communication problem and were especially pronounced in relation to medical terms. Ethno-cultural differences can also lead to communication difficulties because some terms have a different meaning in another ethno cultural setting; indeed, some Canadian terms may not even exist in an immigrant's country of

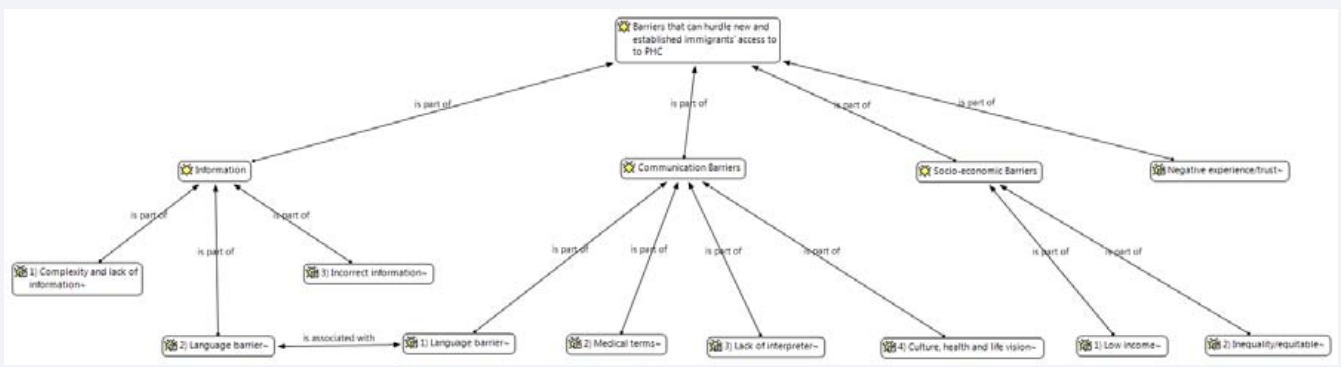

Figure 1 Network view (generated by ATLAS.ti) of identified factors that can influence access to primary health care (PHC) by new and established immigrants. Legend: A→B means that A is part of B; A↔B means that A is associated with B.

origin. This theme is divided into four parts: language barrier; medical terms; lack of interpreter; and culture, health and life vision.

Language barrier : Language barriers create communication difficulties that may limit access to PHC services. Although low language fluency was more pronounced among new immigrants, some established immigrants had had limited opportunities to practice their English and continued to experience communication challenges: *'Language, especially for new immigrants and also for some immigrants, even though they came here for a long time but they don't have opportunity to practice their English so it's a big barrier for them'* (established immigrant). For this reason, some participants in this study preferentially chose to have health care interactions with a medical doctor who shared the same country of origin. This choice often improved communication and enabled the person to express their problem in a more efficient and effective manner. In one participant's words, *'It doesn't matter how many years you lived in Canada, you still have the language problem. I mean you cannot speak like a Canadian; you still have some, some communication problem. That's why people, people like to find the doctor who can speak Chinese, you know, they can, they can communicate well'* (established immigrant).

Participants mentioned that age plays an important role in this regard. Young people were thought to learn language faster than older immigrants in most cases, and as expressed by one new immigrant, *'We come here when we are young, but what about those who are old, the older they lose their hope. It's, the language is very tough for them, to learn.'*

Given that little information was available in the languages of the immigrants, a significant barrier to accessing PHC information was found to be language difficulties. Participants spoke of how people with low written or spoken English proficiency had difficulty accessing and understanding informational resources, resulting in a lack of knowledge about the availability and relevance of services: *'That is no way for them to get, uh, this healthcare and, uh, and they thought there is no healthcare for them, but sometime there is, there is services for them, but no way for them to appraise the opinion or the need'* (new immigrant).

911, the medical care' (established immigrant).

The limited selection of languages in which informational resources were produced was identified as a barrier to access to PHC. The lack of information in their own languages created the most difficulties for new immigrants, sometimes including those who also spoke one of Canada's official languages: *'We don't even have handouts in maternity that are translated into French. French is an official second language and we get - we're getting more and more people from Africa whose mother tongue is French, you know. So, you know, like still some more work needs to be done there'* (established immigrant).

Medical terms: The use of medical terms in the PHC setting without ensuring patient comprehension was thought to lead to communication difficulties for both new and established immigrants. In such situations, the patients may not be able to accurately express their feelings and may not fully understand the implications of the information shared. Both new and established immigrants mentioned this issue: *'If you know, you know English you can, you can speak very well but if you don't know the term, medical terminology and then you can't use it'* (new immigrant). *'I don't know. Sometimes I don't know exactly how to say it in English. Probably there is a problem. But yeah, it's a kind of problem for English, you know. You don't know all the medical English*. Secondary care services have access to telephone interpretation services but it appeared that this was not available in PHC, failure to provide interpretation services results in inadequate provision of information and lack of comprehension by both patients and health care professionals of sometimes fundamental information . Access to an interpreter (translator) facilitates communication and reduces the level of dissatisfaction and the risk of misunderstanding: *'Some of the walk-in clinics can have a translator there; that will also help a lot and we can specify to people who are coming as a new immigrant that, "Listen, these are the places where you can get the services'* (established immigrant).

Culture, health and life vision: Communication difficulties may result from cultural differences. Some immigrants (especially new immigrants) have a very different vision about life, health, and health care and may subscribe to alternative paradigms of medicine. For example, one immigrant had tried to express himself with words that he had directly translated from his language to English. He had tried to say that he had pain in his body, but because of his cultural perspective, he mostly referred to 'pain' as a nerve problem and therefore received an incorrect and potentially risky medication. *'So there is a cultural issue. At the same time you see we are putting in life, in the mind of immigrant people Western, North American concept, which are totally stranger to them. So we are creating a new world. We are introducing them in a new vision of things, of life, that they don't have. . . . I went to the hospital; I had a fever, something in my body. When I arrived there I talked to the doctor and I said, "In my nerves I have some pain, in description." He said, "Oh, don't worry. I will give you a medication." He took a medication which was very dangerous, which could evoke a heart attack for some people'* (established immigrant).

Socioeconomic Barriers

This theme refers to socioeconomic barriers that may limit the ability of new and established immigrants to access PHC. Barriers due to low income can result in a lack of insurance coverage and an inability to pay for medical expenses, whereas inequitable social conditions can result in unequal access to health care services. This theme is divided into two parts: (a) low income and (b) inequality and inequity of services.

Low income: Some immigrants have to work extra hours or double shifts because of their low socioeconomic status, thereby limiting the time available to take care of their health—for example, by engaging in physical activity or by having regular medical check-ups. Economic difficulties were described as one of the main reasons for not seeking medical services, which were thought to be expensive. These barriers existed for both groups but were more apparent among the new immigrants, who were establishing themselves in a new ethno-cultural context. A situation described as common among new immigrants was to access PHC successfully but then not following the medical advice or taking the medication prescribed because of the cost: *'They don't take medication because they can't afford to buy it. May be*

they [just buy] Tylenol, because, Tylenol, everyone take Tylenol and it's just, they can afford to buy it, yeah, they take it for their pain, for anything, they just use Tylenol. That's all. (new immigrant).

Another narrative illustrated that living in a large family could make the purchase of medicines prohibitive. Simply articulated, the financial 'pie' had to be divided to meet the needs of all family members. Again, the use of PHC was inadequate as a result: *'I have, uh, nine kids in my family, plus my wife and myself, we are at eleven and I'm working, even though I make a lot of money I, I cannot afford to buy medication for all of my family, because if I spend all the money, to the medication, and that is will, that will be no food in my, to, in my family'* (new immigrant).

Inequality and inequity of services: Although PHC is provided equally for all in Canada, the exigencies of language, information, knowledge and transportation faced by the new immigrants in this study resulted in diminished use of PHC services – the provision of services is equal but not necessarily equitable, especially for new immigrants, *'Same services for everybody, okay? That is when everybody is on the same level playing field. But because the new migrants are not on the same level playing field, . . . But if they are not able to access it because of their own barriers, you know, it's the services are same but they're not equitable. Equitable is that it's because of the equity. Here they need that - the migrants are here because they have a whole lot of barriers'* (established immigrant).

A new immigrant also described how a lack of information could jeopardize the equitability of accessing health care's services: *'Some people they don't access, because they don't understand the information that they, they get from the doctor. They don't really speak English, they don't know where they can contact even the services that they need, they don't they don't access.'*

Negative Prior Experiences

A negative experience of PHC services may prevent future service utilization by patients or clients, especially those coming from a different ethno-cultural background. Our participants implied that these negative experiences may be the result of cultural clashes and misunderstandings, conflicts of values, or medical mistakes. A lack of trust resulting from negative previous experiences had discouraged some new and established immigrants in this study from using PHC in the future. One such experience was the following: *'My daughter-law time, last year … she, had a runny nose, nose. .. The first doctor said "allergic", the second doctor says "is the flu", the third told me that is, uh, is, "seasonal flu", but fourth doctor asked if he her some antibiotics, and accidently, at that time my daughter has a fever. He gives her some antibiotics…that doctor referred my daughter to see a specialist; we waited another nine months, but finally the, runny nose gone.* It's gone established immigrant).

Disappointment with their experiences and a consequent lack of trust in health care providers may lead some immigrants to make incorrect medical decisions. This lack of trust can result in immigrants seeking alternative medications from their countries of origin, the use of which may be dissonant with the perspectives of their family doctors. *'So, the doctor said, "No, you don't have to worry about this." So for them, it's kind of serious thing. So, they, ordered the medicine from Thailand to come in and kind of take, get it out, this here . . . Yeah, they order, they order medicine back home'* (new immigrant).

DISCUSSION

This study aimed to investigate the experiences of new and established immigrants in accessing Canadian PHC, with particular emphasis on identifying barriers to access and to navigation of the system. Timely access to PHC leads to the best possible health outcomes [32,17]. Other studies have demonstrated that although health care services are available, accessing them can be challenging and several factors can obstruct the process [32,9,17,12]. Barriers to access are experienced more acutely by newly arrived immigrants, because established immigrants in general have better language skills, fewer communication problems, and more knowledge about the health care system [12].

Ethno-cultural differences and conceptualizations of health and illness divergent from those of Western biomedicine may lead to communication difficulties and misunderstanding between health care providers and patients. The health professional is likely to be imbued with Western biomedical perspectives and their perception and understanding of the patient's condition may be very dissonant with those of the patient.

Lack of information and knowledge regarding the navigation of PHC services has been identified as the main issue for new immigrants who are attempting to use services for the first time [45,6,32]. In accordance with our findings, studies by Asanin and Wilson [8] and Setia and colleagues [11] showed that longer immigrant residence time correlated with increased ability to obtain information and better familiarity with the system, thus facilitating access to PHC. However, the arrival of immigrants in a new country can be associated with great turmoil and stress [46], which could force their attention away from seeking PHC during their early residence time.

Although longer residence times will mean increased familiarity with PHC, language and communication challenges may still remain. Our results demonstrate that communication problems continue to be a major concern for established immigrants. These problems are mostly related to a lack of fluency in English or French, to unfamiliarity with medical terms, and in some instances to 'cultural clashes'. Numerous studies have indicated that low language proficiency and other communication barriers negatively influence not only the access to PHC by new immigrants but also the quality of care received [47-51,12]. Confirming our findings, Author *et al.,* [18], found that a lack of shared meanings due to cultural differences may lead to further communication problems. In other words, although immigrants and health care providers speak the same language, they sometimes ascribe different meanings to the words used. In addition, the diverse world views and conceptualizations of health and illness held by immigrants can strongly affect their understanding and acceptance of Western medical practices [18]. Such dissonance is a possible source of misunderstanding between patients and health care providers.

Our third theme identified several ways in which socioeconomic factors can impede access to PHC. The costs

of medical care and medications and the low socioeconomic positioning of many immigrants were found to be significant barriers. Many new immigrants had not yet had the opportunity to establish themselves financially or socially in the new environment. This problem was experienced even more profoundly by refugees who did not have health insurance coverage in the early stages of their immigration to Canada [52]. Although PHC services in Canada are designed to treat everyone equally, several substantial barriers can prevent immigrants (particularly new immigrants) from receiving equitable PHC. This inequity leads to the unequal use of PHC services and ultimately may be detrimental to the long-term health of these individuals – perhaps contributing to the healthy immigrant effect.

Moreover, negative past experiences with PHC—including enduring long waiting lists—can reduce the level of satisfaction of immigrants with the system and erode their trust in the health care providers, thereby affecting future help-seeking behaviours. Experiences such as perceived discrimination or inequality can also potentially jeopardize future utilization of services and lead to potentially risky health decisions and behaviours [17]. These challenges seemed to apply for both new and established immigrants.

Our findings address the barriers faced by new and established immigrants in one province in Canada, but the immigrant population is not homogeneous: wide variation exists between ethno-cultural groups and between classes of immigrants. Therefore, we recommend that future investigations study specific ethnic populations and perform sub-group analyses not only between ethnic groups but also between immigrants and refugees. We also recommend longitudinal studies to determine how length of stay affects healthcare-seeking behaviours. A limitation of the current study was its small sample size; nevertheless, important perspectives were shared by the participants.

CONCLUSION

This study has provided valuable information regarding how lack of information, communication difficulties, socioeconomic barriers, and negative experiences with services can seriously impede the access to PHC by new and established immigrants in Canada. We have also indicated that new immigrants can be more vulnerable to such access barriers than are established immigrants: more attention needs to be directed to the population that is trying to access health care for the first time. Although Canadian PHC services are configured to treat residents equally regardless of their background, it seems that much progress remains to be made before the system meets the country's promise of welcoming immigrants and refugees to foster a multicultural population.

ACKNOWLEDGEMENTS

We thank Drs Jayantha Dassanayake and Ramadimetja S. Mogale for their assistance with data collection and Stan Back for editing this manuscript.

Conflict of Interest

The research was supported by a Killam Research Fund grant administered by the University of Alberta's Office of the Vice-President (Research). Dr Gina Higginbottom and the publication of this article are supported by a Canada Research Chair in Ethnicity and Health (www.chairs.chaires.gc.ca). The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

REFERENCES

1. Statistics Canada. Immigrant population by place of birth, by census metropolitan area. 2006 Census of Population. Ottawa: Statistics Canada. 2007.
2. Statistics Canada. Population growth in Canada: From 1851 to 2061. (Census in Brief No. 98-310-X-2011003). Ottawa: Statistics Canada. 2011.
3. Statistics Canada. Canada census profile. (Census No. 98-316-XWE). Ottawa: Statistics Canada. 2012.
4. Beach CM, Green AG, Reitz JG. Canadian immigration for the 21st century. Montreal: McGill/Queens University Press. 2003.
5. Kymlicka W. Immigration, citizenship, multiculturalism: Exploring the links. Polit Q. 2003; 74: 195-208.
6. Wu Z, Penning MJ, Schimmele CM. Immigrant status and unmet health care needs. Can J Public Health. 2005; 96: 369-373.
7. Hyman I. Immigration and health: Reviewing evidence of the healthy immigrant effect in Canada. CERIS Working Paper # 55. Toronto: Joint Centre of Excellence for Research on Immigration and Settlement. 2007.
8. Asanin J, Wilson K. "I spent nine years looking for a doctor": exploring access to health care among immigrants in Mississauga, Ontario, Canada. Soc Sci Med. 2008; 66: 1271-1283.
9. Lebrun LA, Dubay LC. Access to primary and preventive care among foreign-born adults in Canada and the United States. Health Serv Res. 2010; 45: 1693-1719.
10. Lebrun LA, Shi L. Nativity status and access to care in Canada and the U.S.: factoring in the roles of race/ethnicity and socioeconomic status. J Health Care Poor Underserved. 2011; 22: 1075-1100.
11. Setia MS, Quesnel-Vallee A, Abrahamowicz M, Tousignant P, Lynch J. Access to health-care in Canadian immigrants: a longitudinal study of the National Population Health Survey. Health Soc Care Community. 2011; 19: 70-79.
12. Lebrun LA. Effects of length of stay and language proficiency on health care experiences among immigrants in Canada and the United States. Soc Sci Med. 2012; 74: 1062-1072.
13. Statistics Canada. Definition of "immigrant". Ottawa: Statistics Canada. 2010.
14. Health Canada. About primary health care. Ottawa: Health Canada. 2012.
15. How health systems can address health inequities linked to migration and ethnicity. (Briefing on policy issues produced through the WHO/ European Commission equity project). World Health Organization; 2010.
16. McKeary M, Newbold B. Barriers to care: The challenges for Canadian refugees and their health care providers. JRefug Stud. 2010; 23: 523-545.
17. Richardson LD, Norris M. Access to health and health care: how race and ethnicity matter. Mt Sinai J Med. 2010; 77: 166-177.
18. Higginbottom G, Safipour J, Mumtaz Z, Chiu Y, Paton P, Pillay J. "I have to do what I believe": Sudanese women's beliefs and resistance to

hegemonic practices at home and during experiences of maternity care in Canada. BMC Pregnancy Childbirth. 2013; 13: 51.

19. Dean JA, Wilson K. 'Education? It is irrelevant to my job now. It makes me very depressed. . . ': Exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada. Ethn Health. 2009; 14: 185-204.

20. Williams DR, Mohammed SA, Leavell J, Collins C. Race, socioeconomic status, and health: complexities, ongoing challenges, and research opportunities. Ann N Y Acad Sci. 2010; 1186: 69-10.

21. Creese G, Wiebe B. 'Survival employment': Gender and deskilling among African immigrants in Canada. IntMigr. 2012; 50: 56-76.

22. De Maio FG, Kemp E. The deterioration of health status among immigrants to Canada. Glob Public Health. 2010; 5: 462-478.

23. Lorant V, Bhopal RS. Ethnicity, socio-economic status and health research: insights from and implications of Charles Tilly's theory of Durable Inequality. J Epidemiol Community Health. 2011; 65: 671-675.

24. Newbold KB. Self-rated health within the Canadian immigrant population: risk and the healthy immigrant effect. Soc Sci Med. 2005; 60: 1359-1370.

25. O'Loughlin J, Maximova K, Fraser K, Gray-Donald K. Does the "healthy immigrant effect" extend to smoking in immigrant children? J Adolesc Health. 2010; 46: 299-330.

26. Aglipay M, Colman I, Chen Y. Does the healthy immigrant effect extend to anxiety disorders? Evidence from a nationally representative study. J Immigr Minor Health. 2013; 15: 851-857.

27. Laroche M. Health status and health services utilization of Canada's immigrant and non-immigrant populations. Can Public Policy. 2000; 26: 51-73.

28. Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: cross-sectional study. Lancet. 2006; 367: 2005-2009.

29. Higginbottom GM. 'Pressure of life': Ethnicity as a mediating factor in mid-life and older peoples' experience of high blood pressure. Sociol Health Illn. 2006; 28: 583-610.

30. Chen AH, Youdelman MK, Brooks J. The legal framework for language access in healthcare settings: Title VI and beyond. J Gen Intern Med. 2007; 22: 362-367.

31. Fenta H, Hyman I, Noh S. Health service utilization by Ethiopian immigrants and refugees in Toronto. J Immigr Minor Health. 2007; 9: 349-357.

32. Sanmartin C, Ross N. Experiencing difficulties accessing first-contact health services in Canada: Canadians without regular doctors and recent immigrants have difficulties accessing first-contact healthcare services. Reports of difficulties in accessing care vary by age, sex and region. Healthc Policy. 2006; 1: 103-119.

33. Derose KP, Bahney BW, Lurie N, Escarce JJ. Review: immigrants and health care access, quality, and cost. Med Care Res Rev. 2009; 66: 355-408.

34. Edge S, Newbold B. Discrimination and the health of immigrants and refugees: exploring Canada's evidence base and directions for future research in newcomer receiving countries. J Immigr Minor Health. 2013; 15: 141-148.

35. Ye J, Mack D, Fry-Johnson Y, Parker K. Health care access and utilization among US-born and foreign-born Asian Americans. J Immigr Minor Health. 2012; 14: 731-737.

36. Hammersley M, Atkinson P. Ethnography: Principles in practice. London: Routledge. 1994.

37. Fetterman DM. Ethnography: Step by step. 2nd ed. Thousand Oaks: Sage. 1998.

38. Brewer JD. Ethnography. Buckingham: Open University Press. 2000.

39. Miles MB, Huberman AM. Qualitative data analysis: A sourcebook of new methods. Beverly Hills: Sage Publications. 1984.

40. Cruz E, Higginbottom G. Focused ethnography in nursing research. Nurse Res. 2013; 20: 36-43.

41. Higginbottom G, Pillay J, Boadu N. Guidance on performing focused ethnographies with an emphasis on healthcare research. The Qualitative Report. 2013; 18: 1-16.

42. Roper JM, Shapira J. Ethnography in nursing research. London: Sage Publications. 2000.

43. Brislin RW. Back-translation for cross-cultural research. J Cross Cult Psychol. 1970; 1: 185-216.

44. Jones L, Watson BM. Developments in health communication in the 21st century. J Lang Soc Psychol. 2012; 31: 415-436.

45. Neufeld A, Harrison MJ, Stewart MJ, Hughes KD, Spitzer D. Immigrant women: making connections to community resources for support in family caregiving. Qual Health Res. 2002; 12: 751-768.

46. Beiser M. The health of immigrants and refugees in Canada. Can J Public Health. 2005; 96: 30–44.

47. Bowen S. Language barriers in access to health care. (No. H39-578/2001E). Ottawa: Health Canada. 2001.

48. Bischoff A, Bovier PA, Rrustemi I, Gariazzo F, Eytan A, Loutan L. Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. Soc Sci Med. 2003; 57: 503-512.

49. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. 2007; 19: 60-67.

50. Guruge S, Berman R, Tyyska V, Murphy Killbride K, Woungang I, Edwards S, et al. Implications of English proficiency on immigrant women's access to and utilization of health services. Women's Health Urban Life. 2009; 8: 21-41.

51. Binder P, Borné Y, Johnsdotter S, Essén B. Shared language is essential: communication in a multiethnic obstetric care setting. J Health Commun. 2012; 17: 1171-1186.

52. Miedema B, Hamilton R, Easley J. Climbing the walls: Structural barriers to accessing primary care for refugee newcomers in Canada. Can Fam Physician. 2008; 54: 335-336, 338-389.

Cite this article

Higginbottom GMA, Safipour J (2015) Access to Primary Health Care by New and Established Immigrants in Canada. J Family Med Community Health 2(5): 1046.