



Identifying Barriers to Healthcare Access for New Immigrants: A Qualitative Study in Regina, Saskatchewan, Canada

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Abstract

Despite universal healthcare, immigrants often face unique challenges accessing healthcare. Employing an interpretative phenomenological analysis approach, four focus groups were conducted with 29 women and eight men from 15 different countries attending English language classes hosted at a non-governmental organization in Regina, Saskatchewan, Canada in 2016 and 2017. Personal factors such as language barrier, lack of transportation, childcare and others interacted with systemic factors such as lack of appointment, long wait times, etc. delaying access at each point of contact with the healthcare system. Participants expressed dissatisfaction with the potency of medications, time spent in appointments and the way healthcare professionals communicated health information. The referral process and wait times were viewed as barriers to accessing specialist, diagnostic and acute care services. Participants were concerned that appropriate healthcare will be unavailable when needed. Strategies addressing systemic and person-specific barriers are needed to provide equitable client-centered care.

Keywords Healthcare · Access · Barriers · New immigrants

Introduction

Immigrants support Canada's population growth, address the skilled labor shortage, and need for temporary labor [1]. International students contribute \$21 million in revenue while also creating home-trained skilled workers [2]. According to the 2016 census, 296,346 permanent residents were admitted in Canada [3]. India, China, Philippines, Nigeria, and Pakistan were the top 5 source countries for immigrants to Canada in 2019 [1]. Although bigger urban areas such as Toronto, Vancouver, and Montreal are the preferred choice of residence for half of the overall immigrants, and new immigrants, the immigrant population in the prairies is fast increasing [4]. In Saskatchewan, the proportion of immigrants grew from less than 1.0% in 2001 to 4.0% in 2016. Between 2011 and 2016, Regina Saskatchewan

welcomed 16,195 new immigrants [4]. Saskatchewan's government proposed to integrate lessons learned from other provinces and develop strategies to enhance population and economic growth by supporting immigrants to the province. [5].

Studies consistently report that the healthy immigrant effect or better health status of new immigrants compared to their Canadian-born counterparts deteriorates over time with an increased stay in the host country [6–8]. Despite efforts to provide high quality healthcare services to all Canadians, differences are observed between foreign-born and Canadian-born residents in the extent to which primary healthcare services [9] and preventative healthcare services, in particular, are accessed or utilized [9–11]. This phenomenon is observed in other European and North American countries receiving immigrants and refugees [9, 12, 13]. Factors such as geographic access, economic barriers, limited hours of operation, language barriers, difficulty navigating the healthcare system, and cultural differences are major barriers to accessing healthcare services [13–17]. Additionally, reliance on others to take time off for appointments [16], transportation [16–18], child care [18], prioritization of household responsibilities [18] over health [16], preference for home remedies, and delaying healthcare access until it is urgent

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[15, 18] might impede new immigrant women's access to healthcare. Immigrants with linguistic barriers were more likely to experience medication errors, delays in diagnosis, and suboptimal care [19]. Immigrants were more likely to have a poor therapeutic relationship with their providers, not be able to communicate their health needs effectively, develop mistrust, and experience racism and discrimination [19–21]. Certain ethnic groups may have preferences for gender-specific providers and particular expectations about healthcare, when these are unmet it created dissatisfaction with the Canadian healthcare system [20]. Immigrants and refugees report feeling overwhelmed while interacting with the healthcare system. This was due to a lack of knowledge and lack of support to help them navigate the new system. Many studies have examined immigrants' healthcare needs in Ontario and British Columbia which have larger immigrant populations; studies exploring the healthcare needs of immigrants in Saskatchewan are scarce [22].

The Saskatchewan healthcare system serves a population of almost 1.2 million people with an annual budget of \$5.1 billion [23]. In the year 2016–2017 healthcare was delivered through 12 health regions, the Saskatchewan Cancer Agency, the Athabasca Health Authority, affiliated healthcare organization, and a diverse group of professionals [24]. Visits to physicians' offices, X-ray and laboratory services, diagnostic, and surgical procedures, and other inpatient or outpatient hospital care are covered by the provincial healthcare plan [25]. Additional, coverage for some prescription medication, dental, optometric care is covered for low-income families and seniors. Residence permit holders with a minimum of 6 months' stay annually are eligible for healthcare benefits [25]. Healthcare coverage for immigrants begins on the first day of the third month following their arrival [25]. New immigrants are responsible for any healthcare cost until the coverage begins. Additionally, many healthcare services are concentrated in the urban care centers, namely Saskatoon and Regina [23], leading to access issues for those geographically dispersed. Saskatchewan is uniquely positioned in terms of population density, geographic locations, economic and social aspects. Unprecedented population growth in the past few years increased demands on the healthcare system in Saskatchewan [23]. The Saskatchewan Health Advisory Report indicated that Saskatchewan residents have difficulty accessing healthcare services in general [23] and these problems might be further augmented for immigrants [15, 26]. The objective of the study was to (1) explore the experience of new immigrants with the healthcare delivery system and (2) identify barriers that new immigrants face when accessing healthcare services in Regina Saskatchewan Canada.

Theoretical Framework

An interpretative phenomenological analysis (IPA) [27, 28] approach was employed. IPA is a collaborative process of meaning creation [27, 28]. In this approach, the researcher attempts to gain an insiders' perspective of the persons' worldviews while acknowledging that their own life experiences also influence the interpretation of the persons' experiences [27, 28]. The understanding of the situation is co-created by combining the perspectives as shared by research participants and the researchers' interpretation of the conversation held with participants [27, 28].

Methods

The research team consisting of two family physicians and a health researcher, partnered with Regina Immigrant Women Center (RIWC), a local non-governmental organization serving new immigrants in Regina. The research and the focus group questions were developed in collaboration with the executive director of RIWC. Teachers facilitating English Language classes at RIWC reviewed the focus group questions to ensure they could be comprehended by participants with limited English language proficiency. Saskatchewan Health Authority (SHA) Research Ethics Board approved the study (REB 14-122). In collaboration with the teachers the research objective, participants' role, and consent forms were presented to 43 individuals attending English language classes offered by RIWC in 2016 and 2017.

Participants

Twenty-eight women and 9 men from 15 different countries signed the consent form. Six participants were excluded due to travel plans and lack of interest. RIWC primarily provides services to new immigrant women however, a small number of male participants attending the language classes during data collection expressed interest in the study and were included.

Focus Groups

Four focus groups were conducted during the scheduled class times. As recommended by the teachers, questions were shared with participants prior to the focus group. This allowed participants to become familiar with the topic, reflect on their experiences with the healthcare system and organize their thoughts. All participants completed an open-ended demographic questionnaire and provided information on their current health status using a three-point

Likert response scale. Completed paper copies were collected before the focus group discussions began. Each focus group lasted 2 hours and was attended by 10–12 participants. Two family physicians, a health researcher, and two medical students facilitated the focus groups each of whom were a member of an ethnic group and spoke a second language. None of the participants was a patient of the family physicians on the research team. Each facilitator worked with a small group of 2–3 participants and 2–3 sub-groups were held concurrently during each focus group. Participants with limited English language abilities were either paired with a facilitator speaking their language or with other participants from the same ethnic group with advanced language proficiency. Facilitators posed the questions in English and wrote participants' responses verbatim. The responses written by the facilitators were read back to the participants ensuring their views were captured accurately. Facilitators clarified the responses with the participants as required. Some participants chose to bring prewritten responses using online translators to the focus group. These helped participants verbalize their thoughts fluently during the focus group discussions. Participants read out their notes during the focus groups and submitted the written responses to the research team after the focus group. After each session, facilitators collectively discussed the salient points emerging from their respective group's discussions and identified important points that needed further clarification with subsequent groups. Additionally, all facilitators kept field notes, documenting their expectations about the project, the main themes they identified, challenges reported by the participants, solutions offered by facilitators, unexpected issues mentioned by the participants, and their overall experience coordinating the focus group discussions. These field notes were also treated as data.

Analysis

The data from the demographic survey was analyzed employing software package SPSS version 22 © IBM [29] and represented as means (standard deviation) and percentages.

Focus group data were analyzed qualitatively using QSR NVivo® 9 [30]. The data gathered from the four focus groups were converted to electronic files. Data were analyzed qualitatively employing procedures proposed by Miles, Huberman, and Saldana [31]. The transcribed data was read line by line and broken into smaller meaningful chunks giving rise to 125 base level codes [31]. Data categorized under individual base codes were reviewed again, a summary statement and a title representing data points grouped under each base code were developed [31]. The base codes were next categorized under intermediate codes. Diagrams representing the intermediate codes were developed. The field notes

maintained by facilitators were consulted ensuring that the intermediate codes included the salient themes identified by other facilitators [31]. The intermediate codes were then further categorized under the main themes [31]. An interpretative diagram demonstrating a relationship between the intermediate and the main themes, was developed. The first draft of the interpretative diagram was reviewed by the two authors who had also facilitated several focus groups and final adjustments were made.

Results

Demographic Survey

The results of the demographic survey are summarized in Table 1. The majority of male and female participants arrived from Asian countries, were married, had an undergraduate degree, and had 1–3 children. The mean length of stay for males was 3.4 years and 2.8 years for women. All participants rated their overall health positively, more women participants reported being tired and reported sleep problems compared to men (See Table 2).

Focus Group

Six main themes describing new immigrants' overall experience and how barriers impact access at various point of contact with the healthcare system are illustrated in Fig. 1.

Appointments

Appointments were the first point of contact with the healthcare delivery system and participants mentioned that doctor appointments were not available when required as a participant mentioned "I need to see doctor, but I need an appointment and they say everything is booked". Some women participants could only access healthcare in the evenings and weekends due to lack of transportation and childcare. However, few medical clinics are open after hours. Individuals with language barriers reported experiencing challenges booking appointments that required following automated instructions.

Medical Consultation

Consultation with family physicians was the second point of contact with the healthcare delivery system. Several participants mentioned experiencing 1–2 hour wait times after booking appointments at medical clinics. A participant mentioned:

Table 1 Comparison of the demographic variables and current health status between male and female participants

| | Female | Male |
|--|------------|-----------|
| N (%) | 28(75.7%) | 9 (24.3%) |
| What is your age? (mean, SD), (years) | 37.6 (7.9) | 41.1(7.1) |
| What is your marital status? n (%) | | |
| Married or common law | 25 (89.3%) | 8(88.9%) |
| Divorced | 1 (3.6%) | 1 (11.1%) |
| Missing | 2 (7.1%) | N/A |
| What is the level of education you completed? n (%) | | |
| Elementary Schooling (grade 10) | 1 (3.6%) | 1 (11.1%) |
| High school | 5 (17.9%) | 5 (55.6%) |
| Trades and or vocation | 1 (3.6%) | 1 (11.1%) |
| Undergraduate | 18 (64.2%) | 2 (22.2%) |
| Missing | 3 (10.7%) | N/A |
| How many children do you have? n (%) | | |
| 0 | 5 (18%) | N/A |
| 1–3 | 20 (71%) | 8 (88.9%) |
| > 3 | 2 (7.1%) | 1 (11.1%) |
| Missing | 1 (3.6%) | N/A |
| How many other individuals live with you in the same house? n (%) | | |
| 1–3 | 17 (60.7%) | 3 (33.3%) |
| 4–6 | 10 (35.7%) | 3 (33.3%) |
| >6 | N/A | 1 (11.1%) |
| Alone | N/A | 1 (11.1%) |
| Missing | 1 (3.6%) | 1 (11.1%) |
| What is the total family income in a year? n (%) | | |
| 0–\$30,000 | 9 (32.1%) | 1 (11.1%) |
| \$30,000–\$50,000 | 6 (21.4%) | 2(22.2%) |
| \$50,000–\$100,000 | 4 (14.3%) | 3 (33.3%) |
| Missing | 9 (32.1%) | 3 (33.3%) |
| How long have you stayed in Canada? mean (SD), (years) | 2.8 (1.9) | 3.4(.15) |
| Continent of origin | | |
| Asia (Afghanistan, China, India, Pakistan, Philippines, Russia, and South Korea) | 22 | |
| Europe (Hungary, Poland, Turkey, and Ukraine) | 10 | |
| Africa (Egypt, Tunisia, Eretria) | 4 | |
| South America | 1 | |
| Current Health Status | | |
| How is your health at present? | | |
| Good | 18(64.3%) | 6(66.7%) |
| Alright | 10(35.7%) | 3(33.3%) |
| Bad | N/A | N/A |
| Do you get tired easily? | | |
| Yes | 6(21.4%) | 2(22.2%) |
| No | 4(14.3%) | 3(33.3%) |
| Sometimes | 18(64.3%) | 4(44.4%) |
| Do you have problems with your sleep? | | |
| Yes | 18(64.3%) | 4(44.4%) |
| No | 3(10.7%) | 2(22.2%) |
| Sometimes | 7(25%) | 3(33.3%) |

Table 2 Focus groups prompt questions

1. What does health mean to you?
2. What are some of the things/services needed to keep you healthy?
3. Describe the healthcare system in your country?
Prompt with if needed:
 - a. What do you need to get healthcare in your country?
4. How is it different here (in Canada)?
5. What are some of the challenges you face or have faced when you tried to get healthcare for yourself or your family?
6. Do you have a family doctor?
Prompt with if needed:
 - a. How often do you go to a doctor?
 - b. What are some of the problems you face when you or your family members need to see a doctor/need medicine/need tests or surgery?
7. What are some of the cultural views, beliefs about health?
Prompt with if needed:
 - a. Do you have home remedies that you still use when you are sick?
 - b. Are any of the cultural remedies different from the type of care you have received here?
 - c. Who makes decisions about healthcare in your family?
8. Did you need an appointment with a specialist?
9. Have you visited the hospital or emergency room?
Prompt with if needed:
 - a. How was your experience? Please give an example

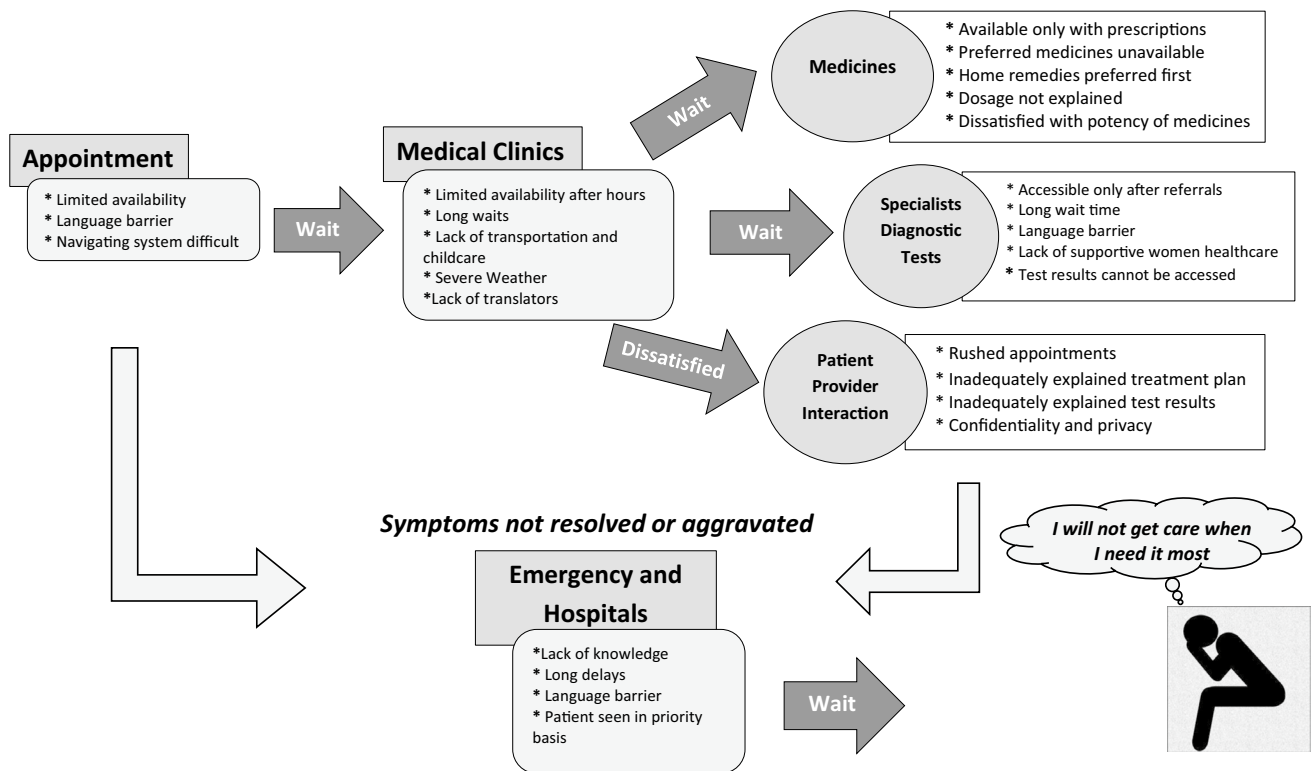


Fig. 1 New Immigrants’ experiences with the healthcare delivery system and challenges faced when accessing healthcare in Regina Saskatchewan

“We have to take an appointment and even after that there is a long wait and then the doctor hardly spends time explaining everything.”

New immigrants without sick times and those dependent on others for transportation, language assistance, and child-care, experienced problems accessing healthcare as participants indicated:

“The weather is very cold here and sometimes very hard to go to the doctors by myself [...] I have language problems.” [...] “I do not know about the bus service so I am not sure I can go to the doctor’s office by myself. But it is not very far from my house.”

Participants indicated accessing care when necessary and when they had multiple complaints. However, a patient indicated that: “Doctor told me I can only talk about one problem at a time. So I prioritize which one to talk about”.

Facilitators’ notes indicated that many participants accessed family physicians only when needed and their services were underutilized. Underutilization of family physicians services was also influenced by prior experiences with the healthcare system in their country of origin. A few participants from different countries mentioned: “Back home we only go to the doctor when we need. We did not have family doctors we can go to any doctor we need.” Individuals expected some tangible action during their consultation with family physicians such as a prescription, referral to a specialist, or a diagnostic test. Medications and provider-patient interactions associated with family physicians were discussed by most participants in all focus groups and are therefore discussed separately.

Health Behaviour and Beliefs

Most participants relied on home remedies and herbs as the first line of treatment. A participant mentioned: “for cold gargle with warm salt water, drink warm turmeric milk if it doesn’t get better then go to doctor”. Individuals felt comfortable using home remedies handed down by family members especially for minor health issues, for children, for pain and stress, sleep problems, etc. Some participants were concerned about the side effects of pharmacological treatments. They preferred using medications only when necessary or preferred medications they had used in their country of origin. Participants indicated that medications cannot be purchased without a prescription as is evident from one participant’s comment:

“Medication must be prescribed and can’t be purchased. Sometimes I know what I need and what my symptoms are, but I simply just can’t go to the pharmacist to purchase meds I need.”

A facilitator noted that participants were unfamiliar with over-the-counter medications and their usage. Participants were dissatisfied with the prescribing practices. A participant visiting a doctor for menstrual cramps mentioned: “how can she [the doctor] give me pills when she did not even check me?” and “decide what I had and how bad my pain was”.

A few participants were dissatisfied with the potency of the medications and mentioned,

“Our bodies are used to strong medicine, the medicine available here are too weak it does not have any effect on our bodies, it takes longer to get well”.

Provider–Patient Interactions

Participants were dissatisfied with how providers shared information during medical consultations. Due to rushed appointments and language barriers, participants often had difficulty following the conversation. For example, a participant indicated: “the doctor met with me 5 min and spoke very fast and left, and I didn’t follow fast language and didn’t understand”.

Due to language barriers, conversations with the doctors were difficult and progressed slowly even with an interpreter and patients were unable to advocate for their needs. Participants with language barrier mentioned that time was insufficient to explain their concerns or get answers from the healthcare providers as a parent mentioned:

“Once I used walk-in clinic and my daughter had food-poisoning doctors gave medication for just one day. I had to make another appointment to see the doctor the next day; I cannot believe that the doctor gave medicine for just one day. I know the kid’s condition he did not even check with his stethoscope. I am worried and anxious that it will get worse. It is very frustrating.”

Few participants reported suboptimal experiences during their medical appointment due to language barriers “I was treated with disrespect they think we are uneducated and come from a very poor background.”

Many participants pointed out that the provider missed explaining why or why not medication was given, the dosage, or discuss the time it takes for the condition to resolve. One parent provided a written comment:

“My child had high fever for three days I give Tylenol and Advil and the fever didn’t get better. I got an appointment and saw the doctor; ...doctor says give Tylenol and Advil!!, but my child is so sick the medicine is not working!!! What to do?”.

Individuals with language barriers often depended on other family members as a participant indicated: “hard to communicate with doctors so my husband translates for me”. Facilitators noted, consulting the doctors privately for confidential issues was challenging without involving the husband or other family members who served as translators.

Many participants indicated that they managed their health records and received their diagnostic reports in their country of origin. Participants indicated that all medical records, diagnostic tests results are stored at the doctor’s office in Canada and were inaccessible. Participants seldom heard back from the doctor following a diagnostic test and a separate appointment was required to review the results. Participants mentioned receiving minimal information about tests results such as “everything is good or sugar is a bit higher”. Some participants wanted more detailed information to better manage chronic conditions like diabetes, high cholesterol, etc. as a participant mentioned:

“I would like the doctor to explain the blood test results to me in detail. They say it is alright, but I need some more information so that I can take care and keep things normal. I want to compare it with past test reports to see how I am doing and become better.”

Specialist

Most participants indicated that a specialist should be consulted when conditions deteriorated. However, referral to a specialist is coordinated by family physicians and they were perceived as gatekeepers which were also viewed as a barrier in itself as this participant mentioned, “Getting an appointment with the specialist is hard. The family doctor usually doesn’t refer”. Many participants were used to a two-tier healthcare system in their country of origin where specialists and healthcare services could be accessed privately as a participant mentioned:

“When I need to go to a specialist, I can pay and go myself in my home country, but here we need a referral from the family doctor first and then we have to wait for a specialist appointment”.

Participants observed that with few available specialists wait times were long as a participant mentioned “My wife is yet to see a specialist for that and we have waited one month already to go to a specialist” Participants were concerned that accurate diagnosis and treatment was delayed and their conditions might deteriorate.

Women participants were dissatisfied with the care received for women’s health issues, pregnancy, and postnatal care. Many participants claimed that care in their country of origin was more supportive, usually delivered by a

specialist, providers were more involved and some action was taken when they visited the specialist as one participant mentioned:

“I have been to the doctor three times and I was pregnant. I had bleeding and they did not do an ultrasound. In my country, they will do the ultrasound to check immediately. Not here they just did a blood test and let me go. I had a miscarriage after 2 weeks.”

Diagnostic Care and Treatment

Some participants lacked knowledge about referrals for pathological and diagnostic tests as a participant indicated “Doctor told me to get a blood test. Now I need an appointment to get the blood test? Where do I go in the hospital?”.

A participant mentioned long wait times for diagnostics and imaging procedures:

“My wife has a bad stomach ache the doctor says she need ultrasound I get an appointment for the ultrasound after 2 months. She is in pain how can we wait 2 months”.

Participants were concerned that delays in ultrasound, CT scan, and MRI, can delay diagnosis and treatment leading to poor prognosis as this participant indicated:

“I needed a CT scan, and am waiting for 2 months now. My doctor called to ask and they said that they lost the form and now the doctor has sent the form again and I am on a waiting list again. The scan is important because my medication will be changed after the scan.”

Hospital and Emergency Department

Participants were unclear about the services available through the hospital and ways to access them. Participants mentioned accessing emergency department (ED) services after hours and when their health conditions deteriorated. However, participants observed that patients were seen on a priority basis and some participants mentioned waiting up to 5 hours for services at the ED. Due to language barriers, they were often unable to explain the emergent nature of their health status as a participant mentioned:

“Last year had gallstone went to emergency 3 times they gave medicine and sent home. I waited for 5 months to get surgery. The wait time is too long for surgery and in the emergency, I was in pain. I was feeling like I was going to dying I tried to show by my body language. I have to wait for my ultrasound for too long I was upset and sad.”

Few participants also mentioned positive experiences at the ED. One patient got a much-needed referral to a pediatrician. Another participant mentioned that the ED nursing staffs were very supportive, provided excellent care and the participant's privacy was respected as indicated in this comment:

“I like Canadian medical emergency room separate room I am happy with the caring nurse, the nurse made me feel comfortable and they are kind, but back home you are almost alone, no help [...] open common room”

Overall, participants consistently experienced wait times at various points of contact with the healthcare delivery system that impacted access to existing healthcare services and is evident from this comment:

“Out here it is easy to make appointments. But there is a long wait. First, wait at the doctors', then at the pharmacy, and time is a factor. I had to wait for 2 months to get an ultrasound for the stomach and was feeling very sick”

Discussion

This study describes the experience of new immigrants at each point of contact with the healthcare delivery systems throughout the continuum of care in Regina Saskatchewan Canada (Fig. 1). Consistent with the literature a complex interaction between systemic and personal barriers impedes new immigrants' ability to access existing healthcare services [12, 14, 15]. Systemic barriers such as lack of appointments, limited hours of operation, referral system, wait times at diagnostic tests and ways acute care is coordinated affect all residents irrespective of their immigration status [26]. However Canadian-born and acculturated immigrants may be better able to navigate the healthcare system, self-advocate, and have different expectations regarding the healthcare system [14, 32, 33].

Consistent with the literature, at the individual level language barriers, lack of transportation, child care, and health practices (e.g. unavailability of familiar medicines, preference for home remedies), lack of translators, confidentiality issues, and lack of supportive care were also reported in the present study [12, 14, 15, 17, 32, 34]. As shown in Fig. 1, the personal factors interacted with systemic barriers consequently participants had to *wait* for appointments, *wait* at medical clinics, *wait* for referrals to specialists, *wait* for diagnostic tests, and *wait* to access acute care. A study indicated that only 43% of Canadians are getting the same day or next day appointment compared to 77% individuals in Netherland and 57% individuals across 11 other comparable countries.

Canadians wait longest in emergency departments and experience longer wait times to see a specialist compared to other similar developed countries [35]. The expected wait time ranged between 9.3 weeks for magnetic resonance imaging and 3.4 weeks for ultrasound [36]. The delays at each point of contact were particularly frustrating for study participants arriving from countries with a two-tier healthcare system where they could access care privately whenever needed. Consistent with the literature present study indicated that wait times delayed treatment initiation, prolonged suffering, increased anguish, and reduced quality of life [37]. Approximately 44,000 additional deaths among women in Canada between 1993 and 2009 are associated with wait times for medically necessary care [37].

Studies show that due to a lack of knowledge about the Canadian healthcare system, new immigrants were often guided by health beliefs shaped by experiences with healthcare in their country of origin, cultural norms, and traditional health-seeking practices [12, 14, 15, 17]. Consistent with literature these health beliefs influence the type of care that is (a) perceived as necessary, (b) accessed, (c) when it was accessed, and (d) expectation from providers [12, 20, 32, 34, 38]. As seen in prior research, study participants accessed healthcare when home remedies were inadequate and a tangible action was expected [38]. Due to language barriers [12, 17, 34], lack of interpreters, and rushed appointments, participants reported that communication with healthcare providers was inadequate [14, 17, 39]. Other studies reported that language barriers led to confusion about the treatment process, inability to explain health concerns due to privacy issues [15, 17, 32, 38] and dissatisfaction with the care received [14, 39]. Consistent with the literature participants often felt a lack of control over their healthcare and many were dissatisfied, frustrated, and anxious that appropriate healthcare will be unavailable at the time of eminent need [32, 34]. Findings from a systematic review indicated that individuals arriving from countries with a different healthcare system have difficulty finding health services leading to dissatisfaction and unmet needs [20]. Several qualitative studies report new immigrants and refugees experiencing discriminatory behavior from clinics staff and healthcare providers due to limited language abilities, cultural and religious background [21, 40, 41]. These experiences interfere with the development of therapeutic relationships with providers, discourage healthcare access and new immigrants and refugees report feeling exhausted, fearful and helpless while interacting with the Canadian healthcare system [19, 20].

Implementation of strategies to reduce surgical wait times and amalgamation of the 12 health regions to consolidate healthcare services irrespective of geographic location have improved access to care for all residents [42–44]. The median wait time between a referral made by family

physicians and a visit with a specialist in Saskatchewan is 51 days, compared to the national wait time of 78 days [45]. As of December 2020, 74.9% of surgeries were completed within 3 months in Saskatchewan despite the COVID-19 pandemic [46]. However, the present study emphasizes that additional challenges faced by new immigrants require focused attention.

The present study findings are consistent with Andersen's model of health services' use [47]. The model proposes that the healthcare delivery system and individuals' predisposed conditions e.g., age, socioeconomic status, education level, etc. can impede healthcare access [47]. These factors affect all residents irrespective of immigration status. Additionally, an individual's beliefs about health and healthcare services influence what services are utilized, and satisfaction with care received [47]. The presence of supporting family members and social networks assisting with transportation, language support, or healthcare navigation can enable individuals to overcome barriers to access healthcare [47]. The study highlights how new immigrants' health beliefs and lack of community or family enabling factors create an additional layer of barriers at each point of contact with the healthcare system delaying access to care and increases dissatisfaction with care received [47]. The study findings are very timely and relevant for other countries in Europe and North America accepting immigrants and refugees [12].

Recommendation

Saskatchewan's healthcare administrators, might benefit from learning about effective healthcare delivery strategies implemented in provinces that have historically received immigrants [48–51]. Strategies such as information videos featuring new immigrants' healthcare journey, implemented by Toronto Public Health (Ontario) can be adapted to assist Saskatchewan's new immigrants to navigate healthcare [52]. Ethnically and linguistically diverse providers offer services to targeted ethnic groups at Fraser Valley Clinics in British Columbia [53]. Similar clinics can be established in Saskatchewan in areas with larger immigrant populations. Health information in different languages provided through the provincial health website and brochures can address language barriers. Studies suggest that interpreter-assisted information sessions, educational videos, and information about healthcare navigation can be delivered in partnership with community organizations such as RIWC and community health workers as is done by the Multicultural Health Broker Cooperative in Edmonton Alberta [49, 54, 55]. Studies suggest that peers from ethnic groups can be employed to disseminate information about preventative health, screens, and existing healthcare services [16, 48]. Healthcare providers should be encouraged to use CanTalk (SHA-approved telephonic interpreter services) to address language barriers.

Studies indicate that cross-cultural brokers can liaise with healthcare providers and new immigrants to ensure care is patient-centered, confidential, and enhances patient's experience [16, 25, 49, 50]

Limitation

Participants were recruited from a local NGO offering English language classes to newcomers and the sample from each country was small and likely not representative of specific ethnic groups. The views are more representative of the female participants as the number of the male participants was small although no gender difference was observed during discussions. A potential pitfall of sharing focus group questions prior to the discussion is that it might bias participants' thought processes rather than allowing them to respond spontaneously. Knowledge of the discussion questions might have led study participants to selectively focus only on aspects of their experiences related to the questions. Although several measures were taken to address language barriers it is still possible that some participants with language barriers were unable to express their views effectively and some information was lost in translation.

Conclusion

The study illustrates how the interactions of person-specific and systemic barriers at each point of contact with the healthcare delivery system delay access to existing healthcare services for new immigrants, aggravating anxiety that adequate healthcare services will be unavailable when needed. The study results call upon health policymakers and administrators to adopt a comprehensive approach and address barriers at systems and individual levels enhancing healthcare access, and satisfaction with care.

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