HUMAN DEVELOPMENT FOCUSING ON ACCESS TO HEALTH CARE OF SOUTH ASIAN IMMIGRANTS LIVING IN THE GREATER TORONTO AREA (GTA)

by

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ACCESSIBILITY CLAUSE AND PERMISSION TO USE

Abstract

Immigrant populations enter Canada hoping for a better quality of life and usually with higher health status because of the Canadian immigration process which screens out those who have health problems. However, after living in Canada for a time, visible minority immigrants experience barriers/challenges to accessing health care and their health declines. Visible minority immigrants are more likely to reach their full potential when they have equal and appropriate access to health-care opportunities in their host society. The objective of this study is to investigate the challenges/barriers South Asian immigrants face in accessing the appropriate health-care opportunities in the Greater Toronto Area (GTA) needed for maximizing their human development. Using the convenience sampling technique, a sample of 307 self-administered survey questionnaires and five focus groups of South Asian immigrants living in the GTA were collected. To analyze and measure human development, this research used Amartya Sen's capability and freedom approach that considers human development as a process of expanding people's choices and opportunities which could enhance their capabilities and freedoms for their quality of life and human development. Access to health care is one of the significant components contributing directly to that quality of life. Using the SPSS software, this research tested the hypotheses, conducted cross-tabulation, chi-square tests and Cramer's V; the results show that there are statistically significant associations between South Asian immigrants' self-rated health before and after coming to Canada; between self-rated health and access barriers; and between access barriers and capabilities and freedom variables. The results also show that South Asian immigrants' self-rated health declined after living some time in Canada because of the barriers/challenges to accessing health-care opportunities in the GTA. The study also confirmed that access to health care challenges/barriers is limiting the South Asian immigrants' growth of capabilities and freedoms and quality of life. For good quality of life and building of capabilities they need access to culturally appropriate health-care services.

Key words: Access to Health Care, Human Development, Quality of Life, Visible Minority Immigrants, South Asian, Greater Toronto Area (GTA), Capability & Freedom.

Acknowledgments

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Dedicated

To

My Parents

Chapter 1

1   Introduction

Immigration has been a key component in Canadian nation building and social development from the Confederation era. The state uses immigration to address the problems of labor shortage, economic development and population growth to stimulate the economy and investment. At the same time, the Canadian government has provided millions of dollars for immigrants' settlement support services: "This is all good news because Canada needs immigrants, and it needs them to succeed. Immigrants drive Canada's economy, both as consumers and in the workforce. In 2012, immigration was responsible for two-thirds of Canada's population growth" (Ryan, 2014, p. 53). Immigrants are more likely to reach their full potential when they have equal and appropriate access to health-care opportunities (health-care opportunities include appropriate access to health care, education and employment opportunities) in their host society.

 Recognizing this need, the Canadian government has introduced settlement support services to immigrants since the 1950s. As well, because of the growing needs of immigrants, policy has changed periodically. The most significant changes in immigration policy occurred in the 1960s and 1970s, when a point system based on human capital was introduced for admission to Canada. As a result of the changes, immigrants are coming from non-traditional sources and are called "visible minority" immigrants. The settlement support services for immigrants' full participation and their integration into Canadian Society started in the 1970s; however, evidence suggests that visible minority immigrants are experiencing barriers/challenges to access to health care, education and employment opportunities. This study analyzed how barriers to accessing health care affect the health status and capability building of the fastest-growing visible minority group—South Asian immigrants living in the Greater Toronto Area (GTA). These challenges also limit their well-being and the full development of their capacities and freedom.

This introductory chapter provides some background to the issues related to immigrants' health. It offers a statement of the problems and describes objectives, a theoretical framework, a methodological consideration, the study population, study area profile, interdisciplinary application of the research and the significance and organization of the thesis.

1.1   Healthy Immigrants Effect

Canadian immigration processes require pre-screening of immigrants' health before they are allowed to admission into Canada. Those diagnosed as healthy are allowed to enter Canada. Immigrants generally arrive in Canada with better health than those who are Canadian born; this is called the "healthy immigrant effect" (Newbold, 2005; Ng, Wilkins, Gendron & Berthelot, 2005). A study by Statistics Canada suggests that after six months of entering into Canada 97 percent of immigrants rated their health as good, very good or excellent. However, as time passes, the health of immigrants tends to deteriorate (Statistics Canada, 2005). Longitudinal data from five cycles of the National Population Health Survey (NPHS) show that over the period 1994/1995 to 2002/2003, visible minority immigrants were twice as likely as the Canadian-born population to report a deterioration in their health—that is, they had rated their health as good, very good or excellent in 1994/1995, but subsequently in 2002/2003 described their health as from fair to poor (Ng et al., 2005).

Immigrants, particularly visible minority immigrants, are more vulnerable to serious health inequalities and accessibility challenges. The literature suggests that although Canadian universal comprehensive health care have equal opportunity of access to appropriate health care services for all, at any time and free for all, an increasing number of visible minority immigrants report accessibility problems. For newcomer immigrants, limited personal resources, lack of social networks, limited social services provided by the Canadian government and non-governmental organizations, and inadequate coordination of multiple sectors contribute to these challenges (Asanin & Wilson, 2008;

Ng et al., 2005; Stewart, Anderson, Beiser, Mwakarimbs, Neufeld, Simich and Spitzer, 2008; Zanchetta & Poureslami, 2006).

1.2   Statement of Problems and Research Questions

Immigrants are sometimes unsuccessful in attempting to access a basic settlement service such as health-care services after arriving in their new country. When immigrants move to Canada, their health status is usually high (excellent or very good); their good health is associated with the Canadian immigration process that screens out those applicants who have serious health problems (Ali, McDermott, & Gravel, 2004; Chen, Ng, & Wilkins, 1996; Citizenship and Immigration Canada, 2014, & Newbold, 2005). After living some time in Canada, however, their health declines (Statistics Canada, 2006). Such deterioration is caused by various problems: lack of opportunities to access appropriate health care including those relating to language, culture, lack of employment, and socio-economic factors, as well as a lack of the social supports and information that are important for health and well-being (Asanin & Wilson, 2008; Kreps & Sparks, 2008; Pottie, Ng, Denise, Ali, & Glazier, 2008; Zanchetta & Poureslami, 2006). Kreps and Sparks (2008) also note that vulnerable immigrants (children, the elderly, pregnant women) suffer significant health disparities and are desperately in need of culturally relevant, accurate, and timely health-care information. However, the literature suggests that the information on health services available to immigrants is inadequate. Stewart et al. (2008) point out that the network to support newcomers is limited. Preston mentions that "the perspectives of service providers and policy decision-makers regarding formal supports offered to immigrants and refugees and requisite changes to practice, programs and policies have not been sought" (cited in Stewart et al., 2008, p. 125). From this perspective, a research question emerges: What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)?

The research question contains interrelated parts: access to health care, appropriate health care, barriers to accessing health care and human development are defined below:

Under the Canada Health Act, Canadians have come to expect "reasonable access to health services without financial or other barriers" (Canada Health Act—Annual Report 2008-2009, p. 3). Access to health care means "getting the right care, at the right time, by the right care providers, in the right setting" (CIHI, 2008, p.27). Access to care across the health-care spectrum includes accessing primary health care, emergency department care and wait times in priority areas, diagnostic imaging, and rehabilitation (CIHI, 2008). Anderson and Davidson (2001) define access as "actual use of personal health services and everything that facilitates or impedes their use…Access means not only getting to service but also getting to the right services at the right time promotes improved health outcomes" (cited in Chen, 2010, p. 52). This definition espouses several quality indicators of health system performance proposed by the Canadian Institute of Health Information (1999)—availability, accessibility, appropriateness, acceptability, competence, safety and effectiveness—as essential components of access (cited in Chen, 2010).

Appropriate health care is the cultural and linguistically competent ideal defined by Cross et al. (1989) as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross cultural situations" (cited in Barone, 2010, p. 455). Appropriate health care for visible minority immigrants means that access to health care must be linguistically and culturally competent, accurate, timely and understandable (Asanin & Wilson, 2008; Kreps & Sparks, 2008; Stewart et al., 2008).

Barriers to accessing health care are the obstacles that limit visible minority immigrants in their understanding of health information, health-care services, and the health-care system, as well as in receiving the culturally appropriate health-care services required for a healthy life. These barriers are lack of social support services, information and health literacy barriers, geographic accessibility barriers, Canadian official language proficiency barriers, cultural barriers, and financial and employment barriers.

In this dissertation "human development" is used as process of

> Enlarging people's choices and enhancing human capabilities and freedoms, enabling them to: live a long and healthy life, have access to knowledge and a decent standard of living and participate in the life of their community and decisions affecting their lives. ((cited in Ruhs, 2009, p. 8)

Access to health care is one of the significant components contributing directly to the quality of life (Sen, 2001). Since 1990, the United Nations Development Program (UNDP) has been producing global estimates of human development based on indices of education, income, health, mortality, and government spending. The Human Development Index (HDI) was created as the statistical benchmark for human progress at the global level in order to allow for a more robust measure of development than economic strength alone. The first Human Development Report points out that "the basic objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives" (UNDP, 1990). Ranis and Steward (2000) define human development as, "the improvement of the human priorities so that people live longer, healthier and fuller lives" (p. 2).

1.3 The Objective of the Study

As soon as the Canadian Government's department of Immigration and Citizenship was established in the 1950s, it introduced settlement services for newcomer immigrants. In addition, in the 1960s and 1970s the settlement services were bolstered because of changing immigration policy, which allowed the entrance of immigrants from non-traditional countries. In the 1970s and 1980s various settlement support services were introduced by the federal government, provincial governments, and municipalities through various government and non-profit organizations. The main objective of these programs was better integration of immigrant populations into Canadian society. Although previously there were settlement services, research on government and other sources shows that immigrant populations are facing tremendous challenges in accessing appropriate health-care services, education and employment opportunities to achieve the

well-being they were expecting in Canada. The objective of this study is two-fold: i) to investigate the challenges South Asian immigrants face in accessing appropriate health-care opportunities in the Greater Toronto Area (GTA) needed for maximizing their human development; and ii) to facilitate the creation of a model accommodating visible minority immigrants' challenges/barriers within the existing resources and system.

1.4   Theoretical Framework of the Study

To analyze and measure the human development of South Asian immigrants living in the GTA, this research used the human development concept of Nobel Laureate Amartya Sen's capability and freedom approach. Here "human development" is used as a process of

> Enlarging people's choices and enhancing human capabilities and freedoms, enabling them to: live a long and healthy life, have access to knowledge and a decent standard of living and participate in the life of their community and decisions affecting their lives. (cited in Ruhs, 2009, p. 8)

Access to health care is one of the significant components contributing directly to the quality of life (2001). According to Sen,

> Human development, as an approach, is concerned with what I take to be the basic development idea: namely, advancing the richness of human life, rather than the richness of the economy in which human beings live, which is only a part of it. (UNDP-Human Development Reports, hdr.undp.org/en/humandev)

Sen's "capability approach" investigates human well-being and development (Sen, 1990). The approach is concerned with ensuring that people, cultures and societies can enjoy the capability (or freedom) to lead the kind of life that they have reason to value. Sen (2001) points out that "the creation of social opportunities makes a direct contribution to the expansion of human capabilities and the quality of life" (p.144). While income and material things may be necessary to facilitate a good life, the capability approach

recognizes that it does not automatically follow that there will be a strong link between income and access to resources and the ability to achieve valuable capabilities which are necessary for full participation in society and state (Sen, 2001). This capability approach considers people at the centre of the development process, where they are regarded as the primary ends as well as the principal means of development (Sen, 2001).

Sen's approach is used to analyze how the barriers to accessing health care are hindering people's development process in their new society. The goal of development is the promotion and expansion of human capabilities. Capabilities vary from elementary freedoms, such as being free from hunger and undernourishment, to such complex abilities as achieving self-respect and social participation (Nussbaum & Sen, 1993). Immigrants, those who are immigrating to Canada in the skilled independent immigrants category, are highly educated and skilled in their home countries, but when they come to Canada their education credentials and work experiences are not recognized and they face multiple challenges in the settlement process. Immigrants also face barriers to accessing health care. As a result, they experience a decline in health that hinders their capabilities and freedom for overall development and limits their quality of life.

1.5   Methodological Consideration for this Research

For this research, a cross-sectional research design was used, along with the application of quantitative and qualitative methods. The research focuses on South Asian immigrants living in the Greater Toronto Area (GTA). The case of South Asian immigrants is studied as a single entity, because Canadian research and Statistics Canada treat the South Asians as a single entity in their research.

For this research, a wide range of primary and secondary data sources are used: a self-administered questionnaire, focus group interviews and relevant secondary data from Statistics Canada, the Canadian Institute for Health Information (CIHI), and the Canadian Institute of Health Research (CIHR) data. The questionnaire focused on the respondents' individual encounters and experiences in accessing appropriate health-care services and

education and employment opportunities, as well as how these affect their capabilities and well being. The questionnaire was developed in English and translated into six other South Asian major languages spoken in the GTA, namely Hindi, Bengali, Tamil, Urdu, Nepali and Punjabi, for the better understanding of the participants and their improved feedback. The data were collected from December 2011 to October 2012. Before the data collection, an approval from the Laurentian University Research Ethics Board (REB) was obtained. To comply with REB protocols, the participants were provided a research information sheet; as well, written consent was obtained from the participants in the self-administered survey questionnaire and focus group discussion.

1.6   Population and Study Area Profile

This study focuses on visible minority immigrants of South Asian origin living in the Greater Toronto Area (GTA). Regardless of the time of landing, people born in Asia (including the Middle East) formed the largest group of immigrants to settle in Canada as of 2006. Many were born in the People's Republic of China, Hong Kong, India, Vietnam, Philippines, Iran or Pakistan (Statistics Canada, 2008a).

The Greater Toronto Area (GTA) is the largest urban area in Canada and one of the biggest in North America. According to the 2011 census its population is 5,986,310 and its size is 7124 km (Statistics Canada, 2014).

A Statistics Canada study, "Projections of the Diversity of the Canadian Population 2006–2031" (2010) shows that foreign-born population will continue to rise, reaching between 25 percent and 28 percent in 2031. Since 1981, the number of Asian-born persons has been steadily increasing in the immigrant population, from 14 percent to 41 percent in 2006, while the number of persons born in Europe has steadily declined, from 67 percent to 37 percent in 2006 (Statistics Canada, 2010). According to Statistics Canada projections, the Asian-born population will be 55 percent of the foreign-born population by 2031 (Statistics Canada, 2010). In addition, by 2031, nearly one-half (46%) of Canadians aged 15 and over will be foreign-born, or will have at least one foreign-born

parent, up from 39 percent in 2006 (Statistics Canada, 2010). Among the foreign-born population, visible minority persons will reach approximately 71 percent in 2031, compared to 54 percent in 2006. In addition, the South Asian will be the largest visible minority group, rising to approximately 28 percent in 2031, compared to 25 percent in 2006 (Statistics Canada 2010).

It is also predicted that more than 78 percent of Toronto's population will be either immigrants or children born in Canada of immigrant parents by 2031. Similarly, by 2031 the visible minority population will account for nearly 63 percent of Toronto's total population, up from 43 percent in 2006. It will also represent 43 percent of Canada's entire population of visible minority people. Among the visible minority population, South Asians are already the largest minority group in the Census of 2006 and will represent 24 percent of Toronto's population by 2031, up from 14 percent in 2006 (Statistics Canada, 2010). Statistics Canada (2010) data shows that South Asian immigrants are the fastest-growing population in Canada.

According to the National Household Survey (NHS) 2011, in the GTA nearly 44 percent of the population is from visible minority groups and among them approximately 32 percent are of South Asian origin. In addition, South Asians are slightly more than 14 percent of the total population of the GTA (Statistics Canada, 2014).

1.7   Significance of the Study

The population of interest in this research is the South Asian immigrants living in the Greater Toronto Area (GTA). The South Asians are the fastest-growing population in Canada but have been studied very little. In addition, little or no research has been done so far on how this fast-growing immigrants group copes with the challenges of access to health-care, education and employment. In general, this study investigates how barriers or challenges are limiting the capabilities and freedom of South Asian visible minority immigrants in the course of their human development in the GTA.

People from different countries immigrate to Canada to live a better quality of life. They want to enjoy culture and society and to achieve the capabilities and freedom to lead the kind of life they have reason to value. However, the barriers to accessing health care are challenging their ability to achieve these capabilities and freedom. Barriers to accessing health care are also limiting their physical, social and professional activities and participation. Their well-being is being compromised and the problems with health-care access are a serious obstacle to their integration into their new society. From this perspective, the human development of South Asian immigrants is an issue that deserves more investigation. Considering this fact, this research examined the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the GTA. Considering the above, a specific logic for the study can be identified:

 ➢ There has been very little study exclusively on the South Asian immigrants' access to appropriate health-care services.

 ➢ There are very few studies on the settlement services appropriate for the visible minority and best practice settlement services.

 ➢ Little research has focused on the vulnerable populations such as women, older and new immigrants who are concerned about cultural values and have the difficulty of lacking language proficiency.

 ➢ Barriers to accessing health-care challenge South Asian immigrants' ability to achieve capabilities and freedoms and well-being in their new society.

 ➢ Challenges/barriers to accessing appropriate health-care services, education and employment opportunities make the immigrants' integration to their new society difficult.

From this perspective, the human development focusing on access to health care of South Asian immigrants is an issue that deserves more investigation.

1.8   Interdisciplinary Application of the Research

1.8.1   How is this Research Interdisciplinary?

The research question of this study contains interrelated parts: visible minority immigrants (South Asian), appropriate health care, barriers to accessing health care and human development. Visible minorities are defined based on the *Employment Equity Act* (1986) definition as persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color, including Chinese, South Asian, Black, Filipino, Latin American, Southeast Asian, Arab, West Asian, Japanese, Korean, other visible minorities and multiple visible minorities (Statistics Canada, 2008a).

Appropriate health care for visible minority immigrants means that access to health care must be both linguistically understandable and culturally appropriate. Barriers to accessing health care are the obstacles that limit a person's understanding of the health-care system and information as well as in receiving appropriate health services required for a healthy life.

 Here "human development" is used as a process of

> Enlarging people's choices and enhancing human capabilities and freedoms, enabling them to: live a long and healthy life, have access to knowledge and a decent standard of living and participate in the life of their community and decisions affecting their lives. (cited in Ruhs, 2009, p. 8)

Access to health care is one of the significant components contributing directly to the quality of life. Human development is the expansion of human capabilities and the quality of life necessary for full participation in society (Sen, 2001). The support gaps hinder the successful settlement and integration of newcomers into their new society, preventing immigrants from building the quality of life they wish to enjoy. As a result their human development is imperiled and they can become a burden on society.

Research on immigration studies has become a part of the mainstream agenda of several social-science disciplines. As Morawska (2003) argues, "the aim is to build up a

knowledge of differences so that immigration scholars in different academic fields become interdisciplinary polylogues, conversant in many languages, and thus capable of "translating" into and in-between disciplines" (p. 612). The examination of human development of visible minority immigrants is enmeshed in culture, language, employment, education, ethnicity, and other socio-economic factors, along with immigration policy, multiculturalism policy, health Acts and settlement support services, employment and access to other social opportunities. The study of visible minority immigrants, therefore, needs to explore both the global migration and socio-structural determinants of the immigrant experience in their host society. Such explanations are possible through the collaboration of various relevant fields and areas such as psychology, sociology, economics, anthropology, education, law, political science, health, nursing, geography and others (Morawska, 2003). In this way, the barriers to access to health care experienced by the immigrant populations are understood from a variety of viewpoints. This interdisciplinary approach analyzed access barriers to health care, immigrants' settlement services, participation in their host society, the process of integration and their human development as a whole in the Greater Toronto Area (GTA).

In recent years many disciplines have developed research skills and specialties in health research. Health-care services research is related to many disciplines and areas and studying health services requires various analytical approaches and tools. These requirements are being meet by interdisciplinarity in health-services research. As a result, disciplinary boundaries and the gate-keeping of the disciplines have been disappearing and new directions for research are being developed by researchers. At the same time, interdisciplinary research is creating more easily accessible, applicable to real-life, evidence-based knowledge for academics, as well as for general public and policy makers (Giacomini, 2004). The changing pattern of integrative health-care research has also been commented on by many scholars and researchers. Aboelela, Larson, Bakken, Carrasqillo, Formicola, Glied, Hass, & Gebbie (2006) mention, for instance, that "health care and health policy research are by their very nature interdisciplinary" (p. 343). In addition, the study of human development is also related to development economics, health, psychology, political science, sociology, geography and so on.

For the present study, conceptual framework, study design and execution, data analysis, and conclusion were used to establish the true degree of interdisciplinary perspective. Aboelela et al. (2006) mention that "many researchers have conducted interdisciplinary research because they have recognized the limitations of this disciplinary perspective when faced with complex health care and health policy research questions" (p. 342). For this research, cross-disciplinary sharing of resources was used as follows:

➢ International migration, Canadian immigration policy, process, history and patterns were analyzed to understand the dynamics of the Canadian immigration perspectives. In addition, this research also analyzed the South Asian immigrant population, their education, professional experiences, and so on. The studying of immigration is a part of the mainstream agenda of several social sciences disciplines, such as political science, geography and sociology.

➢ Nobel laureate economist Amartya Sen's capabilities and freedoms approach is used to understand a population's health, wellbeing and human development, which is also studied in economics (Phipps & Stabile, 2005). For wellbeing and human development people need opportunities and choices that give them alternatives. In the context of Sen's concept, the importance of socio-economic status for population health, as well as how education, employment and unemployment experiences affect immigrants' health, is studied.

➢ Health policy and the health-care system are also related to disciplines such as political science, economics, anthropology, sociology, geography, law, nursing and psychology, health sciences, public health and nursing (Deber & Martens, 2005). This research also studied health administration and access to health care; these are the traditional areas of public health sciences.

➢ Religious traditions have a significant impact on the concepts of health, healing, prevention and ethics in health-care research (Coward, 2005). The social determinants of health form most of the challenges to access to care faced by the immigrant community. The South Asian visible minority groups include Islamic, Christian, Hindu, Sikh, Jain and Buddhist religious groups. These religious and

cultural groups have their 'own ways of living' philosophies, rituals and religious obligations, along with traditional concepts of health and alternative medicines (Coward, 2005).

➢ In addition, this research examined the Canadian health-care system, including the social organization and delivery of health-care services. It also paid attention to particular community-based health and public-health services as well as policies influencing health and health care. These kinds of focuses are very common in sociology (Penning, 2005). Canadian health-care regulations, as well as the various acts of the Canadian Government such as the *Canada Health Act 1984*, *Immigration and Citizenship Act 1978*, *Canadian Multicultural Act 1988*, *Employment Equity Act 1986*, *The Romanow Commission Report on the Future of Health Care in Canada 2002*, *Canada Health Act—Annual Report 2008-2009*, were also studied. These health laws provide the governing structure of the various levels and units of governments (Downie, 2005).

➢ This study analyzed the social determinants of health, health status, and access to health-care services. At the same time, it also focused on community health and community capacity-building, an integral part of the nursing discipline (Reimer, 2005).

➢ The immigrant population's physical and psychological stress and well-being, which are studied in Psychology, were also examined (Bouchard & Smith, 2005). In addition, the effects of stressful life events, social supports, and coping were examined. The study analyzed the quality of life and human development of the participants as well.

➢ The research also analyzed the geographical accessibility of the newcomer immigrant populations in the GTA. This included the immigrants' in particular geographical areas and human activities in their neighborhood. (Eyles, 2005).

➢ This research analyzed the health policy, urban health, understanding and improving of the individual as well as community health, a part of the public health sciences (Skinner, 2005).

➢ A cross-disciplinary sharing of resource techniques and analysis methods was also used. In addition, the literature review indicates that the present research problem is an issue requiring interdisciplinary research. This study followed Klein's integrative process (1990) to increase the interdisciplinary aspect of this research.

1.8.2   How is the Interdisciplinary Process Used?

Klein (1990) points out that interdisciplinarity is "a process for achieving an integrative synthesis that usually begins with a problem, question, topic, or issue" (p.188). Interdisciplinary researchers find a way to overcome problems created by differences in disciplinary language and world view. Klein (1990) notes that although there is no perfect straight process, there are a number of different steps that can be taken in achieving interdisciplinary research:

➢ Defining the problem: This research has defined a problem-oriented research question which cannot be studied within a single discipline. The research question, 'What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)?' is a multifaceted, problem-oriented issue, involving disciplines such as economics, public health, health policy, sociology, geography, nursing and political science. The research problem indicates the need to use more than one discipline.

➢ Determining all knowledge needs: The literature indicates that this is an issue that might need to be addressed from the perspectives of sociology, psychology, geography, cultural study, political science, literature, economics, history, nursing, public health sciences, and so on.

➢ Developing an integrative framework and appropriate questions to be investigated: For the research, the analysis of the conceptual framework, study

design and execution, data analysis, and conclusion encompasses various disciplines. Data were collected by the survey method and focus group discussion as well as from Statistics Canada. Data on demographic, socio-economic and health-related characteristics were also collected. The research also used both qualitative and quantitative techniques for data analysis.

➢ Specifying particular studies to be undertaken: The research question 'What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)?' was studied in an interdisciplinary manner.

➢ Engaging in "role negotiation": The researcher's disciplinary background involves political science and international development. In addition, the thesis committee constitutes a team from various disciplines such as geography, psychology and sociology, which was helpful in achieving an integrative synthesis.

➢ Gathering all current knowledge and searching for new information: This research reviewed literature from various disciplines and perspectives to address the research problem. Canadian health policy and administration, the immigration process and policies, as well as relevant Canadian immigration and health regulations and acts were examined. In addition, access to health-care regulations, social-support services and the barriers that exist to accessing health care in Canada were analyzed. The physical and psychological problems that arise from the frustration of the lack of social network and access to support services were also examined. In addition, the research also looked at how the barriers to health care limit the capabilities and freedom of visible minority immigrants in Toronto. Having studied the relevant disciplinary knowledge, techniques, and the data analysis process and use, many of these were also used. For example, Statistics Canada data is also used.

➢ The researchers resolved disciplinary conflicts by working toward a common vocabulary: The nature of a discipline is to build disciplinary walls, develop disciplinary language, and refuse to talk to anyone who does not speak the language, claim its own truth, and claim to own what is important. This research,

however, is problem-focused, with an open mind on breadth, novelty and divergence was useful in resolving disciplinary conflicts. A successful communication across disciplines was attempted. In these ways this research resolved conflicts and worked toward a common vocabulary.

➢ Building and maintaining communication through integrative techniques: Successful communication across disciplines is important for interdisciplinary research. An understanding of immigrants' health research is related to the phenomena of culture, language, employment, ethnicity, and socio-economic factors along with the legal/formal political arena of state institutions, practices, policies and laws.

➢ Collating all contributions and evaluating their adequacy, relevancy, and adaptability: This research tried to integrate all related disciplinary knowledge in a fashion that provided a common ground with collaborating disciplines and areas. For the study of the South Asian visible minority population, the sociological knowledge of community-based studies was also used to achieve the objective of the study.

➢ Integrating the individual pieces to determine a pattern of mutual relatedness and relevancy: The research showed an awareness that the knowledge collected from the various disciplines was used in an integrative fashion that determined its mutual relatedness and relevancy.

➢ Confirming and disconfirming the proposed solution: The research problem proposed changes in policy formulation related to immigration, health care services and employment and social development. As well, it proposed the required establishment of social opportunities and support systems with easy access to information and settlement services for immigrants upon arrival.

➢ Deciding about future management or disposition of the task/project: This research is a part of the researcher's PhD thesis. The researcher was trying to complete the research/project within the time frame of the program; however, because of the delay in collecting data, he required extra time.

In these ways, this research followed Klein's (1990) integrative process to study the research problem of the interdisciplinary study to achieve the objective of the research.

1.9   Organization of the Thesis

This thesis contains eight chapters, including the introductory and concluding chapters. The overview of the healthy immigrants' effect and immigrants' barriers to accessing appropriate health-care services has been provided in Chapter 1. This chapter also provides a short overview of the statements of problems and research questions, theoretical framework of the research, goals and objectives of the research, the population and the study area, interdisciplinary application of the research, significance of the research and organization of the thesis.

Chapter 2 analyzes Canadian health policy and the Health Care Act. It focuses on the *Canada Health Act of 1984* which provides the basis for equal opportunity of access to appropriate health care services for all and at any time. This chapter also discusses the Ontario Provincial Health Care Act and the services available to Ontario as well as GTA's residents. At the same time, it investigates Canadian immigration policy relevant to health and health care services and the healthy immigrants' effect.

Chapter 3 provides the review of relevant literature. This chapter reviews literature related to immigration policy relevant to health-care services, and the research literature regarding healthy immigrants' effects, access to health care theories as well as theories regarding immigration integration, barriers and challenges in accessing appropriate health-care services.

Chapter 4 discusses the research methodology. It also discusses and provides the justification for quantitative and qualitative methods of the research, sample recruiting process, data collection processes, variables of this research, site selection, how the data processing and analyses were done and the Laurentian University Research Ethics review.

Chapter 5 analyzes participants' health status and barriers to health-care access in the GTA presenting the descriptive statistics of this research.

To analyze health and human development of the sample, Chapter 6 demonstrates the statistical analyses to probe the research hypotheses, discusses in detail the statistical results of the research and presents the main objectives of the research.

Chapter 7 presents a discussion of the barriers to accessing health care by analyzing the focus group discussions. This chapter provides a broader picture of the immigrant populations' expectations, frustrations, along with suggestions for better access to appropriate health-care services and how important they are. The need for better and appropriate settlement services which could enhance the capabilities of the immigrant population and their integration into their new society is also investigated.

Chapter 8 discusses the findings and goals of the study: to facilitate the creation of a model accommodating visible minority immigrants' challenges/barriers within the existing resources and system, study limitations and concluding remarks of this thesis.

Chapter 2

2 Canadian Health Care Services and Policy and Immigration Policy

The debate over Canadian universal healthcare is not new. The elimination of barriers to accessing health care, especially the economic barriers, started in 1919, but it was not until 1984 that the *Canada Health Act* provided the basis for the universal health-care services that ensure health equality for all (Vayda & Deber, 1992). The Canadian federal and provincial health-care services are provided under the *Canada Health Act of 1984*, which provides publicly-funded health care for Canadians. The main goals of the policy are to provide universal coverage for medically necessary health-care services to all, as well as equal accessibility. The province, with its support for various regions and communities, administers the health insurance plans, funding for hospitals and other agencies, plans and implements health promotion and public health initiatives, negotiates fee schedules with health professionals and provides any other health services needed for its citizens. This chapter provides an outline of the federal, Ontario provincial, and the Greater Toronto Area (GTA) community health-care services and policies.

2.1 Canadian Health Services Policy

Canada's publicly funded health-care system is free of cost for all citizens whether or not they have the ability to pay. The driving force behind the policy is based on need. Considering the continuous need and reflecting on the societal need, there have been reforms and modifications since the system's inception. From 1867 to 1919, the federal Department of Agriculture carried out Canadian health responsibilities, but in 1919 the Department of Health was established. Before World War II, health care in Canada was mostly privately delivered and funded (Canada's Health Care System, 2011). In 1947, the government of Saskatchewan was the first to introduce a universal provincial health-care plan. Soon after that, in 1950, both British Columbia and Alberta introduced similar provincial plans (Canada's Health Care System, 2011). In 1957, the federal government

passed the *Hospital Insurance and Diagnostic Services Act*, which reimbursed one-half of the provincial and territorial costs for specified hospital and diagnostic services.

In 1962, Saskatchewan introduced universal provincial medical insurance which covered doctors' services to all its residents. Following that, the federal government passed the Medical Care Act in 1962 which provided for half of doctors' services outside hospitals (Canada's Health Care System, 2011). In 1977, the federal government passed the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, under which a block funding system was introduced and provided opportunities for provinces to invest more funding for health-care needs. Canada's health care act, the *Canada Health Act* of 1984 was passed providing universal health care for all Canadians. Under this act the universal health care criteria of portability, accessibility, universality, comprehensiveness and public administration were the pillars of Canada's health care system (Canada's Health Care System, 2011). These pillars are the main phenomena for the Canadian universal health care system and provide health care services for all.

However, reforms and modifications continued after 1984. In 2003, the Accord on Health Care Renewal provided structural changes for health-care support access, quality and long-term sustainability (Canada's Health Care System, 2011). According to the *Canada Health Act* of 1984, the federal government's role is to set and administer national principles for the system and the provincial governments' responsibilities are to deliver health care and other social services. The federal health policy, therefore, provided the framework for medically necessary services without fee for Canadians and the implementation and delivery of services are up to the provinces to ensure the quality of health care services and equal accessibility.

2.2   Canada Health Act

The *Canada Health Act* of 1984 is the only legal document that administers Canadian health care. The goal of this *Act* is to ensure access to medically necessary services for all Canadians regardless of ability to pay. The *Act* is Canada's federal legislation for

publicly-funded health-care insurance, setting out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (*Canada Health Act—Annual Report* 2008-2009, p. 3). Under this Act all the provinces and territories must abide by five principles—universality, accessibility, comprehensiveness, portability and public administration—in order to receive federal funding for health. The principles are designed to ensure a publicly funded health-care system administered by the provinces (public administration) through which all Canadians (universality) receive medically necessary health-care services (comprehensiveness), regardless of where they live in Canada (portability), which is free prepaid at the point of delivery (accessibility).

The **public administration** criteria are set out in Section 8 of the *Canada Health Act*, and apply to provincial and territorial health care insurance plans. The plan is administered and operated on a non-profit basis by public authorities accountable to the province or territorial government (*Canada Health Act—Annual Report* 2008-2009). **Comprehensiveness,** as set out in Section 9, requires that the health-care insurance plan of the province or territory must cover all insured health services provided by hospitals, physicians or dentists where the law of the province permits. Hospital services are in turn defined by a list of specific in-patient services that are "…medically necessary for the purpose of maintaining health, preventing diseases or diagnosing or treating on injury, illness or disability" (*Canada Health Act—Annual Report* 2008-2009, p. 4) The **universality** criterion in Section 9 requires that all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. **Portability,** described in Section 11, states that residents moving from one province to another must continue to be covered for insured health services by the home jurisdiction during any waiting period imposed by the new province or territory of residence (*Canada Health Act—Annual Report* 2008-2009). The **accessibility** criterion in Section 12 ensures that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or

unimpeded, either directly or indirectly, by charges or any other means (*Canada Health Act—Annual Report* 2008-2009).

The present problems within the Canadian health-care system are cost and access (Flood, 2002). The *Canada Health Act* has removed income-based barriers to accessing health care "to ensure that all eligible residents of Canada have reasonable access to medically necessary services on a prepaid basis, without direct charges at the point of service for such service" (*Canada Health Act—Annual Report* 2008-2009). However, Fraser Institute research in 2013 stated that in 2013, 10 percent of Canadian families with the lowest incomes are supposed to pay an average of $482 for public health care insurance. Another 10 percent of families with a middle income of CAD$56,596 will have to pay an average of $5364 and the highest 10 percent income earners of Canadian families will have to pay CAD$35,309 in 2013 (Esmail & Palacios, 2013).

Thus there are still inequalities in healthcare within Canadian populations (Flood, 2002; Ng et al., 2005). A Royal Commission on Aboriginal Peoples in 1996 reported that the infant mortality rate is twice as high for native people and three times as high for Inuits in the Northwest Territories than for other Canadians (Flood, 2002). The Standing Senate Committee on Social Affairs, Science and Technology Study on the State of the Health Care System in Canada reported that " in the view of the Committee, the health of our Aboriginal peoples is a national disgrace" (cited in Flood, 2002, p. 7). Flood (2002) reported that access to health care in general involves a number of concerns, "including lack of comprehensiveness, failure to respond to health needs proportionately, access to health services in remote areas, shortages in physician and nursing staff, and growing waiting lists and times for service" (p. 7).

Although the two health care commissions—The Commission on the Future of Health Care in Canada (Romanow, 2002) and the Standing Senate Committee on Social Affairs, Science and Technology Study on the State of the Health Care System in Canada (Kirby & LeBreton, 2002)—did not mention any access barriers to health care experienced by the immigrant population, Asanin & Wilson (2008) commented that the two committees overlooked the immigrants' accessibility issue and this caused a significant knowledge

gap in the reports (Asanin & Wilson, 2008). Immigrants do face multiple barriers when attempting to access health-care services.

2.3   Ontario Health Services and Health Insurance

The provincial health care system's basic components are Public Health, Hospital Services, Ambulance Services, the Ontario Health Insurance Plan (OHIP), Telehealth Ontario and Community Services. Other services, such as Cancer Care Programs, Mental Health and Addictions Services, Seniors Care, the Ontario Public Drug program, etc, also exist. Public Health Units are located in every community/district and they are involved in providing disease prevention and health promotional activities in the community. The activities include immunization, parenting education, inspecting food premises, and health education for all ages and groups. There are 36 public health units in Ontario (Ontario Ministry of Health and Long Term Care, 2014).

There are 211 general and other types of hospitals in Ontario: Public Hospitals, Private Hospitals and Specialty Psychiatric Hospitals (Ontario Ministry of Health and Long Term Care, 2014). These hospitals provide primary and long-term care as well as emergency, surgical, chronic care and rehabilitation services to Ontarians. Community services such as Community Care Access Centers, Community Health Centers and Nurse Practitioner-led Clinics also provide care. There are 14 Community Care Access Centers in Ontario (CCAC); they provide information on living independently at home, and support housing, day-care programs and long-term care at home. The CCACs also provide information regarding the local community support services agency. Ninety-two Community Health Centers exist in Ontario (Ontario Ministry of Health and Long Term Care, 2014). In addition, Nurse Practitioner-led clinics in Ontario provide primary health care as well as health promotion and other health care services (Ontario Ministry of Health and Long Term Care, 2014).

Ontario residents are eligible for provincially funded health coverage under the Ontario Health Insurance Plan (OHIP). To be eligible for OHIP coverage, a resident must be (a) a

Canadian citizen or permanent resident; (b) be physically in Ontario for 153 days in any 12-month period; (c) be physically present in Ontario for at least 153 days of the first 183 days immediately after establishing residency in the province; (d) make the resident's primary home his/her place of residence in Ontario. According to these OHIP provisions, newcomer immigrants have to wait for 153 days for OHIP coverage (Ontario Ministry of Health and Long Term Care, 2014).

In addition to health-care services agencies, for better services and quality the Province of Ontario established the Local Health System Integration Network (LHIN) with the *Local Health System Integration Act,* 2006 (Ontario Ministry of Long-Term Care, 2014). There are 14 not-for-profit LHINs working with local health providers and community members to determine the health service priorities of the regions. As the Local Health Integration Network, they plan and fund local health services including hospitals, community care access centers, long-term care, mental health and addiction services and community health centers (Ontario's Local Health Integration networks, 2014).

2.4   Health Care System Delivery

Primary health care forms the basic structure of the Canadian health care system. As soon as anyone seeks health-care services, primary health care is the first point of contact with health professionals. It may be a doctor, nurse, or another health professional or may happen through phone or computer-based services (Health Canada, 2014). At the same time, it may be a hospital, clinic, a community clinic or any other specialized hospital or even home or community. Primary health-care professionals provide services to individuals, families and communities. These services are publicly funded. From this first contact point a patient may be referred to and transferred to a specialized hospital, long-term care services, community clinics, home-health service providers or any other health-care service providers (Health Canada, 2014).

The provinces also provide coverage to certain groups of people (e.g., seniors, children and social assistance recipients) for health services (Health Canada, 2014). These

supplementary services may also include prescription drugs, dental care, vision care, medical equipment and appliances. The level of coverage differs for all of the provinces and territories.

In recent years, the Ontario Government has set out an agenda to realize an unprecedented paradigm shift in the delivery of health care, particularly around quality of services delivered, integration of services across the continuum of care, cost of services, and the long-term sustainability of the health-care system as a whole (Ontario Ministry of Long-Term Care, 2014). Healthy Change has a number of parts:

➢ Strengthening health network integration for better coordination
➢ Right care, right place, right time delivery—maximizing health-care investments by making better use of available resources
➢ Based on patient need, funding model for better and highest quality care
➢ Promoting wellness (Ontario Ministry of Long-Term Care, 2014).

2.5   Health and Social Services Delivery System in the GTA

The Greater Toronto Area (GTA) includes the City of Toronto and the Regions of Peel, York, Durham and Halton. The City of Toronto and all of the regions have their public health and other community health service agencies according to the Province of Ontario. The City of Toronto also has a strategic Plan: A Healthy City for All (2010-2014). The foundation principles of the strategic plan are to ensure accountability, diversity, community engagement, health equity and commitment to excellence.

Table 1: **Organizations providing health-care services in the GTA**

	Public Health Units	Hospitals	Community Care Access Centres	Community Health Centres	Nurse Practitioner-Led Clinics	Local Health System Networks
Province of Ontario	48	211	14	92	25 (plan)	14
GTA	**10**	**64**	**4**	**30**	**2**	**5**

Source: Ontario Ministry of Health and Long Term Care, 2014.

Table 1 shows that there are 64 Hospitals, 4 Community Care Access Centers, 30 Community Health Centers, 2 Nurse-Led Clinics and 5 Local Health Integration Networks (LHIN) in the GTA (Ontario Ministry of Health and Long-Term Care, 2014). There are also public health units for each of the regions and the City of Toronto. The health-care services and delivery systems were introduced for the emerging needs of immigrant populations living in the GTA. The immigrants' success also depends on their health status; if they are not healthy they could be a burden on Canadian society. In this regard, Canadian immigration policy plays an important role which is discussed below.

2.6   Canadian Immigration Programs and Processes

Canada has been a country receiving immigrants since Confederation in 1867. However, the flows of immigrants were not steady all the time (Inglis, Birch and Sherington, 1994). The end of the Second World War offered an opportunity for Canada to be considered as a soft player in world politics. According to Simmons (1999)

> The independent role of Canada in the war, its rising industrial and economic capacity, and its investment opportunities increasingly placed the nation as an emerging force on the world stage. Policy changes that reflected Canada's new role, however, took place gradually in a series of steps largely concentrated in the 1960s. (p. 43)

In this period, Canada abandoned its previous immigration policy because of the decline of qualified European immigrants interested in immigrating into Canada. As a result, the Canadian government was forced to change its immigration policy from a traditional to a new one. The new immigration policy was based on a point system using human capital for admission, not nationality; additional immigration posts were opened in third-world countries (Simmons, 1999; Stewart et al., 2008). The point system was used to assess the eligibility of all skilled workers and professionals for immigration to Canada. This point system has been changed and reformed many times, based on Canadian needs.

The new Federal Skilled Worker Program (FSWP) came into being on May 4, 2013; applicants must obtain at least 67 points in the point assessment out of a maximum100

points (Table 2). Other than FSWP, there are programs that have different requirements set by the Canadian governments. These are the Canadian experienced class (those who have Canadian education and work experience); federal skilled trades; business immigration programs; provincial nominee; live-in caregivers; Quebec-selected skilled workers; refugees and family sponsorship (Immigration & Citizenship Canada, 2014). In the new Federal Skilled Worker Program (FSWP), six selected factors are considered in determining how many points applicants should receive: education; languages (English and/or French); work experience; age; arranged employment in Canada; and adaptability (Immigration & Citizenship Canada, 2014). For example, a specific number of points correspond to the level of completed education, years of work experience, various levels of language proficiency, age, arranged employment and adaptability factors such as previous study, education, partner's education and relatives living in Canada (Table 2). An applicant with a Master's degree or PhD and at least 17 years of full-time equivalent study will have a maximum 25 points.

Table 2: **Skilled workers and professionals who can apply for Canadian immigration—six selection factors and the points system pass mark.**

Factors	Examples: Years/Experience/ Proficiency	Points	
Education	Masters or PhD and 17 years of full-time education	Maximum points	25
Languages (English & French)	High	Maximum points	28
Work Experience	4 years or more	Maximum points	15
Age	Within 21- 49	Maximum points	12
Arranged Employment in Canada	Job offer or working on a valid work permit in Canada	Maximum points	10
Adaptability	Previous work or study in Canada, partners education, relative in Canada	Maximum points	10
Total		Maximum points	100
Pass Mark		67 points	

Source: Citizenship and Immigration Canada, 2014. Retrieved April 22, 2014, from http://www.cic.gc.ca/english/immigrate/skilled/apply-factors.asp

In the same way, language (English and/or French) proficiency will garner a maximum of 28 points. For four years or more of work experience, an applicant will receive 15 points, and an age between 21 and 49 will earn a maximum of 12 points. An arranged employment in Canada or adaptability factors such as previous study and/or work in Canada, partner's education, and any relative living in Canada will achieve a maximum of 10 points respectively (Citizenship and Immigration Canada, 2014). New immigration policy is more focused on the applicants' ability to succeed economically in Canada. Another important change to the new immigration application is that those whose education was achieved outside of Canada are required to submit their Educational Credential Assessment (ECA) in support of their application (Immigration & Citizenship Canada, 2014).

From 1968 to the 1990s, immigrants' population in professional and technical occupations from non-European countries started to increase and exceeded 50 percent of the annual number of immigrants; some years it was more than 70 percent (Li, 2003). It is clear that the number of European immigrants has declined as the regulations of Canadian immigration have changed since 1962.

The selection criteria were changes to attract immigrants from all over the world. The search for experienced managerial and professional immigrants included non-European countries as well. According to Li (2003) "throughout the 1980s and 1990s, immigrants from Asia, Africa, and other non-traditional sources made up more than half of the total number of immigrants to Canada" (p. 33). Statistics Canada data show that in the first decade of the twenty-first century more than 75 percent of the landed immigrants of Canada were from Asia, Africa and South America. The number of immigrants from European countries is decreasing (Chagnon, 2013).

2.7   The Changing Face of Immigrants to Canada

As a consequence of immigration policy changes, the proportion of newcomers who belonged to a visible minority group also increased. In 1981, 55.5% of the newcomers who arrived in Canada in the late 1970s belonged to a visible minority group. In 1991,

slightly over seven in 10 (71.2%) recent immigrants were members of a visible minority group, and this proportion reached 72.9% in 2001. The 2006 Census showed that three-quarters (75.0%) of the immigrants who arrived between 2001 and 2006 belonged to a visible minority group (Statistics Canada, Census 2006). The 2006 Census enumerated 6,186,950 foreign-born persons in Canada, representing virtually one in five (19.8%) of the total population. This was the highest proportion in 75 years. The Census estimated that 1,110,000 immigrants came to Canada between January 2001 and May16, 2006. These newcomers made up 17.9 percent of the total foreign-born population, and 3.6 percent of Canada's 31.2 million total populations (Statistics Canada, 2006). Recent immigrants born in Asia (including the Middle East) made up the largest proportion of newcomers to Canada in 2006 (58.3%). This proportion was virtually unchanged from 59.4 percent in 2001. In contrast, in 1971, only 12.1 percent of recent immigrants for this period were born in Asia. Newcomers born in Europe made up only 16.1 percent of recent immigrants in 2006. Although Europe was previously the main source of immigrants, in 1971 Europeans accounted for only 61.6 percent of newcomers to Canada (Statistics Canada, 2006).

A majority (70.2%) of the foreign-born population in 2006 reported a mother tongue other than English and French (Statistics Canada, 2006). The growth of the visible minority population was due largely to the increasing number of recent immigrants (landed immigrants who came to Canada within five years prior to a given census year) who were from non-European countries. In 1981, 68.5 percent of all recent immigrants to Canada were born in regions other than Europe, and by 1991, this proportion had grown to 78.3 percent. The 2006 Census showed that 83.9 percent of the immigrants who arrived between 2001 and 2006 were born in regions other than Europe (Statistics Canada, 2006). Table 3 shows that most of the countries are of non-traditional source countries of top ten countries from where immigrants came to Canada from 1981 to 2011. According to a National Household Survey 2011, visible minorities make up 78 percent of the total immigrants those who arrived between 2006 and 2011(Statistics Canada, 2014). More precisely, Statistics Canada data of 2010 and 2011 show that more than 80

percent of the immigrants living in Canada are visible minority immigrants (Chagnon, 2013).

Table 3: Immigrants from 10 main birth countries in Canada, 1981 to 2011

Rank Order	2011	2001	1991	1981
1	Philippines	China	China	UK
2	China	India	India	China
3	India	Pakistan	Pakistan	India
4	Iran	Philippines	Philippines	US
5	United States (US)	South Korea	South Korea	Vietnam
6	Pakistan	Iran	Iran	Philippines
7	Haiti	Sri Lanka	Sri Lanka	Poland
8	Iraq	Romania	Romania	Haiti
9	United Kingdom (UK)	US	US	Guinea
10	Colombia	Russia	Russia	Jamaica

Source: Statistics Canada, 2014. Retrieved June 29, 2014, from

http://www.statcan.gc.ca/pub/91-209-x/2013001/article/11787/tbl/tbl3-eng.htm and

http://www.statcan.gc.ca/pub/91-209-x/2011001/article/11526/tbl/tbl-eng.htm#a3

Table 4 shows the growth of the visible minority population from 1981-2011 in Canada as well as in the Greater Toronto Area (GTA). In 1996, visible minorities were 31.6 percent of GTA's population whereas in 2011, this had risen to 44.3 percent. In 2011, in the Peel Region of GTA, almost 57 percent of the total population was made up of visible minorities and in the City of Toronto it was 49 percent (NHS 2011, Statistics Canada, 2014).

Table 4: **Growth of visible minority population from 1981 to 2011.**

Year	Visible minority population (millions)	% of the total Canadian population	GTA's Total Population (millions)	% Visible minority population in the GTA
1981	1.1	4.7	Not available	Not available
1991	2.5	9.4	4.2	Not available
1996	3.2	11.2	4.6	31.6 (only CMA)
2001	4.0	13.4	5.0	34.5
2006	5.0	16.2	5.5	40
2011	6.2	19.1	5.9	44.3

Sources: Statistics Canada, Census of Population, 1981 to 2011.

A Statistics Canada study, Projections of the Diversity of the Canadian Population 2006-2031 (2010), shows that according to all its projections the proportion of the Canadian population consisting of foreign-born persons will continue to rise. Under the low- and high-growth scenarios of these projections, Canada will have between 11.4 million and 14.4 million persons belonging to a visible minority group by 2031, more than double the 5.3 million reported in 2006 (Statistics Canada, 2010). In addition, the South Asians are the largest visible minority group recorded in the 2006 Census as well as the 2011 National Household Survey (NHS 2011, Statistics Canada, 2014). The South Asian population will also be the largest visible minority group; it is projected that it will double from roughly 1.3 million in 2006 to between 3.2 million and 4.1 million in 2031 (Statistics Canada, 2010). The projections of the diversity of the Canadian population also reported that by 2031 visible minorities would comprise 63 percent of Toronto's population (Statistics Canada, 2010).

2.8   Immigration Policy Related to Health

As a part of the immigration process, applicants have to go through a mandatory medical screening before they are granted an immigration visa to Canada. Only those who are declared healthy are approved: "To protect the health and safety of Canadians, as well as

reduce and prevent excessive demand on Canada's health and social services systems, permanent resident applications are required to undergo a medical examination" (Citizenship and Immigration Canada, 2014). This process is undertaken by Canadian embassy/visa posts. The principal applicants and their dependents must undergo a medical examination. Even if the dependents are not coming with the principal applicants, they must also have an immigration medical examination (Citizenship and Immigration Canada, 2014).

2.9   Summary

This chapter discussed the Canadian health policy and immigration policy, its perspectives, and its relationship to immigrants' health. Canadian health policy began in 1867 and to date it has tried hard to meet Canadian needs and aspirations. As it is today Canadian health policy is designed as a universal health-care system; the Canada Health Act provides the basis for free medically necessary access to all, as implemented by the provinces and territories. On the other hand, as an immigrant nation and with the growing needs of immigrants, the policy has been changed periodically, with the most significant changes of immigration policy occurring in the 1960s and 1970s. As result of the changes, immigrants are coming from non-traditional sources and are also called "visible minorities," as discussed in this chapter. According to the emerging needs of immigrants and their settlement, access to health care is a very important phenomenon. Evidence suggests that visible minority immigrants are facing challenges in accessing appropriate health-care services. The *Canada Health Act* of 1984 and the spirit of a universal health-care system ensure free, equal and appropriate health care access for all, as discussed. The delivery of the health-care system of the study area and the changing face of immigrant populations are also discussed in the chapter.

Chapter 3

3   Literature Review

Chapter 3 provides an overview of the theories and concepts reviewed for this research that are used to fulfill the objectives of the study. The chapter investigates the history of settlement support systems introduced for immigrants' communities from the very beginning in the 1950s. The Canadian government's introduction of settlement services in various ways to help immigrants and their integration into Canadian society is also discussed. The programs and initiatives taken for immigrants' settlement services and integration strategies for their full participation in the host society are examined. The question remains: if Canadian health-care services are free for all, then why is immigrants' health declining? The chapter also reviews the literature on access to health care.

3.1   Migration

3.1.1   International Migration Theories

Human migration is as old as human history. However, in the age of globalization migration is an important issue for developed and developing countries. International migration has many faces and causes. A United Nation Population Fund (UNFPA) report states that in recent history most migrations happen because of better economic and social opportunities. The migrants for economic reasons are the fastest-growing migrant population in the world (UNFPA, 2014). According to UNFPA, in 2010, 214 million people consisting of 3 percent of the world's population lived as migrants outside of their country of origin (UNFPA, 2014). There are many reasons for and causes of migration and based on that perspective there are many migration theories; they are neoclassical micro and macro-economic theories, world system theory, dual labor market theory, migration system and networking theory (Massey, Arango, Hugo, Kouaouci, & Pellegrono, 1993).

Neoclassical macro-economic theory is the oldest and most prominent migration theory that explains how labor wages cause international migration. The labor movement occurs from low-wage countries to higher-wage countries when highly skilled workers respond to differences in the rate of return (Massey et al. 1993). Neoclassical micro-economic theory focuses on the choice of individual actors to migrate (cited in O'reilly, 2012). One of the most prominent economic theorists explaining the cause of international migration is Earnest George Ravenstein. In his *Laws of Migration* (1889, 1976), Ravenstein explained the push and pull of migration (cited in O'reilly, 2012). According to him, push factors are those that force someone to migrate, such as fewer job opportunities; poor living conditions; lack of quality of life; lower per capita income; lack of social security; lack of social satisfaction; political oppressions; conflicts; wars; or adverse physical conditions. On the other hand, pull factors are opportunities for higher quality of life; better job opportunities; political freedom; individual choice of better education; and demand for highly skilled laborers (cited in O'reilly, 2012) Neoclassical economics considers economic factors as the cause of migration; for example, poverty as a push factor and better economic opportunity and quality of life as a pull factor, based on an individual behavioral-choice model (O'reilly, 2012).

Wallenstein's (1974) world system theory considers the world as one capitalist system with the relation between underdeveloped and developed countries making an uneven development. Massey et al. (1993) reported that "International migration is a natural consequence of capitalist market formation in the developing world; the penetration of the global economy into peripheral regions is the catalyst for international movement" (Massey et al., 1993, p. 447). Another important migration theory is migration networking, which focuses on migration decisions as the result of the role of family and community networking, thus encouraging people toward international migration (O'reilly, 2012). Such communication creates a kind of social capital for employment or prospect for better opportunities (Massey et al., 1993; O'reilly, 2012).

In such a discussion of migration theories, it is assumed that migration to Canada in recent history from all over the world has occurred largely from pull factors such as better quality of life, human security, political stability, multicultural society and so on.

However, push factors also resulted in immigration to Canada, because recent immigrants are coming from the developing world of Asia, Africa and Latin America, where factors like lack of social security, lower per capita income and lower quality of life push people to immigrate to developed countries like Canada for better quality of life. In the case of Canada, migration network theory also works in the event of family reunification. Political instability, civil war, and sectarian conflicts are also pushing refugee immigrants to immigrate to Canada from the Middle East and Africa.

3.1.2   Changing Phase of Canadian Immigration Policy

Canadian immigration policy has changed regularly over time with the demand and priority of national interests, such as the imagined future of rising European nations to emerging world powers; economic growth and expansion; population growth and skills; economic immigrants; competitive skilled immigrants; and the entrepreneurial character (Iglis, Birch & Sherington, 1994; Simmons, 1999). From the historical perspective, Simmons (1999) divided Canadian immigration policy into three phrases: 1850-1962; 1962-1989; and 1989-2008. In the first phase, Canada's immigration policy was to become a nation similar to a European one. Immigration policy goals were to expand the labor force through the immigration of farmers and factory workers from Europe and their families were invited to settle in Canada. However, non-European immigrants were restricted (Simmons, 1999).

In the second phase (1962-1989) of Canadian immigration policy, Canada abandoned its previous country preference policy. New regulations were passed in 1962. In this period regulations were passed meant to eliminate racial, color and religious discrimination in Canada's immigration policy (Inglis, Birch & Sherington, 1994). Any person who had the necessary qualifications could be considered for immigration to Canada, regardless of skin color, race, or ethnic origin. In 1967 new regulations were passed in which the basis was a point system based on human capital and no specific country preference. The Canadian immigration policy of 1976 was also a cornerstone of present-day immigration policy. Based on this regulation an immigration act was also introduced to recognize

immigrants as equal to Canadian citizen. This *Canadian Citizenship Act* of 1977 states that naturalized and native-born Canadian citizens have equal citizenship rights and obligations (Citizenship and Immigration Canada, 2014).

During the third phase (1990 to the present) Canadian immigration policy has focused on economic development and investment. Entrepreneurs and business immigrants have been welcome in Canada, and this is still continuing. However, Canadian immigration policy is still changing rapidly on a trial-and-error basis.

3.1.3 Canadian Multiculturalism Policy

The process of multicultural policy started from 1947 when the *Canadian Citizenship Act* was passed. However, it was not until 1962 that actions began to base immigration policy on human capital: regulations that removed racial discrimination in the selection of immigrants, the creation of a new Department of Manpower and Immigration in 1965, the 1967 regulations that recognized human capital and introduced a "point system." This was further advanced by the new Immigration Act of 1978 (Citizenship and Immigration Canada, 2014). Although systemic changes were occurring, the most striking policy to emerge was based on a new socio-political awakening taking place among native people, French-speaking Quebecois and other ethnic immigrants.

The most important phenomenon of the period was the independence movement of Quebec which resulted in the appointment of the Royal Commission on Bilingualism and Biculturalism in 1963 (Fleras & Elliot, 1992). The Royal Commission on Bilingualism and Biculturalism issued a series of reports between 1965 and 1968 that made recommendations to eradicate the inequalities between the two founding groups through the promotion of bilingualism and biculturalism. As a result, official language legislation, recognizing Canada's languages as English and French, was implemented in 1969 (Fleras & Elliot, 1992). The public debate regarding the status of other ethnic minorities and the work of the Royal Commission on recognition of French and English Canadians raised the question: if it is valuable for French-Canadians to maintain their distinctive culture

and identity, why not other groups? (Palmer, 1976, p. 102). During this phase, various ethnic groups made special presentations to the government, claiming that their contributions to Canada were being ignored, and arguing for the adoption of a policy of multilingualism and multiculturalism in Canada. Prime Minister Pierre Trudeau announced the multiculturalism policy in Canada's House of Commons on October 8, 1971:

> National unity, if it is to mean anything in the deeply personal sense, must be founded on confidence in one's own individual identity; out of this can grow respect for that of others and a willingness to share ideas, attitudes and assumptions. A vigorous policy of Multiculturalism will help create this initial confidence. It can form the base of a society which is based on fair play for all. (First Annual report of the Canadian Consultative Council on Multiculturalism, 1975: iii)

The 1980s witnessed a growing institutionalization of multicultural policy. In 1982, multiculturalism was referred to the *Canadian Charter of Rights and Freedoms*. In 1984 a Special Parliamentary Committee on Visible Minorities produced its well-known report. In 1985 a House of Commons Standing Committee on Multiculturalism was created. In 1988, the *Multiculturalism Act* was adopted by Parliament, and Canada was the first country in the world to pass a national multiculturalism law. There are six themes that form the cornerstone of the multicultural act: diversity, equality, freedom, overcoming barriers, harmony and resources; these provide a positive picture of Canada's multicultural act. In the Act, the diversity of various cultures has been recognized. It also promotes full and equitable participation, as well as a picture of overcoming the barriers and full participation in communities.

Within the Canadian discourse on diversity, recognition is an important phenomenon. *The Canadian Multiculturalism Act* of 1988 sets out the government's commitment to:

> 3. (1) (a) recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the

freedom of all members of Canadian society to preserve, enhance and share their cultural heritage;

3. (1) (b) recognize and promote the understanding that multiculturalism is a fundamental characteristic of Canadian heritage and identity and that it provides an invaluable resource in the shaping of Canada's future;

3. (1) (d) recognize the existence of communities whose members share a common origin and their historic contribution to Canadian society, and enhance their development. (Canadian Multicultural Act of 1988, Government of Canada: Justice Laws Website)

In addition, the *Multicultural Act* of 1988 also states that all federal institutions shall:

3.2 (a) ensure that Canadians of all origins have an equal opportunity to obtain employment and advancement in those institutions;

3.2 (b) promote policies, programs and practices that enhance the ability of individuals and communities of all origin to contribute to the continuing evolution of Canada;

3.2 (c) promote policies, programs and practices that enhance the understanding of and respect for the diversity of the members of Canadian society. (Canadian Multicultural Act of 1988, Government of Canada: Justice Laws Website)

The Act provides a picture that cultural diversity must be based on the principles of equality and respect.

For the implementation of the multicultural policy the Minister shall take such measures as the Minister considers appropriate to implement the multicultural policy of Canada and, without limiting the generality of the foregoing, may

5.1(a) encourage and assist individuals, organizations and institutions to project the multicultural reality of Canada in their activities in Canada and abroad;

5.1 (b) undertake and assist research relating to Canadian multiculturalism and foster scholarship in the field;

5.1(c) encourage and promote exchange and cooperation among the diverse communities of Canada;

5.1(d) encourage and assist the business community, labor organization, voluntary and other private organizations, as well as public institutions, in ensuring full participation in Canadian society, including the social and economic aspects, of individuals of all origins and their communities, and in promoting respect and appreciation for the multicultural reality of Canada;

5.1(g) assist ethno-cultural minority communities to conduct activities with a view to overcoming any discriminatory barrier and, in particular, discrimination based on race or national or ethnic origin. (Canadian Multicultural Act of 1988, Government of Canada: Justice Laws Website)

The Multiculturalism Act of 1988 provided a direction to promote the cultural and language preservation of all origins, promoting the full and equitable participation of all individuals and communities. It also searched for a balance of cultural diversity and equality within a bilingual framework. The Act provided a framework for the policy implementation in all public life and public institutions. It was also intended to encourage immigrants' full participation in the decision making that affects their lives which will foster their integration into their new society.

3.2   Integration of Immigrants

Berry (1997) identified four strategies of acculturation by the adaptation in a cultural sense; they are (a) integration, (b) assimilation, (c) separation, and (d) marginalization. *Integration* is defined as the maintaining of one's cultural identity and interacting and accepting some values and customs of host society and/or others. *Assimilation* is defined as when the non-dominant groups abandoned their own cultural identity and adopt the

host societies cultural values and customs. *Separation* is defined as rejecting the host society's new cultural values and customs and retaining one's original cultural identity. *Marginalization* is defined as minimum interest in one's own cultural values and customs and those of the host society as well (Berry, 1997).

The course of absorption or assimilation into a new society requires new values; immigrants must accept the possibility that their aspirations may have to be modified to fit those that the society offers. Eisenstaedt suggests that "the institutionalization of the immigrant's behavior can only occur if various channels of communication between the absorbing social structure and the immigrant's primary groups function smoothly" (Quoted in Ramcharan, 1982, p. 5). It is in this context that, if immigrants are adapting successfully to their new society, they should be able to identify and achieve the feeling of belonging to society as much as the original members (Ramcharan, 1982). However, in Canada, multiculturalism policy is introduced to integrate immigrants into Canadian society.

Before the multiculturalism policy was introduced in 1971, immigrants were expected to assimilate entirely into Canadian cultural norms. This thesis was known as the Anglo-conformity model of immigration. Assimilation was considered as a part of political stability (O'shea, 2000). Palmer (1988) and Richmond (1988) point out that earlier immigration policy (1850-1962) favored Europeans and the Chinese and Japanese were considered inferior and not assimilable (Driedger & Reid, 2000).

In the 1970s, multiculturalism as a cultural pluralism policy was promoted by the Canadian government for better integration of the diverse population who were coming from non-traditional sources. In this process, policy was designed and implemented to integrate immigrants into the social and economic institutions of the host society. On the other hand, the host society works toward accepting the immigrants with equal status and provides the opportunities for their culture, language and other opportunities to flourish. Ramcharan (1982) points out that "social integration and cultural pluralism, therefore, theoretically provide the conditions for positive intergroup relations and consensus on

basic values by members of all racial groups, and could be the ideal for all multiracial groups to strive towards"(p. 9).

In the 1970s and 1980s there were initiatives to integrate immigrants into Canadian society. The Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in 1988, named *After the door has been opened: Mental health issues affecting immigrants and refugees in Canada,* noted that integration is best achieved through participation of immigrants in mainstream institutions which are taking decisions about their everyday life (Yelaja & O'Neill, 1990). Full participation may occur when the immigrant population's settlement services and their immediate support services are available and their health and other needs are fulfilled by opportunities to access equal and appropriate health care, education, and employment according to their education and experience. Thus they can be made comfortable for full participation in their host society (Yelaja & O'Neill, 1990). From this perspective, settlement support service is crucial for immigrants' integration.

Biles, Burstein and Frideres (2008) have noted that immigrants face challenges in accessing employment and education. They argued that if there are no specific strategies and road map to eliminate the challenges of the immigration and settlement services programs then the initiatives of immigrants' integration are likely to fail. The author also identified some issues behind the slowdown of the integration process in Ontario. These are decreasing job opportunities in the manufacturing sector in Ontario, lower earnings of newcomer immigrants, non-recognition of immigrant education and outside job experience and lack of Canadian official languages proficiency (Biles et al., 2008). Given the above discussion, it is important to mention that without the removal of the challenges/barriers of immigrants' opportunities to access appropriate health care, education, employment and other settlement services, it is impossible to integrate immigrants successfully into Canadian society.

3.3   Acculturative Framework: Settlement Services

The Fifth Report of the Standing Committee on Citizenship and Immigration titled *Settlement and Integration: A Sense of Belonging "Feeling At Home"* (2003) stated the importance of settlement services:

> The provision of settlement services is an important investment. While not all immigrants require assistance upon arrival, many benefit from language and employment training, as well as other services. Canadians in turn benefit from the full participation of newcomers in our society. Settlement services lead to successful citizenship, the ultimate step in the immigration process. (*Settlement and Integration: A Sense of Belonging "Feeling At Home,"* 2003)

In 1950, the Department of Citizenship and Immigration was created; and from the very beginning it provided formal settlement services, and funding for non-governmental organizations to help newcomer immigrants to integrate in their new society (Tolley, Biles, Andrew, Esses, Victoria, Burstein, 2012). At the beginning the Welcome House and in the 1970s and 1980s other settlement services were introduced (Tolley et al., 2012). The settlement services for immigrants as well as integration policy, programs and governance were also introduced in the 1970s. In 1978, the Ontario Council of Agencies Serving Immigrants (OCASI) was established. The elements of the OCASI were federally funded immigration services and adaptation programs (Tolley et al., 2012). In addition, the Metropolis project was introduced with the objective of determining whether the immigrant population could or would be integrated into Canadian society. The Metropolis project started in 1996 and functioned until 2013. Approximately 9000 policy makers, researchers and local community partners contributed to the project (Tolley et al., 2012). However, the question remains of how successful the various projects, program and policies and settlement services programs have been in fulfilling the immigrants' need for better health and well-being.

The delivery of settlement services to newcomer immigrants involves both federal and provincial governments. The Ministry of Citizenship and Immigration Canada (CIC) does not provide services directly to the newcomers. It provides funding to the provinces,

immigrant-serving organizations, and other community-based agencies. Three main funding programs are provided by the CIC: Language Instruction for Newcomers to Canada (LINC), the Immigration Settlement and Adaptation Program (ISAP) and the Host Program (The Fifth Report of the Standing Committee on Citizenship and Immigration, 2003). The province of Ontario has a very rigorous immigration settlement services program in which municipalities play the major role with non-government settlement service providers named as neighborhood services. Other than municipalities and neighborhood service providers, the province provides information on its website regarding settlement, employment. Other settlement services agencies and civil societies also provide some kinds of settlement services.

3.3.1   Municipal Approach

In the mid-1990s a number of changes in settlement services were introduced and greater involvement of municipalities occurred through the provincial program which embarked on a Local Services Realignment program. In this period, the Ontario Settlement and Integration program was replaced by the Newcomer Settlement Programs and funding was reduced to almost half (cited in Tolley et al., 2012). In 2005, the Canada-Ontario Immigration Agreement (COIA) was signed. Under the agreement the Federal Government provided, over the five-year period, $920 million to support the delivery of settlement services and language training for newcomers. Three primary goals were specified in the agreement: a) to improve immigrants' economic and social outcomes; b) to increase the economic benefit of migration; and c) to build partnerships with municipalities and communities (Tolley et al., 2012). Under the COIA, the settlement support services organizations were working in municipalities and communities. As well, the business sector, schools, civil society, and NGOs were involved. A Municipal Immigration Committee was formed for better coordination and consultation among municipalities, provincial and federal departments, those who are working for immigrants. Additionally, a trilateral Memorandum of Understanding between the City of Toronto and the federal and provincial governments was signed which provided the City of Toronto a bigger role for the settlement and language training of newcomers (Tolley et

al., 2012). Under the COIA agreement, Local Immigration Partnerships (LIP) was introduced in 2008. As of 2014, there are now 34 LIPs in Ontario: 8 in the GTA, including 4 in Toronto, city-wide LIPs (City of Toronto: Social Development, 2014). The objective of LIPs is to provide a framework to facilitate collaboration among stakeholders and develop and implement a community-based strategic plan, support better coordination, strengthen local integration capacity and achieve improved outcomes (Burr, 2011).

All of the municipalities in the GTA are providing services to the newcomers in their respective offices along with other residents. At the same time, they have posted the available community settlement services programs for newcomers on their website.

3.3.2   Community Approach

With the support of the province, municipalities, and the Ministry of Citizenship and Immigration, non-government organizations and charitable organizations are providing settlement support services and delivering services to newcomers. A study by Lim et al. identified 238 settlement services agencies called "neighborhood services" operating in 280 locations across the Greater Toronto Area (GTA) (Lim, Lo, Siemiatychi, & Doucet, 2005). In addition to the Ministry of Citizenship and Immigration, other federal government departments—including Health Canada, Human Resources and Skills Development Canada, Industry Canada, and Justice Canada are also providing funding to many settlement services programs (Siemiatycki, 2012).

3.4   Settlement Support Services and Healthy Immigrants' Effect

Although the municipalities and community neighborhood service centers are providing settlement support services to the newcomer immigrants, the literature suggests that immigrants face multiple settlement challenges in accessing the opportunities needed for their health and well-being in their new society. One of these challenges is access to

health-care services. Canadian immigration processes require pre-screening of immigrants' health before they are allowed admission into Canada. Those diagnosed as healthy are allowed to enter Canada. Immigrants generally arrive in Canada with better health than those who are Canadian born; this is called the "healthy immigrant effect" (Newbold, 2005; Ng et al., 2005). A study by Statistics Canada suggests that after six months of entering into Canada 97 percent of immigrants rated their health as good, very good or excellent. However, as time passes, the health of immigrants tends to deteriorate (Statistics Canada, 2005). Longitudinal data from five cycles of the National Population Health Survey (NPHS) show that over the period 1994/1995 to 2002/2003, visible minority immigrants were twice as likely as the Canadian-born population to report a deterioration in their health—that is, they had rated their health as good, very good or excellent in 1994/1995, but subsequently in 2002/2003 described their health as from fair to poor (Ng et al., 2005).

3.5   Access to Healthcare

Under the Canada Health Act, Canadians have the right to "reasonable access to health services without financial or other barriers" (*Canada Health Act—Annual Report* 2008-2009, p. 3). According to the Canadian Institute of Health Information, access to health care means "getting the right care, at the right time, by the right care providers, in the right setting" (CIHI, 2008, p.27). Access to care ranges from primary care to rehabilitation care, including primary health care, emergency department care, accessing care in wait times in priority areas, access to diagnostic imaging, and accessing rehabilitation care (CIHI, 2008). Authors Anderson and Davidson (2001) define access as "actual use of personal health services and everything that facilitates or impedes their use…Access means not only getting to service but also getting to the right services at the right time to promote improved health outcomes" (cited in Chen, 2010, p. 52). This definition is a reminder of the indicators of health system performance proposed by the Canadian Institute of the Health Information in its Final Report on National Consensus Conference on Population Health Indicators (1999): acceptability, accessibility, appropriateness, competence, continuity, effectiveness and safety (CIHI, 1999).

There are two ways health care researchers measure access to care; one is utilization of health-care services which considers frequency of visiting physicians or using medical procedures, and the other is health outcomes which are measured by death rates, disease, incidence and other collected measures of health (Millman, 1993). The theoretical model of access to care—the Behavioral Model of health services utilization—was developed by Ronald Andersen in the 1960s. It is the most recognized model for measuring the access to care (Andersen, 1995). Although health services utilization is considered a valid measure of access to care, it does not provide the full particulars of access (Sanmartin, Houle, Brethelot, & White, 2002). The authors argue that although utilization quantifies the use of the services, it misses many other important factors as well as preferences, experiences and barriers to access to care.

The emerging literature suggests that visible minority immigrants are experiencing difficulties in accessing culturally appropriate health-care services and the health system performance indicators discussed above are also inadequate (Asanin & Wilson, 2008; Chen, 2010; Schellenberg & Moheux, 2008). Although a few articles analysed access to health care by health-care utilization, the authors did not find any consistent use of care, nor could they determine why immigrants' health is deteriorating or deal with immigrants barriers to accessing care (Kirmayer, Weinfeld, Burgos, Fort, Larsy and Young, 2007; Ng et al., 2005; Uiters, Deville, Foets & Spreeuwenberg, Groenwegen, 2009). However, most researchers of immigrants' health care focus on immigrants' accessibility challenges. These accessibility challenges and barriers are reviewed below.

3.5.1   Lack of Social Support Services

In the 1960s immigration policy gradually took a series of steps toward making new regulations in 1962, 1967, 1978; the *Canadian Multicultural Act* of 1988 attracted more and more non-European immigrants. The non-traditional or visible minority immigrants needed more social support to access settlement needs and integrate successfully into the host society. Stewart and Lagille (2000) defined social support as "… interactions with family members, friends, peers and… professionals that communicate information, esteem, practical, or emotional help" (cited in Simich, Beiser, Stewart, & Mwakarimba,

2005, p. 259). One social support service provider described social support in Simich et al. (2005) as a learning process that enhances immigrants' efficiency and possibilities in the new environment for their better resettlement. In his words,

> Social support is a kind of concept that encompasses the economic, political, and cultural… People have cultural needs that relate to the values of the place they grow up, values of their friends and values of their families. When those change, the values in the communities around, they need some type of, maybe not 'support,' but maybe brokerage or translation. They need to know what the things mean here. People say, 'I need to be able to understand the value set where I now live, so I can interact effectively and efficiently in the way I'm used to.' (Simich, et al., 2005, p. 262)

For this study, a few articles on the Canadian immigrants' perspective were reviewed to understand how important the social support services are for immigrants, especially for visible minority immigrants, and what settlement services the visible minority immigrants are receiving. Choudhury (2001), in his article focusing on South Asian immigrant women's experience of resettlement in Canada, analyzed how social support is important for settlement services and how difficult it is for a cultural community to resettle and integrate into a new society. He also argued that the immigrants' cultural differences make it more important for them to have settlement social support services to enhance their opportunities to integration into multicultural society in Canada.

Haque, Khanlou, Montesanti and Roche's (2010) study explored the link between neighborhood and newcomer immigrants' health in a small town in the GTA. For the study, they collected data from new immigrants, non-immigrants and policy makers. The study found that the loss of social support and social networks upon arrival in Canada is a very important concern for visible minority immigrants. A Chinese male immigrant reported:

> Immigrants may not have big problems with physical and mental health, but everyone experience stress which are not possible to be avoided. There is relationship between stress and health. Most times, based on my experience, I

believe that my physical condition is not good like before in China and become worse year by year. The stress is from psychological pressure, feeling not to be accepted by the society, change of life style, different food choice and etc. Overall, our health conditions are not good as before. But some people thought it is much better here than in China, such as cleaner air, not so crowded, not so busy and simple personal relationship, they feel much healthier. Then, they can work and studies with good condition, the stress they are facing create positive effect. But I believe that most of immigrants are not facing positive stress but negative stress, such as cultural shock, pressure from life and work. (p.18)

In the same way, a Chinese woman described losing her social support and social network upon arriving in Canada. Her situation affected her wellbeing here: "We face many problems: no relatives and friends, new environment, no financial foundation, and how to support ourselves. We are not familiar with environment and people here. Being in a bad mood affected our physical health directly" (Haque et al., 2010, p.18).

Another study by Stewart, Anderson, Beiser, Mwakarimba, Neufeld, Simich and Spitzer (2008) on visible minority immigrants and refugees found that immigrants require various formal and informal settlement support services for their resettlement. The study also found that based on their origin and culture their supports seeking ways are also different. The study also revealed that Chinese immigrants expect more support from governmental or formal support services than they are used to. On the other hand, Somali immigrants expect more traditional norms of interdependence and reciprocity with friends and family (Stewart et al., 2008). For example, a Somali immigrant explained how friends and family assisted in their country: "When we (Somalis) think of social support it means someone helping or giving something to another person. But in this country it (social support) means someone who helps in providing health, housing, and jobs" (Stewart et al., 2008, p. 141). The study also reported that newly arrived immigrants have limited or insufficient information about the health, health-care system in Canada because of inadequate social support services available to newcomer immigrants (Stewart et al., 2008).

In a study based on three large cities—Toronto, Vancouver and Montreal—Simich, Beiser, Stewart, Mwakarimba (2005) found that without social support services makes it difficult for immigrants to get information regarding the services and navigating the system. Their study showed that settlement support services play a very important role in immigrant settlement and integration in their early years of immigration. The study also found that newcomers face systematic challenges as well as accessing barriers to health and other opportunities. They argued that "inadequate social support has negative impacts, such as increasing feelings of loneliness and social isolation, loss of identity, discouragement (e.g. about seeking employment), and lack of knowledge of available options" (p. 263).

Reitmanova and Gustafson (2007) discussed the importance of culturally appropriate health-care services and examined how lack of health information or the difficulty of navigating a health-care system different from the previous one makes it difficult for immigrants to access and receive appropriate health care in Canada (Reitmanova & Gustafson, 2007). Clearly, the literature suggests that inadequate social support negatively affects immigrants' resettlement processes.

3.5.2   Information and the Health Literacy Problem

Canada is a multicultural society and English and French are the official languages spoken in the official settings. Although multiculturalism is the state policy, there are limited provisions to accommodate and communicate effectively across various cultural and language groups. The newcomer immigrants require getting new information about health issue, available services, navigating services and their emerging health needs in the new society. The Ad Hoc Committee on Health Literacy (1999) describes "health literacy" as "the ability to obtain, process, understand and use health information to make appropriate decisions about health" (cited in Simich, 2010, p.17).

In their article, Zanchetta and Poureslami (2006) provide examples of how health affects the communication between immigrants from different cultures, languages and health-

care systems. Language is very important to accommodate different perspectives and views of the world. The authors reported that there may be many reasons for low health literacy; however, lower level of education, language, culture, traditional beliefs and other systemic factors do contribute to low health literacy of immigrants (Zanchetta & Poureslami, 2006). They also found that visible minorities face barriers to access and service use because of the lack of information of health services availability in Canada (Zanchetta & Poureslami, 2006).

In another article, Kreps and Sparks (2008) explained that the need for effective communication for understanding the health risks and benefits is particularly important and complex. Immigrants who have difficulties in understanding health and health-related information face challenges in making sense of relevant health information and decision which is also complicated by intercultural communication barriers. Kreps & Sparks (2008) also argue that immigrant groups are "often confused and misinformed about health care services, early-detection guidelines, disease prevention practices, treatment strategies, and the correct use of prescription drugs, which can lead to serious errors and health problems" (p. 329). Members of vulnerable immigrant populations, such as the elderly, the less educated, and women, need culturally-relevant, accurate, and timely health-care information (Kreps & Sparks, 2008). These challenges require easy, understandable, culturally-sensitive communication strategies and understanding of health-related literacy for everyday communication to health professionals. From that perspective, health literacy is a very important component of accessing appropriate health care.

Simich (2010) explains in her article that without basic health literacy skills regarding Canadian health care, immigrants experienced significant difficulty managing health-related information and decisions. The article also reveals that having a higher education does not grantee higher health literacy and low health literacy is a long-term concern for immigrant populations in Canada. Simich (2010) also recommended health literacy intervention for immigrants.

Pirisi's (2000) article stated that low health literacy prevents patients from getting the full utilization of treatment, clinical information and equal access to care. The article reported that lower health literacy leads to poorer health outcomes. Given the literature review above, it is clear that visible minority immigrants, those coming from different cultural and linguistic backgrounds, have lower health literacy, which affects their access to health care.

3.5.3   Geographical Barriers

According to Asanin and Wilson (2008), geographical accessibility refers to "the physical location of a health care service and a person's ability to receive care at that location" (p. 1276). Wang (2007) reported that "medical care is easier to access when it is located nearby" (p. 656).   Geographic accessibility in health care is critical for newcomer immigrants. In the Canadian health-care system family physicians act as "gatekeepers" to primary health care as well as specialist care which is sometimes unknown to the newcomer immigrants (Wang, Rosenberg, & Lo, 2008). However, getting a family physician is difficult and finding a family physician in one's neighborhood in some cases is only a dream. For newcomers to Canada, unfamiliar institutional settings, lack of networking and extended family members and unknown neighborhoods make it difficult for them to find a family doctor in their neighborhood.

A study in the Greater Toronto Area (GTA) by Asanin and Wilson (2008) found that newcomer immigrants in the GTA faced challenges to find a family doctor close to their neighborhood: "You can't find any doctors here. I spent nine years looking for a doctor, so I have to travel far by bus to see my doctor" (p. 1276). Another person said: "Trust me when I say that […] I have been looking for a doctor for my family…no one is taking us right now" (p. 1276). Although finding a family physician is a common problem for everyone in Canada, the newcomers also face higher challenges because of unfamiliarity with the system, navigating the system and neighborhood. Asanin and Wilson (2008), in their research, also found that immigrants face geographic barriers when attempting to access health care service in their community. Accessing primary care is sometimes very

difficult for recent immigrants who have to go long distances to get a physician. One of the participants in the Asanin and Wilson (2008) study shared an experience: "I couldn't find a doctor in the neighborhood and so I went outside, but this is not easy for everyone because they can't travel far especially if they are uncomfortable with public transport" (p. 1276). The study found that three major barriers to accessing health care are geographic accessibility, economic and socio-cultural factors. The literature also suggests that many people do not seek medical services because of the unavailability of health-care services close to their neighborhoods (Asanin & Wilson, 2008).

According to the study of Asanin and Wilson (2008), vulnerable populations such as older women, pregnant women, newcomer women, or senior immigrants who do not have a vehicle and knowledge of Canadian official languages experience higher challenges to access to health care. A study by Wilson and Rosenberg (2002) shows that geographic accessibility is a major barrier to accessing health care. According to the study, within all of the provinces the majority of respondents indicate their inability to receive care for physical problems, ranging from 86 percent in Prince Edward Island to a low of 67 percent in Alberta (Wilson & Rosenberg, 2002).

3.5.4   Language Barriers

Canada is a multicultural society. Although English and French are its official languages, however, there are hundreds of different languages immigrants speak. When it comes to the point of access to health care, there are concerns for different languages and understanding. Every year thousands of immigrants whose mother tongue is not English or French enter Canada. According to the 2011 National Household Survey, of the 6.8 million foreign-born individuals living in Canada, 1,162,900 arrived in Canada between 2006 and 2011. Among the immigrants 200 languages were reported as a home language or mother tongue (National Household Survey 2011). The principal applicant for immigration must have some level of Canadian language proficiency to be approved for admission to Canada; however, dependents do not need any language training. The question of language proficiency remains an important issue. A study by Boyd (2009)

based on the 2006 Canadian Census revealed that immigrants between the ages of 25 and 64 have a low level of English/French proficiency. In 1996, 44 percent of immigrants had a low level of proficiency and this has decreased over time. Of those who arrived between 1996 and 2006, 62 percent had a low level of proficiency in English/French. Over half of those arriving since 1996 are visible minority immigrants, coming from China, India, Pakistan, Philippines and South Korea (Boyd, 2009). These immigrants have a lower level of Canadian official language proficiency.

Language proficiency is a very important issue when the challenges of employment, education and access to health care as well as integrating into a new society arise. Lack of Canadian official language proficiency prevents immigrants' accessing settlement services, employment opportunities and access to health care. A Chinese immigrant with a lack of Canadian official language proficiency described his difficulty with acculturation into Canada:

> The language barrier is a major problem for me. It is very difficult to find a professional job if you have problem with English which is official language in Canada. I am sure that if I had no problem with English, I could find a professional job here. (Haque et al., 2010, p. 17)

In another study, Choudhry (2001) discussed the immigrant women's challenges of lack of Canadian official language proficiency and how it reduces their social networking and communication with neighbors and surrounding people. As soon as immigrants arrive in a new society, they lose their long time known surroundings, neighborhood, community and common language they speak. This situation creates confusion, insecurity, stress and isolation. One of the immigrants described the situation as:

> I felt I was in hell and wanted to go back to India every moment of my life; I was very much home-bound and had no friends, no acquaintances, didn't know the language, had nobody to talk to. We [she and her husband] felt we were trapped. I could not go anywhere and I still cannot because I don't know any English and I feel will get lost if I move out of this house. (Choudhry, 2001, p. 385)

Choudhry (2001) also found that lack of language proficiency affects women's movements because they are afraid of using public transport alone in their new society.

 One participant said:

> I have not gone anywhere and I don't know what there is to see in Canada. I have never gone alone and I don't know how to go alone. In my country I went alone everywhere…I feel I must learn some languages to be able to communicate with people outside. (Choudhry, 2001, p. 386)

A study by Pottie, Ng, Spitzer, Mohammed and Glazier (2008) suggested that lack of language proficiency is one of the main causes of poor self-reported health. They also reported that immigrant women had lower language proficiency than men which subsequently resulted in poorer self-reported health of women (Pottie et al., 2008). They noted that "language proficiency has implications beyond access to health care; for example, impact on job market, access to better paid positions, and developing health knowledge" (p. 509). All of these are interlinked to broader access barriers to health care.

Nimmon (2007), in a qualitative study, investigated the effect of users of English as a Second Language (ESL) newcomers' challenges to access to health care and coping their early time of immigration. In her study, she collected data by interviewing, and then for better understanding of the problems pictured an ethno-drama. The study suggests that newcomer immigrant women's health worsens because they may face language barriers to accessing health care services. It also suggests that immigrant women's inability to communicate well in English also put pressure on their everyday life which eventually creates psychological isolation. The following drama provides a good picture of the problems:

(Maria has just moved here from Brazil and is staying with a Canadian family. She has just started her Master's in Canada. She is talking in Portuguese on the phone with her boyfriend in Brazil)

Maria:…Well, I knew it wouldn't be easy.

Jose: Are you able to talk to the people you are staying with?

Maria: Yes, they are very nice, but I haven't shown them how I really feel. And I am afraid to talk to them about anything in detail because of my poor language skills.

Jose: But you studied so much before you left. You were in the highest level of English classes and you were one of the top students.

Maria: *(holding back tears)* I know, I thought I would come here and be able to talk to everyone. But everybody here talks soooo fast and a lot of vocabulary I just don't know. I met a girl at the meeting I had at the university today and she moved here from Colombia 6 years ago and she says that she still doesn't have the same vocabulary that she has in Spanish. I feel like I should come home. I am not feeling well.

Jose: Have you been eating well Maria? What have you eaten today?

Maria: Ummm…oh my gosh…You know it's 7 pm and I haven't eaten anything all day.

Jose: You need to eat more Maria. That is probably why you are feeling down.

Maria: I think you are right. I feel like so weak for not being able to cope here. And I should just be happy with this opportunity. I can't believe I haven't been eating. I have just been crying all day. Oh… I have to go. They are home now.

Homestay mother: Hi Maria! How was your day today? What did you do? (pp. 387-388)

This conversation reveals that immigrant woman's inability to communicate well in Canadian official language has left her isolated and stressed, because of the language obstacle to sharing her feelings and everyday stress.

A study of Chinese immigrants living in Toronto by Wang, Rosenberg and Lo (2008) found that those who have family physicians reported that almost 96 percent had Chinese origin family physicians; and 90 percent communicated exclusively in Chinese (e.g., Mandarin, Cantonese) with their family physicians. From this scenario, it is very clear

that the preference to go to the Chinese family physicians even though they are a little far away because of the communication and cultural understanding (Wang et al., 2008). The study also found that the Chinese immigrants prefer Chinese physicians because of their lack of Canadian official language proficiency; 59 percent of the respondents reported that they feel more comfortable communicating in their mother tongue and only 3 percent communicate in English (Wang et al., 2008). Having Chinese family physicians helps them to understand health information, instructions, and gives them a better understanding of their cultural related health and health care. In addition, some Chinese physicians, along with Western medicine, prescribe Chinese traditional herbal and healing system, if requested (Wang et al., 2008). The literature suggests that lack of language proficiency is a definite barrier to accessing health-care services.

3.5.5 Cultural Barriers

Multicultural policy originated in 1947 when the *Canadian Citizenship Act* was passed. However, Canada's Parliament passed the *Multicultural Act* in 1988. Multiculturalism represents an alternative policy option that secures an innovative blueprint for living together with differences and recognizing others culture and customs.

Logan and Semmes (1986) noted that culture is a distinctive way of living of a particular community that shares their practices, beliefs, values, and customs from generation to generation (cited in Mensah, 1993). Generally, members of a particular community use a common pattern of behaviors which dominate their everyday life and separate them from others. These patterns of behaviors are ascertained through verbal and nonverbal interaction in community and family (Mensah, 1993). Health is sometimes considered as the absence of illness and is based on their personal and family cultural health beliefs and practice which are shaped in their socio-cultural environment (cited in Anderson, Andrews, Bent, Douglas, Elhammoumi, Keenan, Kemppainen, Lipson, Martin & Mattson, 2010). The same study of Anderson et al., (2010) also notes that the way people defined the health also related to role and responsibilities they play for their family, work, and community. These definitions of culture and health also may be applicable to the

culture of visible minority immigrant groups and also to the collective culture of those who are a part of the Canadian health-care provider.

According to Asanin and Wilson (2008), their study's participants expressed their frustration regarding the approach of Canadian-trained physicians used to diagnose them. For example, Canadian family physicians are too rushed; they listen impersonally and lack depth. Many immigrants said the doctors from their home countries used a holistic approach to health and health care. The literature also suggests that culturally different understandings of health and health care act as barriers to receiving appropriate care (Asanin and Wilson, 2008). Some immigrants' comments follow:

> We need good doctors. There are not very good doctors. You go for a lot of tests but the doctors they do not understand, I do not know why… They do not understand the symptoms and the treatment is not so good… I say that I cannot accept the doctors. (Participant, South Asian Settlement Group)

> Back home it is a big difference because doctors use the mind and they take a chance, but here the doctors are very reserved… They go through a system because they worry that maybe they will be sued. (Participant, Pregnant Mothers Group 2)

> We need better-trained doctors who really take the time to understand the patient's need and really focus on the treatment… I think we need to mix and match (treatments). Like homeopathic, it has good results, without any side effects. Though it is long term but it has no side effects and the problems we have seen being cured completely from the root. (South Asian Settlement Group)

> She says it (Canadian medical system) damages our further health; the customs here damage further health. (Family Daycare Group) (Asanin & Wilson, 2008, p. 1277)

Cross-cultural differences in health care between the Canadian health-care system and immigrants' previous experiences cause further barriers to accessing the Canadian health care system. In a qualitative study Nimmon (2007) investigated how cross-cultural

understanding of health care creates challenges and affects the immigrants' everyday health. In her study, she collected data by interviewing and then, for better understanding the problems, pictured an ethno-drama.

(*Monica is having an allergic reaction to something and she has red patches all over her body. She tries calling a health centre in Victoria and gets a recorded message on the answering machine.*)

Machine (*speaking quite fast*): You have reached the Victoria Medical Clinic. I am sorry we are not available to take your call. We are open from Monday to Friday 9 am to 5pm. If this is an emergency, please contact this number 351-5565 where somebody will respond to your call. (*Monica dials again because she can't understand the message. Monica is starting to panic. She dials twice more and on the fourth time she finally understands the message. Monica calls the number and speaks with a nurse.*)

Monica: Hi, ummm

Nurse: Please speak up dear, I cannot hear you.

Monica: hi, um…ummm. Well, I am really scratchy.

Nurse: Scratchy? What do you mean? You mean itchy?

Monica: Yes, ummm, itchy. I have little points all over my arm…I mean little dots. They are rad… no red.

Nurse: (*It is sooo annoying when English as second Language (ESL) speakers call here.*) Oh, you mean you have a rash. It's called a rash.

Monica: (*This is incredibly embarrassing, I feel like a child.*) Yes, a rash. I am sorry. What should I do?

Nurse: You should go and see a doctor.

Monica: You mean a specialist?

Nurse: well, you have to go to a general practitioner first. And then you will get a referral to see a specialist.

Monica: You mean I cannot go to a specialist on my own? I know what is wrong with me….I need to see a dermatologist. (*Later in the week: After seeing the doctor Monica is at the pharmacist picking up her prescription*.)

Pharmacist: So, you just need to take one of these for 3 weeks at bedtime. (pp. 389-390)

This scenario provided the understanding that cross-cultural differences in health care arise for immigrants when they are dealing with the health-care system in Canada. In some countries they (patients) can go straight to a specialist for medical care at any time. This also shows that second-language English speakers have difficulty understanding health-care information because of cultural barriers.

Literature also suggests that culturally different understandings of routine Canadian procedures are sometimes considered as barriers to receiving care. In the Canadian health care system, if someone wants to go to family physicians they need to communicate with physicians in advance and remember and save the date. At the same time, for seeing consultant or specialist physicians take longer time and waiting period make it more confusion and frustration for the newcomer immigrants, because they are not familiar with the system how it works. In addition, the privacy matter of information to communicate with physicians and appoint a nominee to help needed well in advance also create frustration among them. The situation further frustrating when it come to the issue of touching and undressing during a medical checkup period by same-sex professionals because that is not acceptable in many cultures (Stevens, 1993).

A study by Bottorff, Johnson, and Venables (2001) on South Asian women living in Canada examined the cultural problems they are facing in accessing health care services. The study found that South Asian women live in a joint family and they serve others and sometimes they have little or no time for themselves. In addition, South Asian women, when feeling ill or emotionally disturbed look for validation for their concern from the family member for the decision to visit physicians and they are silent when sensitive

health issues come to the forefront. The study also investigated South Asian women's reports that their health-seeking behavior pattern is different from others; they have problems communicating health concerns, their symptoms are more culturally specific and they also encounter racism (Bottorff et al., 2001). One South Asian woman said that strict family confidentiality impedes effective communication with health care professionals. One woman explained:

> I will not talk about the thing which is worrying me… because with our ladies, we have one fault. If you find out someone's weak point then we keep reminding others of that weak point. That, "Oh such and such happened with the poor woman, how that happened, this poor woman is worried." No, I never tell anyone my worries when I'm worried. (Bottorff et al., 2001, p. 396)

The study also found that the beliefs and values of South Asian immigrants— that is, the keeping of family together and respect for the community—prevents the private interaction between women and opposite gender professionals. In addition, the silence about sensitive health issues which is also part of the South Asian culture also affects their health. They believe that it may be the cause of fate, or from God, and may be related to women's roles enforces that silence (Bottorff et al., 2001).

A study by Asanin and Wilson (2008) found that for cultural and/or religious reasons, many women do not want to go to physicians and they do not feel good about discussing their health problems with male doctors. If finding a family doctor is difficult, then finding a female physician is really challenging. The study also found that because of the lack of female physicians, immigrant women do not go for primary care and their health concerns are left untreated (Asanin & Wilson, 2008). One South Asian immigrant described her frustrations:

> This neighborhood does not have many doctors… especially for the ladies, they need female doctors and there are none. There is only one Indian doctor over there and he is always full. He is male and the ladies cannot go there. They just don't feel comfortable seeing a male doctor…. (Asanin & Wilson, 2008, p. 1277)

Reitmanova and Gustafson's (2008) study revealed that some participants reported the importance of knowing the physicians and those physicians being respectful of their health-related cultural and religious beliefs and practices. One of the participants shared her experience:

> Yes, it was important for me [to have a female attendant] and I told them this but they said, 'Whoever is available.' They can't guarantee a female doctor during labor. I just had to accept it… sometimes when the male doctor has a background about our, you know, culture and religion and he respects it then it's good. Once I went before the delivery for a checkup and it was a male doctor and I found that he can understand it and he suggested that he will let a nurse to check me and she will tell him what she found. He was very helpful. (Reitmanova & Gustafson, 2008, p. 105)

The same study explored the barriers to maternity health services for the Muslim women living in St. John's, Newfoundland. The study found that the specific needs of cultural and religious based needs, their privacy were not honored and they felt embarrassed. One woman told her story:

> There was a male who entered my room. I asked nurses if they can knock before they enter so I can get dressed. I also put a sign on the door but they didn't respect it. This man came and saw me. I was very upset and crying. One nurse came and said: 'Oh, why you are crying, you are beautiful. You don't need to cover yourself.' I explained to her that I do not cover myself because I'm beautiful. She asked me: 'And do you have cars in your country, do you have electricity?' I think she thought we ride on camels, so I told her about my country. (Reitmanova & Gustafson, 2008, p. 106)

The study also reveals that hospital visitors lack prayer rooms and dietary preferences (Reitmanova & Gustafson, 2008).

One woman explained her difficulty in making her dietary needs understood:

> I think they have no idea what is halal food [food that does not originate from pig, contain alcohol and processed with specific religious instruction]. They offered me bacon and asked me if I can eat it. So I said 'I can't.' They told me that there is vegetarian but I'm not sure if everything was vegetarian… They told me that someone will come and ask me what food I need. And nobody came until I left the hospital. Every time they brought food I asked them about it they said they will send someone…I relied on food my husband brought me. (Reitmanova & Gustafson, 2008, p.106)

The study also found that health professionals did not respect participants' cultural and religious-based needs. One woman said, "They made me very sad. I stopped asking them for anything." Such a situation is a barrier to accessing appropriate and quality care (Reitmanova & Gustafson, 2008, p. 106).

Traditional healers had a very common influence among the Asian, African and Latin American cultures (Masi,1993). South Asian women in Canada reported using various herbal medicine and religious healers; non-Western medicines, and therapies provided by Ayurvedic, homeopath, naturopath (natural non-toxic healing method such as herbal), babajis (respected wise men), pundits (holy men), and granthi (holy men) (Hilton, Bottorff, Johnson, Venables, Bilkhu, Grewal, Popatia, Clarke, & Sumel, 2001). Some believe that traditional medicines are natural, more healthy and fresh (Hilton et al., 2001).

The literature suggests that cultural, religious and linguistic communities have different understandings of health and health care, ways of seeking care, communication with care providers, health-care needs, describing symptoms, and interactions between providers and themselves; they even encounter racism when trying to enter the Canadian health-care system for their everyday life.

3.5.6   Education, Employment and Financial Barriers

After arriving, immigrants face three kinds of problems related to their education, employment and health-care services. First, they face a waiting period of three months before access to the public health-care system becomes available; second, immigrants' education and professional degrees are not recognized in Canada; and third, their previous experience is not counted here (Asanin & Wilson, 2008; Li, 2001; Li, 2008). As a result, they are forced to stay unemployed or under-employed for a long time which results in adverse mental and psychological pressures that affect their health, as shown in the literature below.

3.5.6.1   Waiting Period and Extended Health Insurance

A study by Asanin and Wilson (2008) reported that after arriving in Canada, immigrants face a waiting period to access the publicly funded universal health-care system. The waiting period is not the same in all of the provinces and territories; however, in Ontario immigrants have to wait for OHIP for three months. While medical services are free in Canada, immigrants who reside in Ontario, British Columbia and Quebec have to wait for three months for the provincial health plan. During the waiting period, immigrants can buy private health insurance; however, this is a significant concern, particularly for families with young children, pregnant women and seniors who have pre-existent conditions. Moreover, those who reside in the provinces of British Columbia or Alberta have to pay for their general provincial health care whether they are employed or unemployed (Asanin & Wilson, 2008).

The study also reported that a direct cost of buying prescription medication which is not covered by the provincial health insurance is also very difficult for newcomer immigrants in the province of Ontario. Newcomer immigrants also experienced underemployment or unemployment during their early years of immigration. As they do not have full-time employment, most of them lack extended health benefits and this prevents immigrants from getting the appropriate health care in Canada. Recent immigrants and unemployed immigrants who do not have extended health insurance faced difficulties: "Medicine is

very expensive. We can't afford it. Nowadays my husband is sick and we can't afford it" (Asanin & Wilson, 2008, p.1279). Another participant said, "Medicine should be covered. If you can't afford it … healthcare should be free. Even in our countries, most things are free. Medicine is not very costly in Pakistan but here is very costly" (Asanin & Wilson, 2008, p. 1279). The study also found that those do not have extended health benefits avoid complying with the doctor's recommendation:

> I don't understand why you have health card cover specific things but different things like eye doctor they do not cover… it will be minimum four to five years before you make that amount, so it doesn't give a lot of adults a chance to make that amount again. If I pay for an exam or eye test it's once every four to five years, so if you pay for it, it will be in vain because you use it only once. (Asanin & Wilson, 2008, p.1279)

Another participant said, "I need physiotherapy but I am not covered and so it is very difficult for me now to walk" (Asanin & Wilson, 2008, p.1279). The literature suggests those newcomer immigrants, families with vulnerable members, and unemployed or part-time employees who do not have extended health benefits experience significant challenges in accessing care.

3.5.6.2   Education

As discussed earlier, the growth of the visible minority population in Canada was due largely to the increasing number of recent immigrants who were from non-European countries. The census of 2006 also enumerated 4,076,700 persons born outside Canada between the ages of 25 and 64. Of these people, 1, 287,500, or about one-third (32%), had a university degree. Of the 'recent' immigrants—those who immigrated between 2001 and 2006–349,800, or 51 percent, had a university degree. This was more than twice the proportion of degree holders among the Canadian-born population (20%) and much higher than the proportion (28%) among immigrants who arrived in Canada before 2001 (Statistics Canada, 2006).

A study by Li (2003) demonstrates that visible-minority foreign-trained professional degrees are not fully recognized in Canada. The study suggests that visible-minority professional immigrants perceive that they face systemic barriers to their entry into their respective professions for which they trained back home. Although sometimes immigrants' education is recognized, its market value is lower than that of the native-born population.

Li's (2008) study suggests that the foreign credentials of immigrants are racialized and depend on the racial background of the immigrants. There are also substantial gross earning differences among immigrants of different racial and ethnic origins. The study reveals that foreign credentials of immigrants bring advantages for their earning; however, foreign credentials of visible minorities bring disadvantages and penalties for them. Such gross earning differences also indicate that visible minority immigrants earn substantially less than immigrants of European origin. In general, visible-minority men and women earn less than their majority counterparts.

A study by Agarwal (2013) found that although highly educated immigrants benefited when they immigrated to Canada, educational attainment does not help South Asian immigrants' in Canada. Their foreign credentials and experiences are discounted. The study also reported that immigrants who are coming from Bangladesh and Pakistan and studying in Canada do not make more money. The study's results also show that government policies and settlement programs are not effective in assisting South Asian immigrants.

Dean and Wilson's (2009) study suggests that the credentials and work experience of visible minorities are heavily discounted in Canada, which has many negative effects on their everyday life, such as mental health deterioration. They also reported one example of a male mechanical engineer and his lengthy job search and mental health situation: "Not finding work in our line after so much time, it impacts our health. It creates confusion, disappointment, delusion, disillusionment and it creates a lot of stress in both the personal and professional life" (Dean & Wilson, 2009, p.193).

3.5.6.3 Employment

According to a study by Statistics Canada, immigrants born in Southeast Asia, particularly those from the Philippines had the strongest labor market performance of all immigrants to Canada in 2006. The study also assessed the labor force situation for immigrants at their three stages of immigration: very recent immigrants landed between 2001 and 2006; landed between 1996 and 2001; and immigrants who had been in Canada more than 10 years (Statistics Canada, 2008b). The study found that in 2006, newcomer immigrants in their prime working age (aged 25 to 54) faced much more significant difficulties in the labor market than the Canadian-born (Statistics Canada, 2008b).

The study also found that those born in Asia other than in Philippines, Latin America and Africa encounter higher unemployment rates than the Canadian-born population. On the other side, working age immigrants from Europe had experiences similar to the Canadian-born. In addition, immigrants born in Africa experienced stronger difficulties in accessing their employment regardless of their landing among the visible minority immigrants. In 2006, the unemployment rate of African-born immigrants was almost 21 percent, which is more four times higher than that of the Canadian-born (Statistics Canada, 2008b).

Wald and Fang's (2008) study findings suggested that overeducation of immigrants did not produce any employment or earning benefits. The immigrants face increased educational mismatch with their employment. A study by Dean and Wilson (2009) suggests that income is one of the most significant factors affecting the decline of health. After coming to Canada, visible-minority immigrants look for employment in the area of study they are trained for; however, with the Canadian systemic barriers and discounting of foreign credentials, immigrants experience tremendous pressure and loss. One male mechanical engineer described his position:

> Initially when I came, it was a very bleak picture, because I found it very hard to find a job in my field. It was creating a lot of confusion, tensions and we don't know what to do. Now we are just doing a small job of surviving financially. That

is affecting the stress level. It will cause more irritations and more discontentments, and you will feel uneasy. You feel uneasiness. (Dean & Wilson, 2009, p. 193)

These immigrants faced tremendous pressures to support their family without employment and income or with a part-time position, which heavily discounts their foreign education and experience. One female business manager described the situation:

I am concerned and worried about how to keep an income because when you have a family and you have to worry about this constantly. You cannot keep going on without good work; you have to find a solution. So this career situation really affects my health I think… mostly it is the stress and worrying. (Dean & Wilson, 2009, p. 193)

Another important issue is that skilled workers not getting their skill-related jobs which resulted in de-skilling and/or underemployment of the skills they have acquired through their previous experiences. As well, they are losing their social recognition. One male information technology director described the situation:

They brought us as professionals and we are driving taxis and working in the labor jobs, and this is not fair and not healthy. I met a lot of educated people and they are working in the labor job. It's a waste of skills. In fact, if we start doing these things we will be away from our career, we will away from our experience, we will lose everything we know… that is not good for Canada and it is not good for the immigrants, not good for our minds… (Dean & Wilson, 2009, p. 194)

Another male electrical engineer described his experiences:

If you are just getting back to the small kind of work, it not going to make one happy mentally…it also adds tension. The more time that is being spent on those things is taking away from our experience and we are getting away and losing touch with our line, with our area and specialization. You are losing the experience that you gained… (Dean & Wilson, 2009, p. 194)

Lack of income, loss of social status and job security become important mental health problems that eventually result in physical health deterioration. One immigrant stated her situation:

> Physical (health), I would say is directly connected to your mental health. That's my, when you are stressed out, when you are so much worried, depressed sometimes, the physical takes a beating, that's my belief. Once you are mentally happy, happiness in the family, physical will automatically fall in place. (Dean & Wilson, 2009, p. 196)

The lack of educational credentials recognition, disadvantages of higher education, lower income and underemployment, as well as the waiting period before receiving public health insurance, has prevented visible minorities from accessing health care in Canada.

3.6   Summary of Literature Review

This chapter argued that migration to Canada in recent history from all over the world occurs largely from pull factors such as better quality of life, human security, political stability, multicultural society and so on. However, push factors also resulted in immigration to Canada, because recent immigrants are coming from the developing worlds of Asia, Africa and Latin America, where factors like lack of social security, lower per capita income and lower quality of life push people to immigrate to developed countries like Canada for better quality of life. This chapter reviewed the Canadian settlement and integration process and the settlement programs of immigrants into Canadian society. From the very beginning, the federal government introduced settlement services; however, as the process was continued, it was more vigorous in the 1970s and 1980s because of the change of immigration policy and shift of immigrant population from traditional countries. Settlement services for newcomer immigrants changed programs and policy again and again to better serve the newcomers. In this settlement services and integration process, the municipalities and neighborhood agencies are working for the immigrants. However, there is little or no literature assessing whether the

programs are able to fulfill the immigrants' needs or whether they are appropriate services for immigrants. Do those programs in reality help immigrants and what are the responses to those programs? At the same time, are these various programs attractive to immigrants or do they know about the available services in their neighborhood? In addition, there are deficiencies of literature at the local level to identify best practice or the most appropriate available services and practices for settling the immigrants for their full participation in our society.

The literature on access to health care has been reviewed; it consistently suggests that immigrants in general as well as visible minority immigrants are facing various challenges in accessing care. Much of the research identified that there is a lack of settlement services and there are systemic barriers, for example, in the case of education and employment. However, there is little or no literature on Canada's biggest multicultural area, and fastest growing, the Greater Toronto Area, and Canada's fastest-growing immigrant populations—South Asian. There is also no literature at all to identify how these barriers to access are significantly associated with immigrants' health status, growth of capability and well-being.

 In addition, there is no literature on how immigrants' challenges and barriers in accessing their appropriate health-care services, education and employment opportunities limit their capabilities and freedoms and quality of life, which is needed for their human development and integration into their new society as well as for their general well-being. The present study, addressing the research question, "What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)?" will help fill the gap by studying immigrants' access to care. The research also introduces new theoretical insights in analyzing immigrants' human development from Sen's capabilities and freedom perspectives.

Chapter 4

4   Research Questions and Methodology

This chapter provides an overview of the research methodology used in the study, discussing the research design, methods and data collection techniques, procedures, sample size, and variables measured in the study. The chapter justifies the particular research design and techniques and their theoretical perspectives as well as why those were employed in this research. It also discusses the study area, analytical methods and procedures, the research ethics approval process and the representativeness of the data.

4.1   Research Questions and Hypotheses of the Research

Visible minority immigrants usually enter Canada with higher health status because of the Canadian immigration process which screens those with health problems. However, evidence suggests that after living here their health decline (Statistics Canada, 2006). A review of literature and relevant studies related to immigrants and their health deterioration suggests that their health decline is caused by various challenges/barriers, including those relating to language, culture, lack of employment, and socio-economic factors, as well as a lack of social supports and information (discussed in chapter 1 & 3). From this perspective, the research question is: What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)? Based on this research question this researcher formulated three hypotheses:

(a) Hypothesis 1: The health status of South Asian immigrants deteriorates after living in Canada for a few years.

The study of visible minority immigrants' barriers to accessing health care and their negative effect has been an important aspect of their integration into a new society. Canadian immigration processes require pre-screening of immigrants' health before they are allowed to admission into Canada. Those diagnosed as healthy are allowed to enter

Canada. Immigrants generally arrive in Canada with better health than those who are Canadian born; this is called the "healthy immigrant effect" (Newbold, 2005; Ng, Wilkins, Gendron & Berthelot, 2005). A study by Statistics Canada suggests that after six months of entering into Canada 97 percent of immigrants rated their health as good, very good or excellent. However, as time passes, the health of immigrants tends to deteriorate (Statistics Canada, 2005). Longitudinal data from five cycles of the National Population Health Survey (NPHS) show that over the period 1994/1995 to 2002/2003, visible minority immigrants were twice as likely as the Canadian-born population to report a deterioration in their health—that is, they had rated their health as good, very good or excellent in 1994/1995, but subsequently in 2002/2003 described their health as from fair to poor (Ng et al., 2005).

(b) Hypothesis 2: Visible minority (South Asian) immigrants face significant challenges/barriers in accessing health care in the Greater Toronto Area (GTA).

A study by Sanmartin, Gendron, Berthelot, and Murphy (2004) found that the top two barriers to receiving routine or ongoing care were difficulty getting an appointment and long waits for an appointment. Overall, 16 percent of Canadians who had required health information or advice indicated that they had experienced difficulty accessing care. The proportion was significantly lower in Saskatchewan (13%) and Alberta (13%) and significantly higher in Ontario (18%). The study also found that approximately one in four (25%) Canadians who required immediate care for a minor health problem experienced difficulties. The results ranged from a low in Saskatchewan (17%) to a high in Prince Edward Island (27%) (Sanmartin et al., 2004).

However, while the immigrants face challenges, the visible minority immigrants face serious problems in accessing barriers to health care in Canada. Literature suggests that immigrants face multiple barriers when attempting to access health care services (Asanin& Wilson, 2008; Bottorff et al., 2001; Haque et al., 2010; Kreps & Sparks, 2008; Nimmon, 2007; Ng et al., 2005; Pottie et al., 2008; Reitmanova &

Gustafson, 2008; Steward et al., 2008; Wang, 2007; Wang et al., 2008; Zanchetta & Poureslami, 2006).

(c) Hypothesis 3: Health care accessibility challenges/barriers are limiting the South Asian immigrants' quality of life and their human development is being compromised.

Here "human development" is used as a process of

> Enlarging people's choices and enhancing human capabilities and freedoms, enabling them to: live a long and healthy life, have access to knowledge and a decent standard of living and participate in the life of their community and decisions affecting their lives. (cited in Ruhs, 2009, p. 8)

Access to health care is one of the significant components contributing directly to the quality of life (Sen, 2001). Thus the barriers to accessing health care are hindering immigrants' development process in their new society. The goal of development is the promotion and expansion of capabilities and freedom for better quality of life.

4.2   Positioning of this Research

4.2.1   Cross-Sectional Research Design

The research uses a cross-sectional research design. It intensively analyzed the South Asian Immigrants living in the Greater Toronto Area and their barriers to accessing health-care and settlement services. This research observes the South Asian populations' phenomenon at one point in time.

4.2.2 Methods

The study is based on interdisciplinary health services research. Data were collected through self-administered survey questionnaires and focus group discussions from the volunteers in the Greater Toronto Area (GTA). To answer the research question and test the hypotheses, positivism and interpretivism methodology are appropriate. Saks and Allsop (2013) stated that positivism and intrepretivism are the appropriate research methodologies for health services research. To answer the research question and test the hypotheses, surveys and focus group discussions were used; their analysis required quantitative and qualitative techniques. Quantitative and qualitative methods are used to answer the research problems of the study appropriately, excellent methods for conducting high-quality research (Johnston & Christensen, 2004). In addition, quantitative and qualitative methods are chosen to enhance the reliability and validity of the findings. The focus group's open-ended questions were designed to provide better explanation through exploration of the survey questionnaires. Findings of the focus groups, which have immediate face validity, were triangulated with the relevant questions of the survey questionnaires. In addition, relevant data from Statistics Canada, the Canadian Institute for Health Information (CIHI), and the Canadian Institute of Health Research (CIHR) are employed.

4.2.2.1 Quantitative Approach

The demographic variables, socio-economic variables and years in Canada, and sample questions about access barriers to health care were collected and used for the descriptive quantitative analysis. Descriptive statistics present a quantitative description of the data in manageable form. Comparisons of the health status of South Asian immigrants before coming to Canada and after living in the GTA for a certain time were made. The quantitative survey data and Statistics Canada data reveal the patterns of health-care utilization among visible minority immigrants. Demographic and socio-economic data were used to compare barriers within groups: factors such as age, sex and education and socio-economic variables also have a potentially different effect on the health status and

barriers to health care access of South Asian visible minority immigrants. The hypotheses of the research were tested using the chi-square test. To determine the relationships between independent and dependent variables and to measure the human development of South Asian immigrants' cross-tabulation, a chi-square test and Cramer's V were conducted. In addition, a correlation between an access barriers index and a capability index was conducted.

4.2.2.2   Qualitative Approach

Focus group discussion is considered a successful research method for studying marginalized groups (Asanin & Wilson, 2008). The qualitative analysis of focus groups provided an in-depth account of how the immigrants have dealt with the barriers to health care and how these difficulties have negatively affected their human capabilities and freedom as well as their well-being. Focus group discussions allowed the researcher to explore a greater diversity of individuals and their experiences, providing flexibility and in-depth discussion of various perceptions of accessing health care and how it affects everyday life. For this research, five focus group discussions were conducted with a mixture of men and women in each group. The groups consisted of South Asian immigrants living in the GTA as well as South Asian immigrants who were working in the immigrants' settlement services and serving South Asian immigrants.

4.3   Data Collection Techniques

4.3.1   Survey

 Survey research is the oldest and most commonly used data collection technique in social research (Babbie & Benaquisto, 2002). The use of surveys is widespread because of the standardization process and surveys provide an easy way of processing measurement (Bryman, Bell, & Teevan 2012). The sample survey technique is very useful to address descriptive questions, such as what, who, when and how. At the same time, a survey is also very effective when used in explanatory research to explore 'why?'

questions where the main goals of the researcher are to analyze cause and effect through quantitative statistics (Saks & Allsop, 2013). Although survey methods may contain various data collection techniques, the self-administered closed-ended questionnaire is the best for describing the characteristics of a large population and for measurement generally (Babbie & Benaquisto, 2002).

4.3.2   Focus Group

The focus group technique is widely used in qualitative health and behavioral research. Focus group research techniques are more popular in the study of needs assessment, respondents'/populations' perception of particular issues and services and sociological research for the understanding of health (Saks & Allsop, 2013). The focus group can provide a broader view of services and what people know about particular health and illness. In addition, a group setting may work better to generate talk about health and health services and a more user-centered policy in the health-care services (Saks & Allsop, 2013). Overall, a focus group can generate impressions of particular programs and services as well as stimulate new ideas and creative policies or solutions of particular issues/problems (Johnston & Christensen, 2004).

4.4   Sample

This study focuses on visible minority immigrants of South Asian origin who are living in the Greater Toronto Area (GTA). Visible minorities are defined based on the *Employment Equity Act* of 1986 definition as persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color; they include Chinese, South Asian, Black, Filipino, Latin American, Southeast Asian, Arab, West Asian, Japanese and Korean. Tran, Kaddatz and Allard (2005) defined South Asian as:

> A South Asian (sometimes referred to as East Indian in Canada and Asian Indian in the United States) is any person who reports an ethnicity associated with the

southern part of Asia or who self-identifies as part of the South Asian visible minority group. The definition encompasses people from a great diversity of ethnic backgrounds. (p. 21)

South Asia includes the countries of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

A total of 307 respondents living in the Greater Toronto Area (GTA) were recruited by convenience sampling from five countries of South Asia for this research. The countries are Bangladesh, 59; India, 117; Nepal, 28; Pakistan, 37; Sri Lanka, 66. We could not find any sample from two small countries of South Asia: Maldives and Bhutan. Among the participants 163 (53%) were male and 144 (47%) female. In addition, 131 (43%) had been living less than five years in Canada and 176 (57%) had been living five years or more in Canada. The population's mean age was 37.81 and the participants spoke 18 different languages. Most of the respondents are married (79%) and highly educated: 103 had MAs, 107 had Bachelor degrees and 58 had diplomas, 14 had MDs, 8 had PhDs; 17 had high school diplomas.

4.5 Primary Data Collection Process

4.5.1 Survey Participants Recruitment and Data Collection Process

For this research, the following criteria were used to collect participants**:**

Criteria used to enroll participants:
- ➢ South Asian immigrant living in the Greater Toronto Area (GTA);
- ➢ 18 years or older;
- ➢ Understand English or major South Asian languages (Bengali, Hindi, Nepali, Punjabi, Tamil and Urdu) in order to fill out the survey questionnaire.

To recruit the participants, the researcher went to the institutions that are providing settlement support services to the South Asian immigrants and the meeting places of South Asian immigrants such as Temple, Church, Mosque, cultural organizations and

South Asian groceries. In these places, the researcher met with South Asian immigrants and asked them if they were interested in volunteering for the research. The researcher also sent e-mail requests to various organizations that are providing support services to the South Asian immigrants and Mosque, Temple, Church and cultural organizations, asking for help recruiting research participants. Five answered positively to help the researcher in recruiting participants. The organization's responsible person gave an idea about the research to the potential participants who were coming to organizations for services and other activities. If they were interested in volunteering for the research, then the responsible person of the organization contacted the researcher to go to their organizations, and he went to the prospective participants and explained the research. At that time, the researcher gave them a research Information Sheet and explained the research in detail, mentioning that there would be a small honorarium for participating in the research. The researcher provided a CAD$10 gift card for filling out the survey questionnaire and a CAD$15 gift card for participating in the focus group discussion. The researcher gave a Consent Form to those who were willing to participate along with the questionnaires with a postage-paid envelope to send back to him after filling it out; the researcher handed out approximately 450 self-administered survey questionnaires and got 307 responses. The participants were recruited through the organizations and personal contact through friends and family and the South Asians' meeting places noted above. For better understanding and response to the survey questionnaires, the questionnaires were translated into six South Asian languages: Bengali, Hindi, Nepali, Punjabi, Tamil and Urdu.

4.5.2   Focus Group Participants Recruitment and Group Discussion

Among the participants, those who were interested in participating in a focus group interview/discussion ticked the appropriate box of the survey questionnaire and provided their contact address. The researcher contacted them and arranged a date and time at their convenience for the focus group interview/discussion which took place at their organizations or at a convenient location for them.   There were two groups of participants—one group who were South Asian immigrants living in the GTA and

another group who were South Asian immigrants living in the GTA as well as working in the immigration settlement services in the GTA. Three focus groups were in the first category and two in the second.

The researcher used a digital voice recorder and took notes, but no names were mentioned. The researcher has the only access to the notes. He interviewed five focus groups, each group consisting of 6 or 7 people. There were mixed focus groups including men and women. The researcher tried to recruit 50 percent male and 50 percent female in the groups. Each focus group discussion took almost two hours and after one hour there was a 15-minute break.

Before transcription of the focus groups' discussion, the researcher read all of the focus group notes and listened to the discussions. The researcher selected thematically relevant parts of the focus groups' discussions on the basis of importance, relevance to the research, participants' interest of expression and their reactions. To comply with the Laurentian University Research Ethics Board and considering the importance and relevance of the discussions with the theme of the open-ended questionnaire, the researcher himself transcribed selected relevant parts of the focus group discussions. First of all, the researcher selected the relevant parts of the discussions and then transcribed those parts of the discussions. After transcription, the researcher checked the transcription more than twice and edited as necessary. After that he looked for what themes were emerging from the data and what issues most concerned the participants: these were identified with the general theme. The theme-based content analysis method is used to analyse transcription. Data used in content analysis included only participants' speech.

4.6   Site Selection Profiles—the Greater Toronto Area (GTA)

The Greater Toronto Area (GTA) is the largest urban area in Canada and one of the biggest in North America. According to the 2011 census its population is 5,986,310 and its size is 7124 km (Statistics Canada, 2014).

Table 5: **Visible minorities and South Asians in the GTA, 2011**

	Total Population	Visible minority	%Visible minority	South Asian	% South Asian	% South Asian among visible minority
City of Toronto	2576,025	1264,395	49.08	317095	12.31	25.08
Peel Region	1,289,015	732,805	56.85	356430	27.65	48.64
York	1,024,225	442,840	43.23	107,955	10.54	24.38
Halton	495,440	89,850	18.14	31860	6.43	35.46
Durham	601,610	124,250	20.65	34090	5.67	27.44
Total GTA	5,986,315	2,654,140	44.34	847,430	14.16	31.93

Source: National Household Survey (NHS) Profile 2011, Statistics Canada. Retrieved on June 23, 2014, from: http:// http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?

Figure 1: Greater Toronto Area (GTA) map

Located on the north shore of Lake Ontario in the Province of Ontario, the GTA itself is not a political jurisdiction but rather a large urbanized area containing municipalities which are physically, politically, economically and socially interconnected with one another. The "Greater Toronto Area (GTA)," however, refers to the geographic area which includes the City of Toronto, Region of Durham, Region of Halton, Region of Peel and York Region, which includes 25 municipalities (Cukier & Yap, 2009).

4.7   Measurement of the Variables

The dependent variables of the research—self-rated health, activity limitation, capacity and freedom, and access to health care—were collected by a questionnaire survey of 307 participants.

Self-rated health was assessed with the Likert scale of the participants' health as excellent, very good, good, fair, or poor.

Physical activity limitation was also assessed with the Likert scale and such questions as: Does your health limit you in moderate activities, such as grocery shopping, moving a table, or light physical exercise? Does your health limit you in normal activities with family, friends, neighbors or groups? Does your health limit you in your hobbies or recreational activities? Does your health limit your performance of household chores?

Capabilities and freedom were also assessed with the use of Likert scale questions, such as Do you think you are living the quality of life in Canada that you expected before migrating here? Does your socio-economic situation limit you in achieving self-esteem? Do you have access to community resources such as education, employment and housing? Do you have opportunities for professional development in ways which match your training? Do you have the opportunity to choose among alternative options to live your life? Does your current situation limit you in achieving the respect of family, groups and community? Does your current situation help in achieving self-respect in your community? Do you think that your well-being is being compromised by the difficulties you experience in accessing appropriate health care? Are your achievements being compromised by difficulties in accessing appropriate health care? Do barriers to health care limit your integration into your new society?

Access barrier (barriers to health care) variables are language proficiency, information on health-care services, health literacy, social support services, geographic accessibility, cultural sensitivity, and having a family doctor, educational recognition and employment accessibility.

The independent variables of the study—the demographic and the socioeconomic characteristics of immigrants—were collected by a questionnaire survey.

Demographic variables are age, sex, education, and marital status.

Socio-economic variables are employment, income, provincial health insurance, and extended health insurance coverage.

In addition, an **access barriers index** was formulated with all of the barriers with value ranging 0 to 1 (variables are language proficiency, information on health-care services, health literacy, social support services, geographic accessibility, cultural sensitivity, and having a family doctor, geographic accessibility, educational recognition and employment accessibility) combined into one access barrier index using SPSS, the combined value ranging from 25 to 45.

All of the capability and freedom variables (quality of life, self-esteem, achieving respect, community resources, professional development, opportunities for a full and creative life, opportunities to choose one's life among alternative options) with values ranging from 1 to 5 were combined in **one single capability index** with a combined value ranging from 7 to 35 for conducting statistical analysis and correlation analysis between them and with other variables.

4.8   Data Description, Analysis and Analytical Process

Survey data are presented through descriptive statistics of the Statistical Package for Social Sciences (SPSS) software such as cross tabulation, frequencies, charts and other modes of presentation. The data are analyzed using the chi-square test, correlation analysis and Cramer's V. For the test of hypothesis and to determine the association between dependent and independent variables, a chi-square test, Cramer's V and correlation analysis were conducted and analysis is provided accordingly.

To analyze and measure the human development of South Asian immigrants living in the GTA, this research used the human development concept of Amartya Sen's capability and freedom approach. Here "human development" is used as a process of

> Enlarging people's choices and enhancing human capabilities and freedoms, enabling them to: live a long and healthy life, have access to knowledge and a decent standard of living and participate in the life of their community and decisions affecting their lives. (cited in Ruhs, 2009, p. 8)

Access to health care is one of the significant components contributing directly to the quality of life (2001). According to Sen,

> Human development, as an approach, is concerned with what I take to be the basic development idea: namely, advancing the richness of human life, rather than the richness of the economy in which human beings live, which is only a part of it. (UNDP-Human Development Reports, hdr.undp.org/en/humandev)

Sen's "capability approach" investigates human well being and development (Sen, 1990). The approach is concerned with ensuring that people, cultures and societies can enjoy the capability (or freedom) to lead the kind of life that they have reason to value. Sen (2001) points out that "the creation of social opportunities makes a direct contribution to the expansion of human capabilities and the quality of life" (p.144). While income and material things might be necessary to facilitate a good quality of life, the capability approach recognizes that it does not automatically follow that there will be a strong link between income and access to resources and the ability to achieve valuable capabilities which are necessary for full participation in society and state (Sen, 2001). This capability approach considers people at the centre of the development process, where people are regarded as the primary ends as well as the principal means of development.

Sen's approach is used to analyze how the barriers to accessing health care are hindering people's development process in their new society. The goal of development is the promotion and expansion of capabilities. Capabilities vary from elementary freedoms, such as being free from hunger and undernourishment, to such complex abilities as

achieving self-respect and social participation (Nussbaum & Sen, 1993). Immigrants in the independent category are highly educated and skilled in their home countries, but when they come to Canada their education credentials and work experiences are not recognized and they face multiple challenges in the settlement process. Immigrants also face barriers to accessing health care. As a result, they experience a decline in health that hinders the development of their capabilities and freedom and limits their quality of life. From this perspective, the dependent variables of this research were self-rated health, activity limitations, self- respect, social participation and experience of barriers to health care.

Focus group discussion is used not only to validate the survey data but also for better explanation and exploring the issues of the survey questionnaires. Focus group data is analyzed by thematic perspective; as well, issues concerning most of the participants are analyzed. Barriers to accessing health care are identified and broken down into different themes. Preferences for culturally appropriate services and alternative medical therapies were also identified.

In addition, an analytical model also presents how access barriers, health status and human development are interrelated (see Fig. 2).

Figure 2: Analytical model of human development
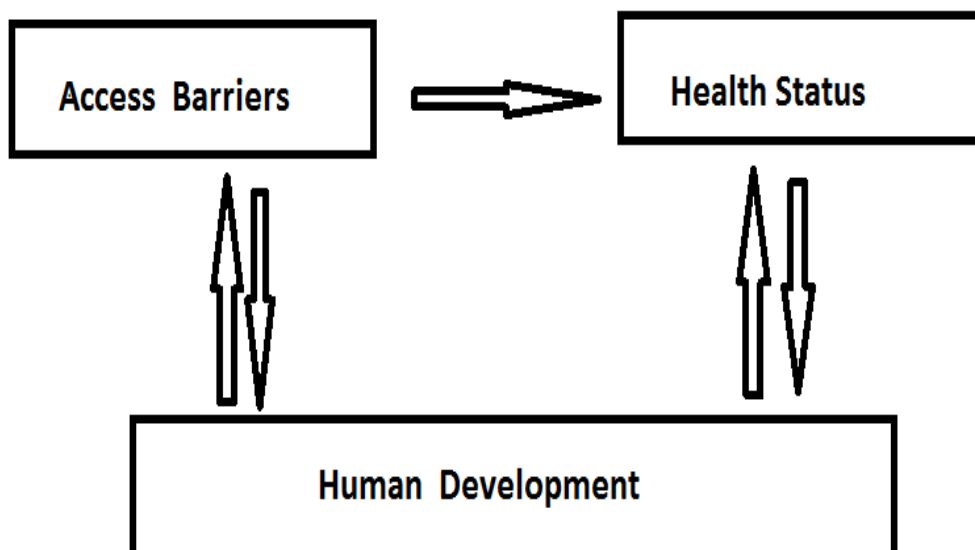
Here, access barriers to health care are accessing challenges/barriers to health insurance and health information, waiting for family doctors, language and health literacy problems, problems of geographic accessibility, problems of education and getting employment in their profession. Health status is considered as the self-rated current health status of the participants. Human development is considered to be the opportunity needed for immigrants building human capability and freedom in their new society. The goal of development is the promotion and expansion of capabilities. These opportunities are access to health care, educational resources, professional development, achieving self-respect, social participation and living a full and creative life with the opportunity to choose from alternatives.

4.9   Representativeness of the Data

Although the data was collected through the convenience sampling method, the researcher attempted to maintain the representativeness of the data. Because of the non-availability of a sampling frame, it was not possible to collect random data of South Asian immigrants living in the Greater Toronto Area (GTA). They are not the only ethnic population in the GTA. For this reason, the researcher used the convenience sampling method to collect data. The population's representativeness is discussed in the next chapter in detail.

4.10   Ethics Review Process and Consideration

The techniques of data collection and procedures of recruiting the samples for survey research and focus groups discussion were approved by the Research Ethics Board of Laurentian University in September 2011, and further change was approved in June 2012.

During data collection, minor modifications to the approval protocol were added for the data collection. The additional measure was taken to recruit participants. To recruit the participants, in addition to organizations and South Asian groceries, the researcher personally communicated with South Asian immigrants through friends and family asking if they were interested in participating in the research. To meet the difficulty in recruiting, the researcher also offered an honorarium—a CAD$ 10 gift card for filling out the survey questionnaire, and a CAD$15 for participating in a focus group discussion.

Collection of survey questionnaires and focus group discussions was conducted in accordance with the guidelines included in the ethics approval form. As per the instructions of the Laurentian University Research Ethics Board, all participants in this study (survey and focus group) were asked to give their informed consent prior to filling out the survey questionnaires and participating in the focus group discussions.

Information regarding the research was provided to the participants, along with an explanation of how the potential benefit could improve their wellbeing and make it easier

for them to get the health-care services they need to have a good life. They were asked to complete a questionnaire, those who were interested also volunteered as part of a focus group discussion. Their participation helped the researcher to learn the difficulties they have living in the GTA and getting the health-care services they need. They were asked to sign the consent form, complete the questionnaire, send/give it back to the researcher, and mention their possible volunteering for a focus group interview/discussion that took place at their organization and/or a place suitable for them lasting two hours (with a break of 15 minutes in between). The researcher collected the completed questionnaires and recorded the focus group discussions on a digital voice recorder. The information is completely confidential. The researcher has the responsibility of ensuring the confidentiality of the data. The memory stick, questionnaire and consent forms are kept in a locked cabinet in the researcher's supervisor's office at Laurentian University, Sudbury. The participation in this research was voluntary and participants had the right to stop their participation at any time. Their participation in the focus group discussion was also voluntary. At the time of the focus group interview/discussions, if they felt embarrassed or emotional, the researcher provided a list of the organizations that could help them.

All electronic data and transcripts are kept in a protected file on a password-protected personal computer at the researcher's home in Sudbury. All hard copy data (consent forms, memory stick) are kept in a locked cabinet in the researcher's supervisor's office at Laurentian University, Sudbury. The data will be kept for 7 years in a password-protected file on a password-protected computer. After that period, the documents will be permanently destroyed using computer software. All hard-copy data will be shredded. In addition, if participants had any questions or concerns about the study or about being a member of focus group discussions, they were provided the contact address of the thesis committee and the Laurentian University Research Ethics Officer by e-mail and given the toll-free number for Laurentian University.

4.11   Summary

For this interdisciplinary health research, a cross-sectional research design was chosen. A total of 307 participants living in the Greater Toronto Area were recruited by convenience sampling from five countries of South Asia: Bangladesh, 59; India, 117; Nepal, 28; Pakistan, 37; Sri Lanka, 66. Among the participants 163 (53%) were male and 144 (47%) female. Among the participants five focus group discussions were conducted. To recruit the participants, the researcher went to the organizations providing settlement support services to South Asian immigrants and the meeting places of South Asian immigrants such as Temple, Church, Mosque, cultural organizations and South Asian groceries; as well, the researcher personally communicated with South Asian immigrants through friends and family. For inclusiveness of the representation from South Asian countries, the researcher also translated questionnaires into seven major South Asian languages. As a conceptual analytical model to analyze the human development of the South Asian immigrants, Sen's capability and freedom approach and the model have also been discussed.

Chapter 5

5   Health Status and Barriers to Health Care

Analyzing the descriptive statistics of the study, this chapter attempts to determine the barriers to access to health care in the form of language, cultural practices, socio-economic factors and support services and their effect on populations' health and human development. The chapter also analyzes how the participants responded regarding their opportunities for building capabilities and freedom and how the accessibility problems compromised their health and well-being.

5.1   Sample

For this research, 307 South Asian immigrants living in the Greater Toronto Area (GTA) participated. Among the participants, data was collected from immigrants from five countries who are living in the GTA: Bangladesh, 59 (19%); India, 117 (38%); Nepal, 28 (9%); Pakistan, 37(12%); and Sri Lanka, 66 (22%) (Fig. 3).

Figure 3: Participants' birth countries/home countries
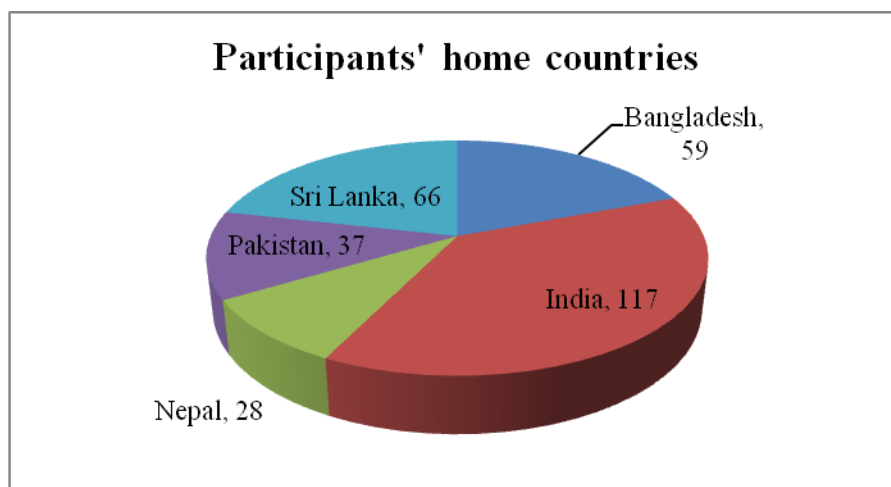
Among the participants, 53 percent are male and 47 percent are female. Figure 4 shows that most of them fall into the age category of 30-49 (61 percent) and 23 percent are

between 18 and 29. The Mean age is 37.8, the Median is 38 and the Std. Deviation is 11.7.

Figure 4: Participants' age group
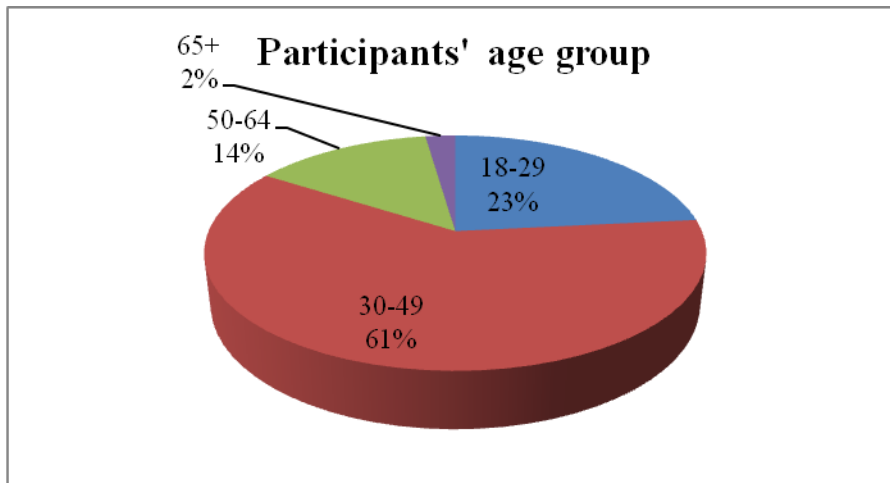
The participants have chosen the Greater Toronto Area (GTA) for job opportunities, friends and family, similar cultural community, education and for a better quality of life.

Table 6: **Socio-demographic characteristics of participants**

	Age (18-29) (%)	Age (30-49) (%)	Age (50-64) (%)	Age (65+) (%)	Sample size	(%) total sample
Gender						
Male	17.7	60.1	18.4	3.6	163	53.1
Female	29.8	61.1	7.6	1.3	144	46.9
Education						
PhD	00	37.5	62.5	00	8	2.6
Degrees in Medicine	21.4	64.2	14.2	00	14	4.5
Masters	8.7	76.7	13.5	0.9	103	33.5
Bachelor	27.1	60.7	9.3	2.8	107	34.8
Diploma /Community	34.4	46.5	13.7	5.1	58	18.8
Others	64.7	17.6	17.6	5.8	17	5.5
Personal Income (Monthly)						
Less than $1000	44.6	47.6	6.1	1.5	65	26
$1000 to $1,999	20.9	70.1	8.9	00	67	26.8
$2000 to $2,999	16.1	70.9	12.9	00	31	12.4
$3,000 to $4,999	19.5	60.9	19.5	00	41	16.4
$5000 to $6,999	8.8	70.5	17.6	2.9	34	13.6
$7000 and up	0	50.0	41.6	8.3	12	4.8
Household (Yearly)						
Less than $20000	25.0	63.5	10.4	1.0	96	31.6
$20000 to $39,999	28.7	54.5	12.1	4.5	66	21.7
$40000 to $ 59,999	16.6	70.8	10.4	2.0	48	15.8
$60000 to $79,999	24.3	54.0	18.9	2.7	37	12.2
$80000 and above	19.3	59.6	19.3	1.7	57	18.8
Employment						
Full time	12.1	66.8	19.5	1.3	148	48.2
Part-time	23.2	69.7	6.9	00	43	14.0
Unemployed	27.0	62.5	10.4	00	48	15.6
Full-time Student	58.3	37.5	4.1	00	48	15.6
Others	15.0	45.0	15.0	25.0	20	6.5
Marital Status						
Single	89.8	10.1	00	00	59	19.2
Married	7.8	73.5	16.5	2.0	242	78.8
Separated	00	00	00	100	02	0.6
Divorce	00	66.6	33.3	00	03	0.9
Widowed	00	00	100	00	01	0.3
Common-law-partner	00	00	00	00	00	0.0

Table 6 shows that among the participants' age groups, the age of 30-49 is the important group; they are highly educated, mostly married couples, working full-time and having higher income.

Figure 5 shows that among the participants, 18 first languages were spoken: Bengali 59, Sinhalese 48, Urdu 29, Telegu 28, Nepali 27, Kannada 26, English 18, Tamil 18, Hindi 17, Punjabi 17 and others, 20. Among the others, the languages are Pashtu, Malayalam, Sindhi, French, Konkani, Maithili, Marma and Gujrati.

Figure 5: Participants' first language
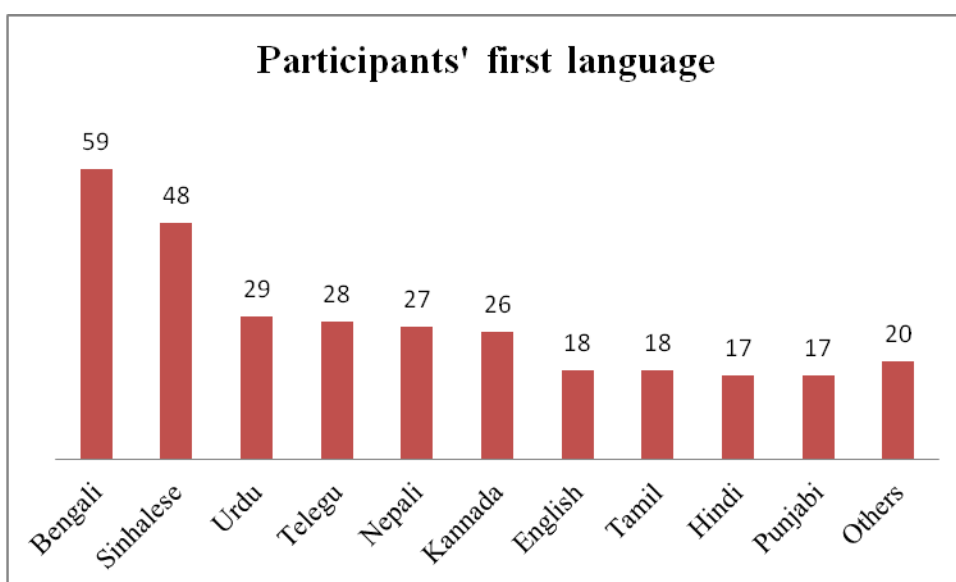
The sample consists of almost 79 percent married people, 19 percent single, 1 percent separated, approximately 1 percent divorced, and less than 1 percent widowed (Fig. 6). This indicates the cultural family-oriented perspectives of the South Asian immigrants.

Figure 6: Participants' marital status
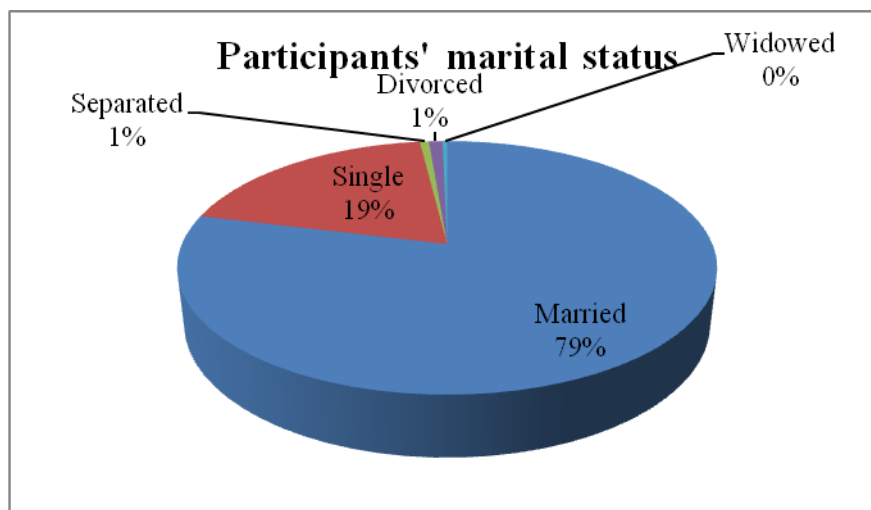
The participants are highly educated. Among them, 3 percent have PhDs, 5 percent have degrees in Medicine, 33 percent have a Master's, 35 percent have a Bachelor's, 19 percent have diploma/community college and the other 5 percent have high school diplomas (Fig. 38). Most of them have lived in Canada more than three years.

5.2   Self-rated Health Status

The self-rated health status of the participants was measured with the Likert scale as Excellent (5), Very Good (4), Good (3), Fair (2) and Poor (1). When entering into Canada more than 80 percent of the participants reported that their self-rated health was excellent or very good. However, after entering and living in Canada for varying periods of time, only 60 percent of the population reported their self-rated health as very good or excellent. Almost 47 percent had excellent health before coming to Canada, but after living here for a time that level declined to 26 percent. After coming to Canada the scale mean goes down to 3.73. Therefore health status declined and became more variable after some years in Canada.

Figure 7: Participants' self-rated health on entering Canada

Participants' self-rated health (on entering Canada)

Fair 2%
Poor 1%
Good 18%
Excellent 47%
Very good 32%
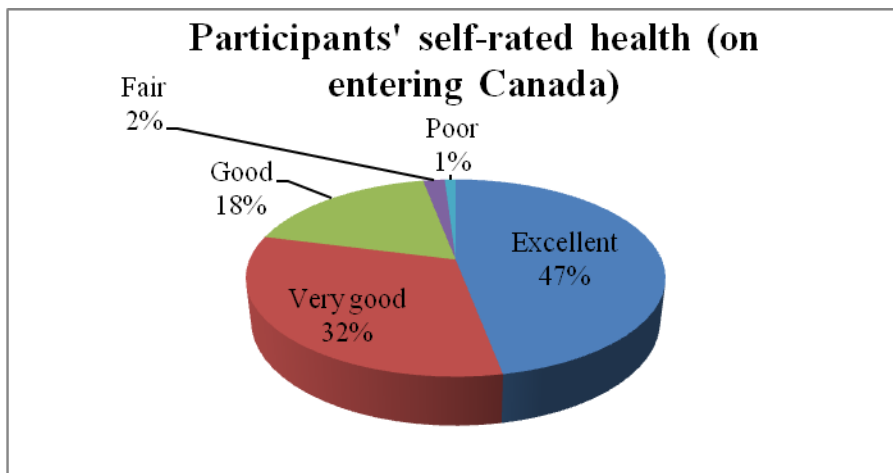
Figure 8: Participants' self-rated health after living less than 5 years in Canada

Participants' self-rated health living in Canada less than 5 years

Fair 10%
Poor 2%
Good 25%
Excellent 28%
Very good 35%
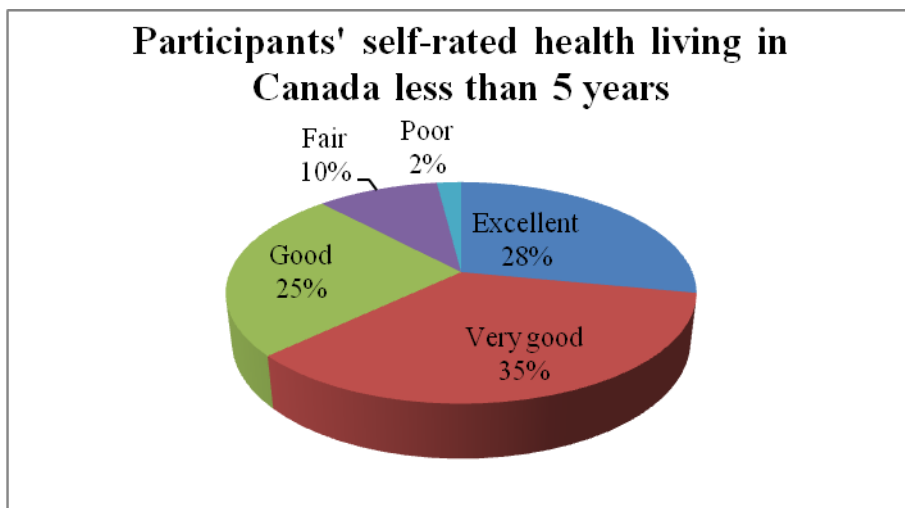
Figure 9: Particpants' self-rated health after living 5 years or more in Canada
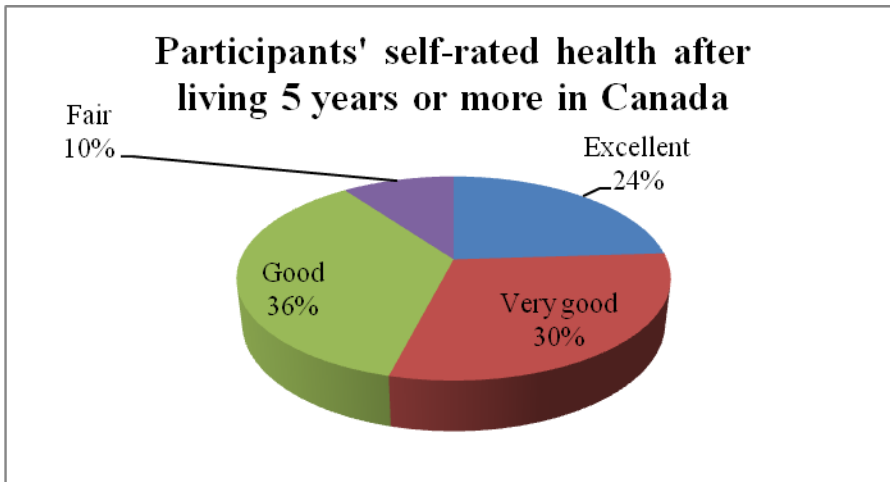
The results of the study show that the health of the population living in Canada less than five years (Fig. 8) is better than the population who have lived five years or longer in Canada (Fig. 9).

Table 7: Self-rated health of the participants using socio-economic factors

	Poor (%)	Fair (%)	Good (%)	Very good (%)	Excellent (%)	Sample size	% of sample
Gender							
Male	0.6	7.4	30.7	35	26.4	163	53.1
Female	0.7	12.5	32.6	28.5	25.7	144	46.9
Education							
PhD	00	00	12.5	50	37.5	8	2.6
Degrees in Medicine	00	00	14.3	42.9	42.9	14	4.6
Masters	00	7.8	35	35	22.3	103	33.6
Bachelor	0.9	10.2	28.9	33.6	26.1	107	34.8
Diploma/ Community	0	15.5	34.4	20.6	29.3	58	18.8
Others	5.8	11.7	41.1	23.5	17.6	17	5.5
Income (Monthly)							
Less than $1000	00	13.8	40	18.5	27.7	65	26
$1000 to $1999	1.5	10.4	37.3	26.9	23.9	67	26.8
$2000 to $2999	3.2	3.2	38.7	35.5	19.4	31	12.4
$ 3000 to $4999	00	9.8	34.1	31.7	24.4	41	16.4
$5000 to $6999	00	8.8	17.6	35.3	38.2	34	13.6
$7000 and up	00	00	25	50	25	12	4.8
Employment Status							
Full time	0.7	9.5	33.8	30.4	25.7	148	48.2
Part-time	2.3	11.6	30.2	20.9	34.9	43	14
Unemployed	00	8.3	31.2	33.3	27.1	48	15.6
Full-time Student	00	6.2	25	43.7	25	48	15.6
Others	00	20	35	35	10	20	6.5
Age							
18- 29	0.7	8.3	20.8	31.9	37.5	72	23.4
30- 49	0.5	9.1	33.8	31.7	24.7	186	60.6
50- 65	00	14.2	40.4	28.5	16.6	42	13.7
66+	00	14.2	28.5	57.1	00	07	2.3
Years in Canada							
Less than 5 years	1.5	9.9	25.1	35.1	28.3	131	42.6
5 years +	00	9.6	36.3	29.5	24.4	176	57.3

Table 7 shows that almost 16 percent of the participants are unemployed and another 14 percent are working part-time. Table also shows that more than 80 percent of the

participants are in the 18-49 age groups, those who are generally healthy and active in the workforce. It is also reflected that the monthly incomes of participants are very low although they are highly educated and in the active age groups.

5.3   General Settlement Support Services

Among the participants 42 percent acknowledged that they were informed by someone or some organization about the social support services and resettlement support services such as housing, employment, language training, education, access to health-care services, health care information, etc., available for immigrants for their resettlement in their new country. The results show that 58 percent were not informed, although in Ontario, as soon as the immigrant lands here, an immigration officer provides a brochure regarding settlement services available in the cities (Fig. 10). However, there is no health-related information brochure provided at the time of immigrants' landing. In addition, other than in Ontario no brochure was provided to earlier landed immigrants. Most of the immigrants reported that they were not informed about the settlement services. The explanation is that when they land in Canada they are very excited about having an easy quality of life with employment and opportunities. They have a preconceived picture about Canada that as soon as they are here opportunities and employments are waiting for them. At the same time they do not understand about the settlement services, why they need those and what kind of services they are; therefore, they do not even read those brochures.

Figure 10: Participants' reporting on being informed about the availability of social support services

Participants informed about social support services

Yes 42%

No 58%
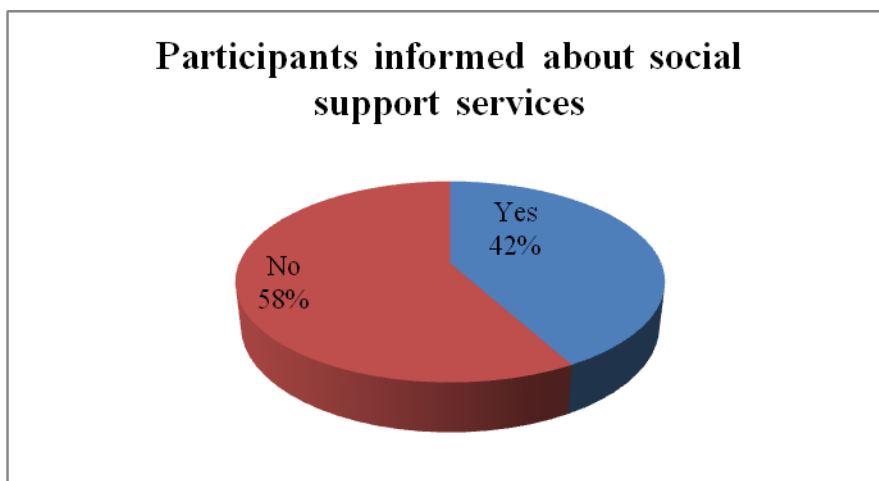
Figure 11: Participants who attended information session regarding the availability of social support services

Participants who attended social support services information session

Yes 27%

No 73%
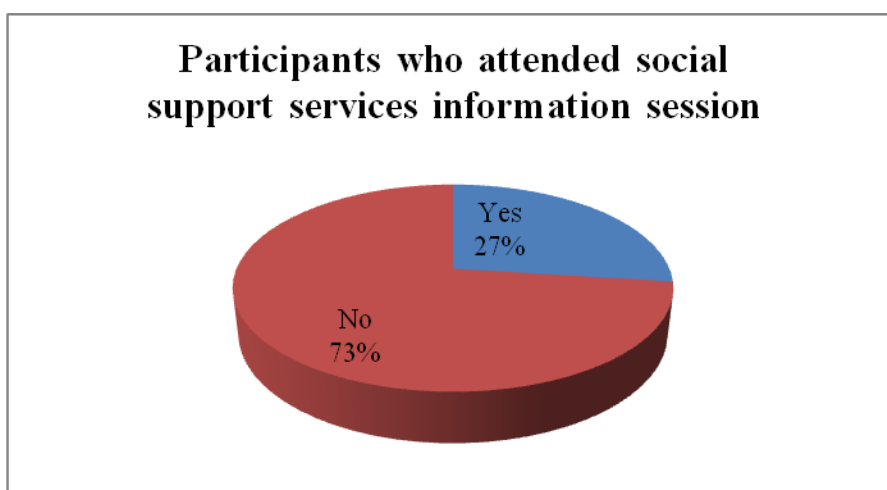
Only 27 percent of the newcomer immigrants attended any information session regarding the available social support services for settlement in the GTA (Fig. 11). Only 20 percent of the population received social support services in areas such as settlement, housing, information regarding services, and other basic needs in the GTA (Fig. 12).

Figure 12: Participants who received any form of social support services
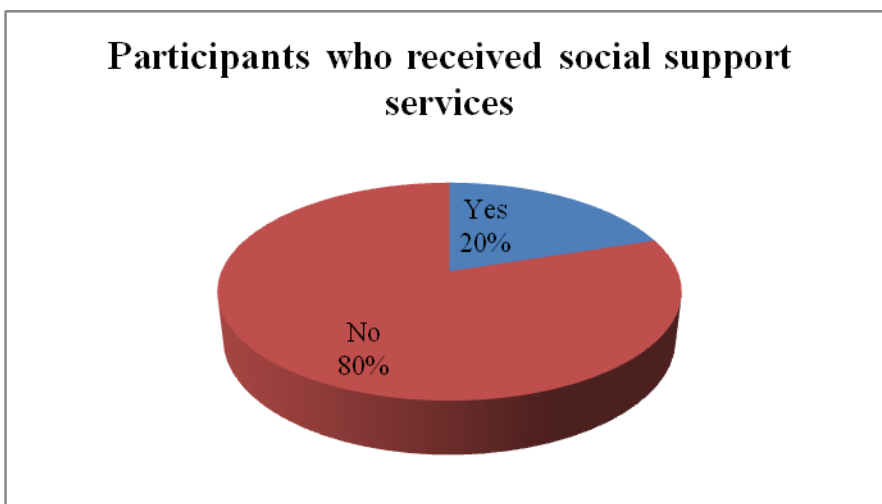
The general settlement support services for the immigrant population are very important for their resettlement in their host society. In the GTA, hundreds of neighborhood organizations, NGOs, the municipality's own support services and other organizations are working to help newcomers. However, the data show that a very small number of the population reported receiving social support services. Although 42 percent were informed by relatives, friends and or/any other person and/or any organization about the social support services available for their settlement in the GTA, only 27 percent attended any information session regarding this availability and only 20 percent received any social support services in the GTA. The data clearly show that the agencies failed to reach those people with their services; there may be a lack of communication between the immigrants and the service provider. Therefore, it can be said that there are problems/barriers to accessing or receiving the social support services or perhaps the services are not convenient to immigrants and/or the services are not sufficient for their needs.

 Only 30 percent of the participants attended Canadian official language classes after coming here to improve their communication skills. Although this percentage is not very high, it is a very good initiative on the part of the immigrants to gain valuable language training for their resettlement. However, among the population 41 percent of women went to the language proficiency class whereas only 20 percent of men attended. It is

important to note that only 68 percent of the sample had internet access immediately after they came to Canada.

5.4   Barriers/Challenges to Access to Health Care Services

5.4.1   Health Insurance and Services Information

South Asian populations have a home health-care system very different from Canada's. For example, in South Asia there are public health-care systems and private health-care systems. People can, at any time choose which one they want to use. The private health-care system is also affordable and readily available. In addition, there is less of a gate-keeping system in the South Asian health-care system. For anyone wishing to visit a specialist the choice is open and they can see a specialist directly. The Ontario health-care system, however, is very different from the South Asian one and is complicated to use from the South Asian population's perspective. It is very important to know the health-related information, where to go for services and how to use and navigate the system. From that perspective, health information is very important for the newcomers and their better health and well-being.

Many of the immigrants living in the GTA do not know the available health-care services and how the system works. The data also show that 30 percent of the participants do not know the needed information about the Ontario health-care services available to them (Fig. 13). Among the participants women are more informed about the available Ontario health care services than men.

Figure 13: Participants' knowledge of availability of health-care services

Participants' knowledge of available health care services

No 30%

Yes 70%
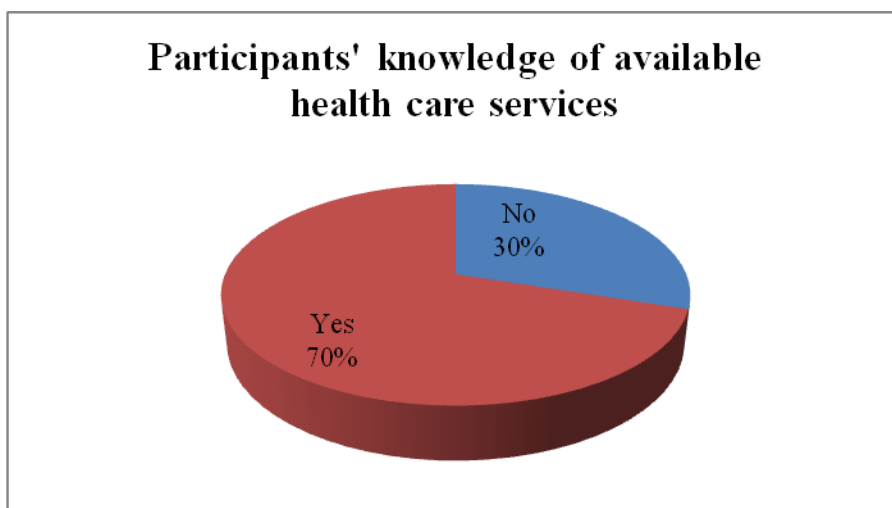
In addition, almost 25 percent of the participants do not have information about the Ontario health-care system (Fig. 14).

Figure 14: Participants' knowledge of Ontario health-care system

Participants' knowledge of health care system

No 25%

Yes 75%
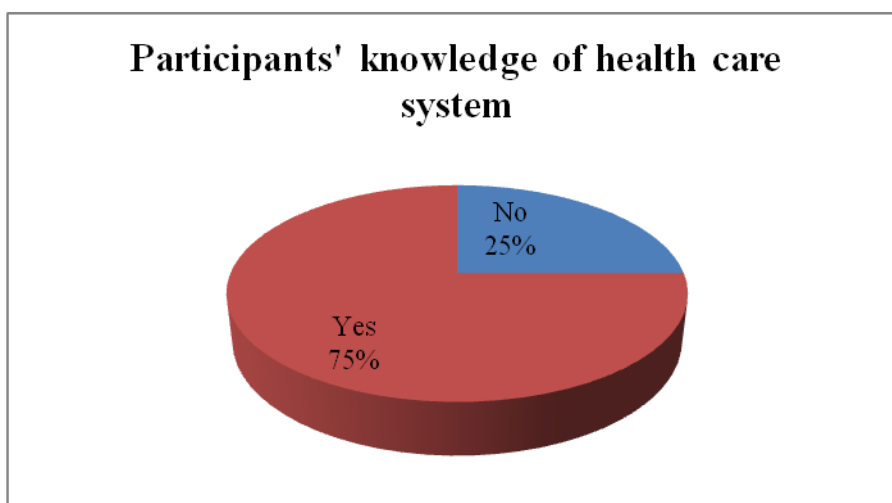
The data also show that 25 percent of the participants do not know how to use the Ontario health-care system (Fig.14). They do not know how to navigate the system, where to go for help and how they can get the expected help.

It is notable that 70 percent of the participants required health information or advice for themselves or their family members: 271 participants had visited family doctors; 129, dentists; 85, optometrists; 62, medical specialists; 17, chiropractors; 17, physiotherapists; 10, nurses; 8, psychologists and 16, and other medical professions during the last 12 months. The data also show that 21 percent of the participants experienced difficulties getting the health information or advice they needed (Fig. 15). Among them, women experienced more difficulties getting the health information or advice they needed.

Figure 15: Participants who experienced difficulties getting health information
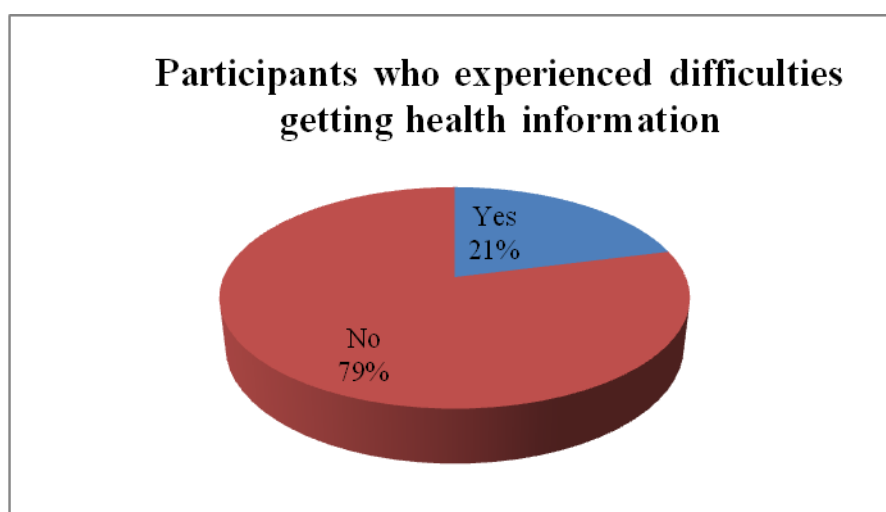
However, of those who had lived less than two years in Canada, almost 31 percent experienced difficulties getting the health information or advice they needed. Among the difficulties they experienced: 35 percent of the participants were not receiving adequate information; 28 percent waited a long time to speak to someone; 20 percent did not know where to go/call; 18 percent experienced problems contacting a physician or nurse; 8 percent could not get through or have their call answered; 3 percent did not have a telephone number to call; and others, 3 percent.

Figure 16 shows that 53 percent of the participants did not have non-medical extended health insurance such as insurance for prescription drugs, eye care and glasses, dental care, chiropractic and so on. Among them half of the men had extended health care insurance; however, only 42 percent of the women had extended non-medical health

insurance to support their prescription drugs, eye care, dental care and other services not covered by provincial health services.

Figure 16: Participants who had extended health insurance
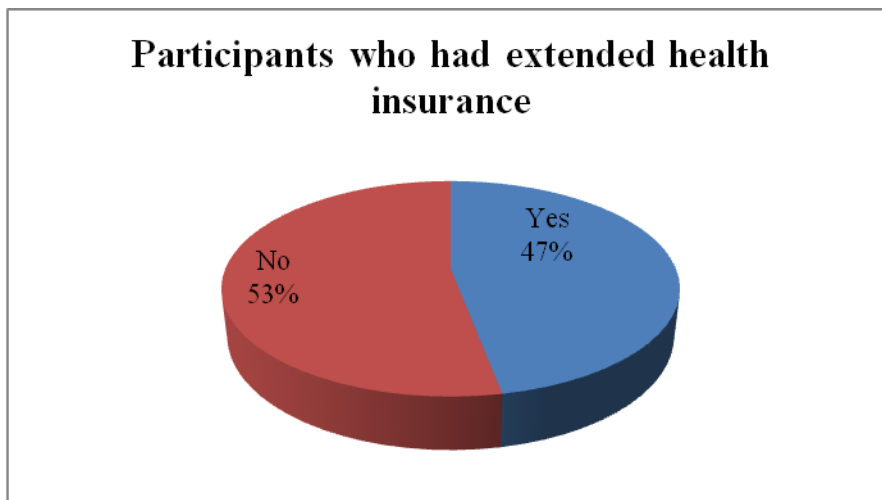
It is important to note that of the participants who had lived in Canada for less than 3 years, 85 percent did not have extended health insurance. In addition, 67 percent of the population believed that the costs of extended health insurance act as a barrier to accessing health care in the GTA (Fig. 17). This response did not change even from those who had lived more than 5 years in Canada.

Figure 17: Participants' perceptions regarding extended health insurance
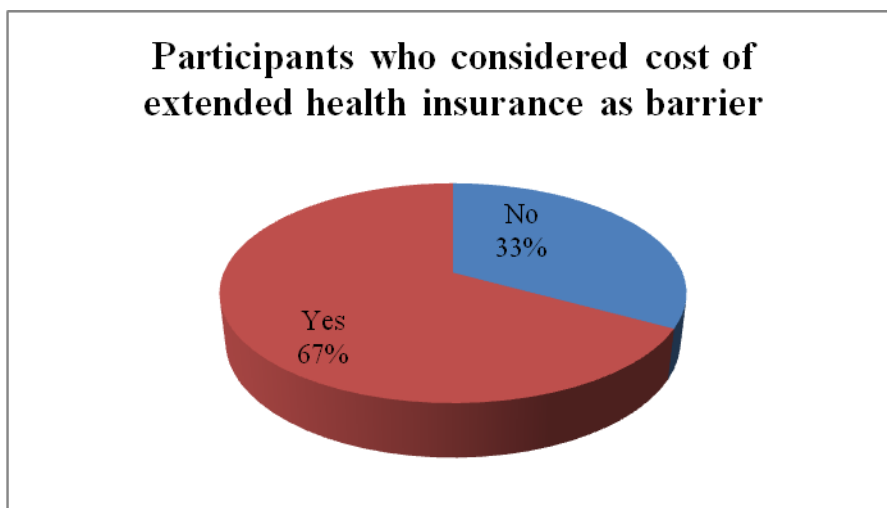
Among the sample, 30 percent needed to get and understand health information for better health and well-being.

5.4.2   Family Doctor

Among the participants, 84 percent had family doctors and 16 percent did not have a family doctor (Fig. 18).

Figure 18: Participants who had a family doctor
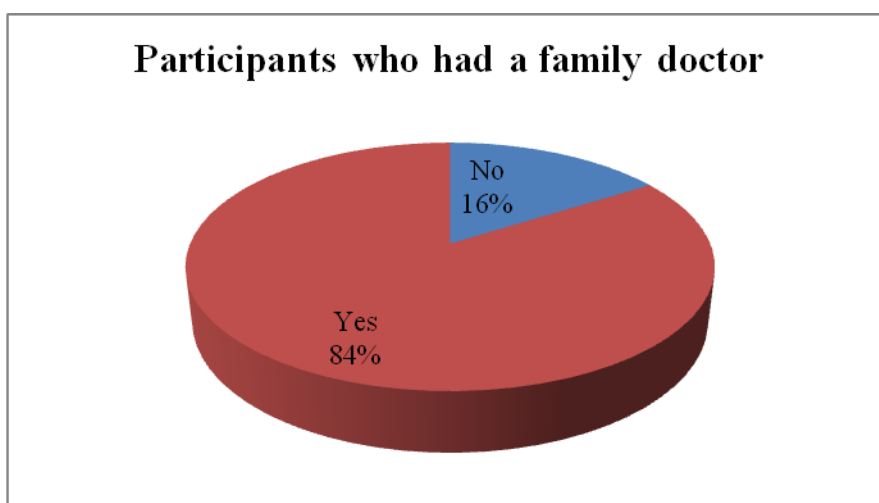
However, of those who had lived less than one year in Canada, 75 percent did not have a family doctor; of those who have lived in Canada less than 3 years, 40 percent did not have a family doctor. The family doctor is very important and the first step to health-care services in Canada. As the South Asian immigrants are not familiar with this very important gatekeeper of the health services, this becomes a barrier in their accessing health care. In addition, 38 percent of the South Asian immigrants waited to find a family doctor and the average waiting time was 11 months (Fig. 19).

Figure 19: Participants who had a lengthy wait for a family doctor
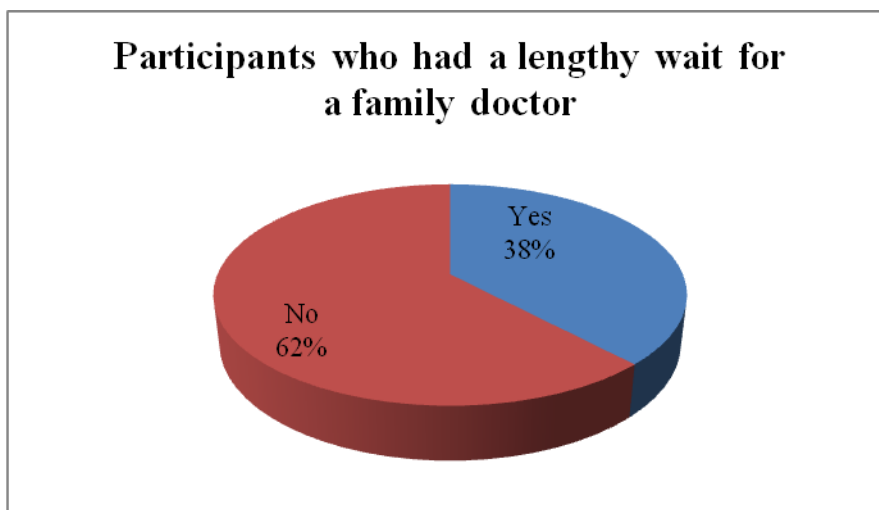
The percentages of immigrants who are waiting for a family doctor decrease as they live longer in Canada. Those who have lived in Canada less than one year, 63 percent; less than two years, 53 percent; less than three years, 48 percent; three to less than five years, 37 percent; and of those who have been in Canada for more than five years 35 percent waited for a family doctor in the GTA. It is very important to note that almost 36 percent of South Asian immigrants' family doctors know their mother tongue.

5.4.3   Language Barriers

Language and other communication barriers are very important elements in accessing health-care services. Among the participants (n=307), 16 percent experienced problems communicating with their doctors (Fig. 20). Among them women experienced higher challenges/barriers to communicating with their physicians.

Figure 20: Participants who experienced difficulties communicating with doctors
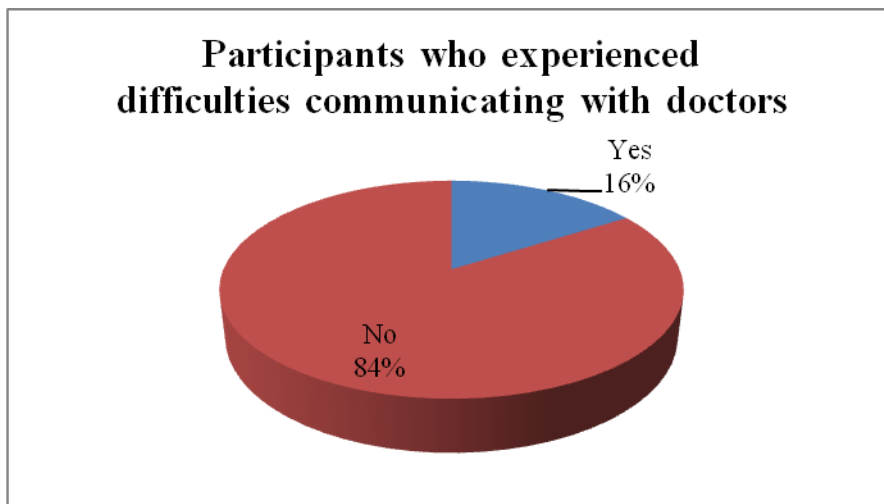
However, among the responders (n=260), 54 percent experienced language barriers when trying to get the routine or ongoing health-care services they needed (Fig. 21). Among them men experienced fewer challenges/barriers getting into a routine of ongoing health care.

Figure 21: Participants who experienced language barriers in general
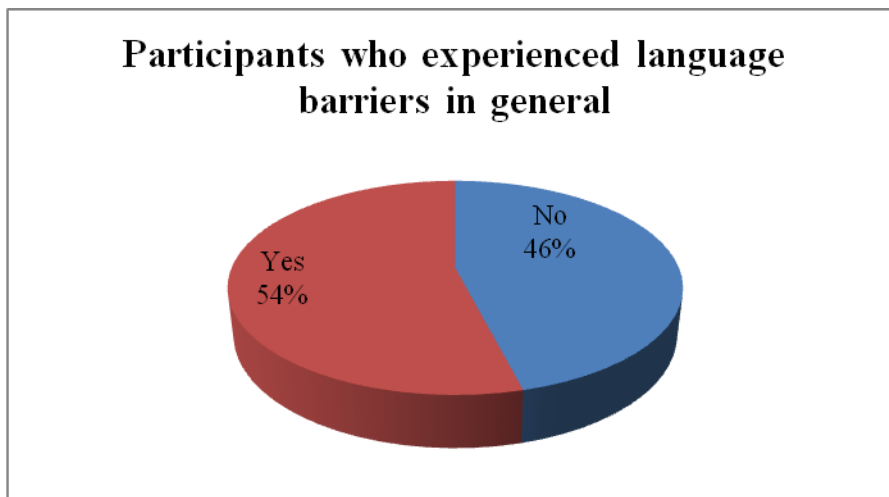
Of those who experienced barriers, 1 percent always experienced language barriers; 7 percent usually; 24 percent sometimes; and 22 percent rarely (Fig. 22).

Figure 22: Participants' experience of language barriers
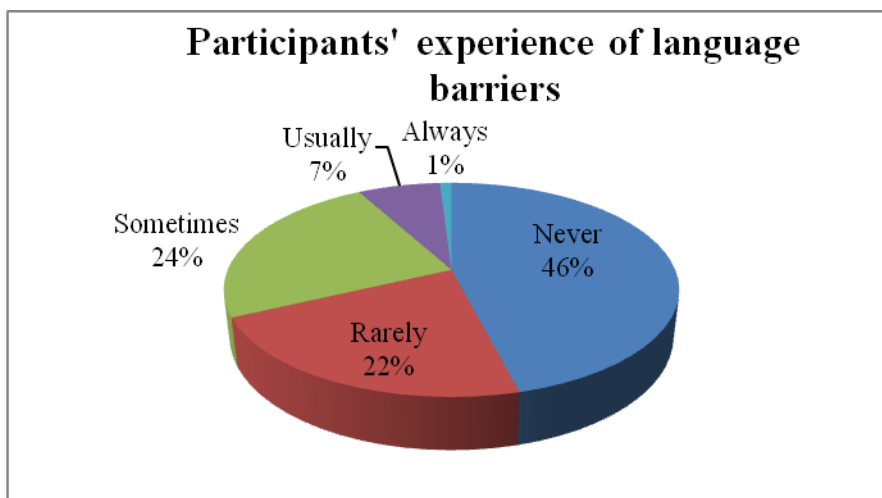
Those who had lived in Canada for more than five years improved their language ability. In addition, among the population 4 percent needed a translator to communicate with their doctors (Fig. 23). Women needed a translator more than men to communicate with their physicians.

Figure 23: Participants' information about using a translator
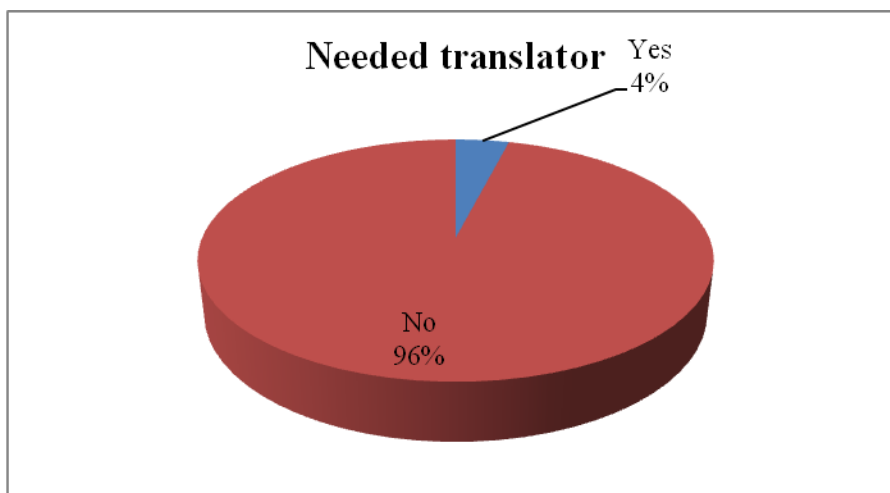
From the data, it is clear that the participants experienced language barriers in accessing health care services in the GTA.

5.4.4 Health Literacy

Health information and literacy are very important for accessing appropriate health care. More importantly, immigrant populations need proper information and literacy to access the Canadian health-care system as well as to communicate and interact with health professionals to get decisions about the health care they need. Among the participants, 26 percent responded that they did not know how to use the Ontario health-care system; women are less comfortable with how to use the system (Fig. 24).

Figure 24: Participants' familiar with how to use the Ontario health-care system
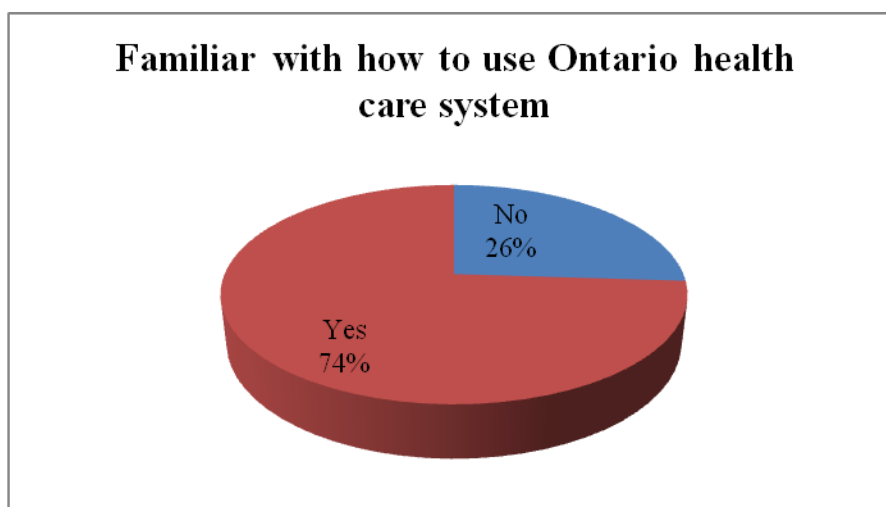
 In addition, of those who had lived less than three years in Canada, almost 41 percent did not know how to use the Ontario health-care system. This response is alarming. If someone has lived for almost three years in Canada and does not know how to use the health-care system, this is a very important barrier to accessing health care.

Among the participants 92 percent understood their physicians' instructions and directions and only 8 percent had problems (Fig. 25).

Figure 25: Participants' understanding of physicians' instructions and directions
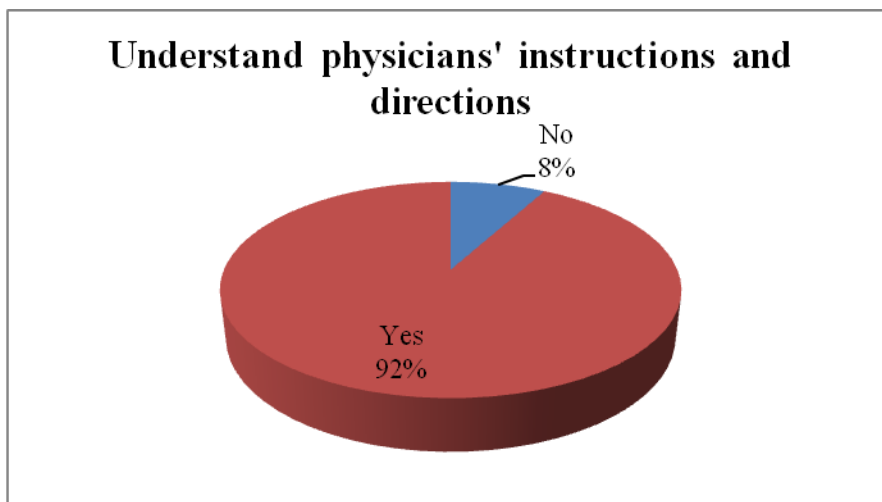
It is a concern that 17 percent do not know the basic information and services needed for making appropriate decisions about their personal health (Fig. 26).

Figure 26: Participants' understanding of basic health-care information
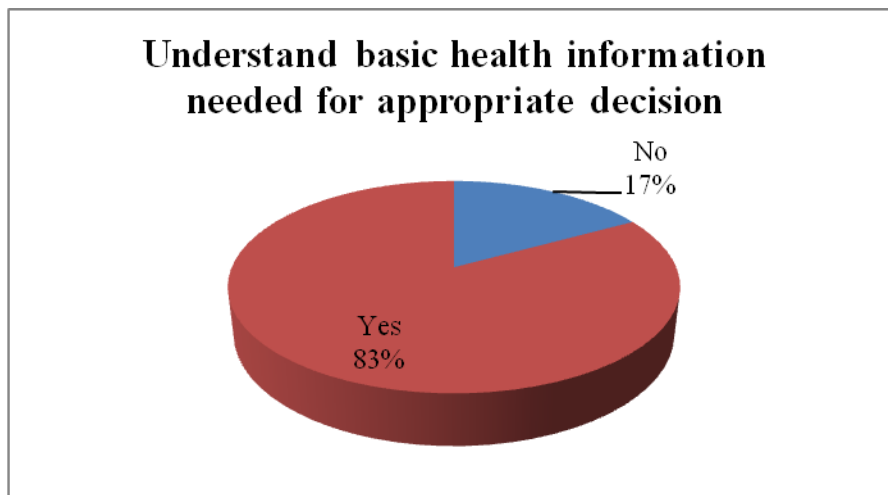
The participants also responded that 13 percent were not able to communicate effectively with their physicians to get information about their health (Fig. 27); 17 percent of women were not able to communicate effectively with their physicians to get information about their health.

Figure 27: Participants' ability to communicate effectively
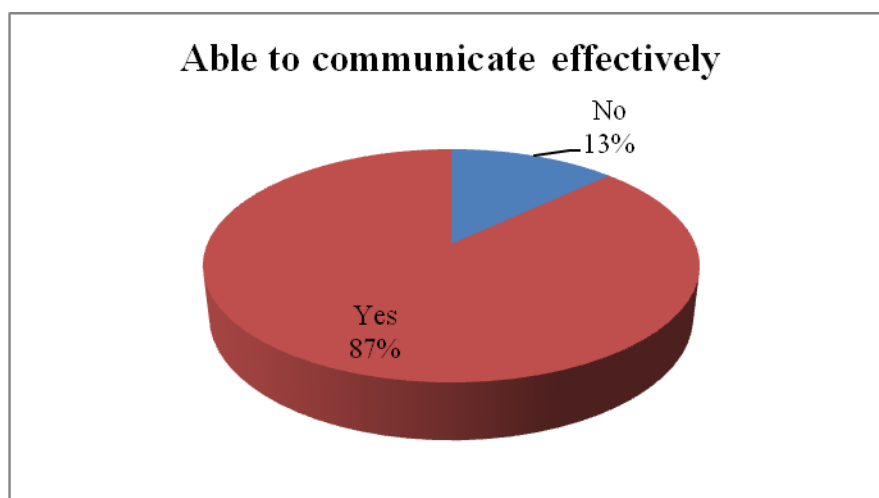
However, of those who have lived less than three years in Canada almost 21 percent are not able to communicate effectively to get information about their health. The data show that almost 25 percent of the population are not familiar with how to use the Ontario health-care system and do not know the basic information and services needed for making appropriate decisions about their personal health.

5.4.5   Culture and Tradition

Culture and tradition play an important role in getting appropriate health-care services. If the physicians and nurses understand the patient's traditions and cultural values, it becomes comfortable for both sides to communicate effectively with respect. This helps to understand the health concerns and provide the appropriate services. It is important to mention that 54 percent of the participants thought that different socio-culturally-based understanding about health and health care is a barrier to culturally appropriate health care (Fig. 28).

Figure 28: Socio-culturally-based understanding about health and health care as a barrier

Socio-culturally-based understanding about health as a barrier

No 46%

Yes 54%
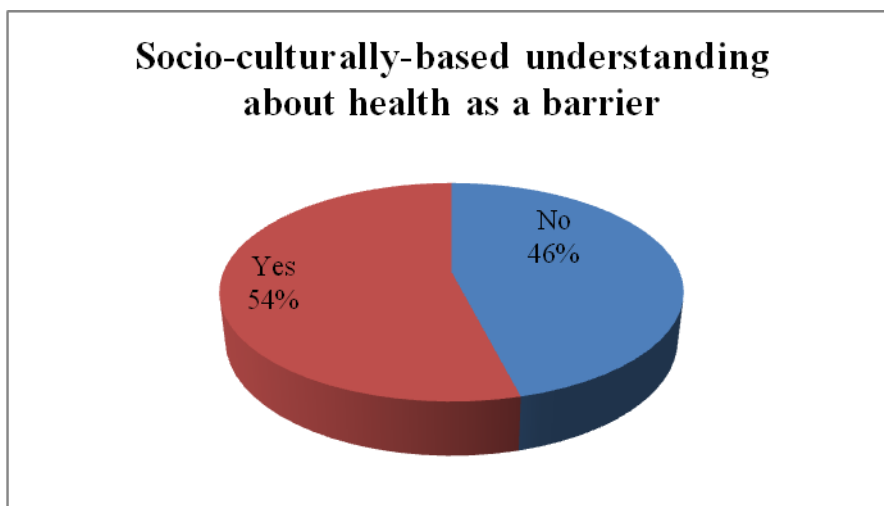
Among the participants (n= 307), 21 percent's perception about physicians' understanding of participants' health-related cultural beliefs is that their physicians do not understand their health-related cultural beliefs (Fig. 29).

Figure 29: Perception of respondents about understanding of physicians regarding health-related cultural beliefs

Perception of respondents about understanding of physicians regarding health-related cultural beliefs

No 21%

Yes 79%
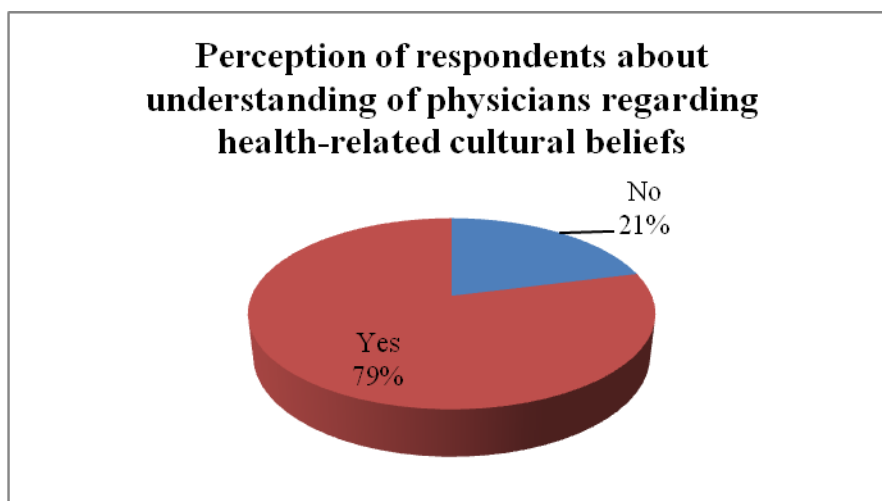
Almost 15 percent's perception about physicians' respect for participants' traditions, beliefs and customs is that their physician did not respect their traditional health-related beliefs and customs (Fig. 30).

Figure 30: Perception of respondents about understanding of physicians regarding respect of participants' traditional beliefs and customs
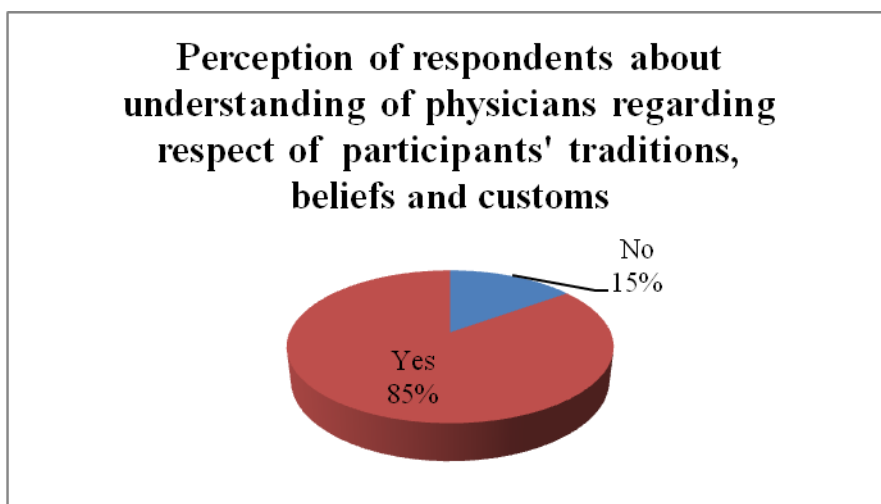
In addition, 21 percent who had lived less than three years in Canada think that their physicians do not respect their health-related traditional beliefs and customs.

To better explain the non-respect of their health-related tradition beliefs and customs, 36 percent of the population responded that they were not comfortable being touched/examined by opposite-gender nurses/physicians (Fig. 31). Among them 45 percent of the women reported that they were not comfortable.

Figure 31: Participants' feelings of comfort being touched by opposite-sex physicians
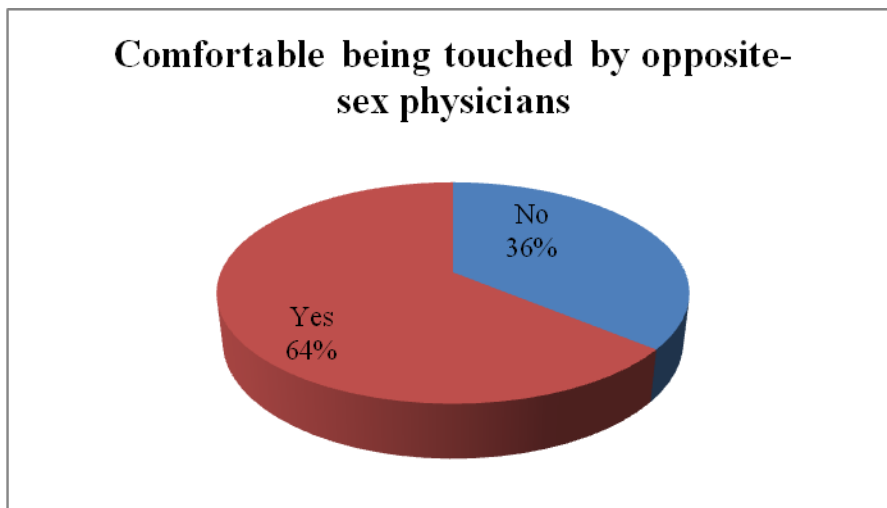
To better indicate the non-respect of their health-related traditions, beliefs, and customs, 43 percent of the population (Fig. 32) and 57 percent of women responded that they were not comfortable being touched/examined on their private body parts, if necessary, by a health provider of the opposite sex. Some people, therefore, are not prepared to face this situation.

Figure 32: Participants' level of comfort being touched on their private body parts by opposite-sex physicians
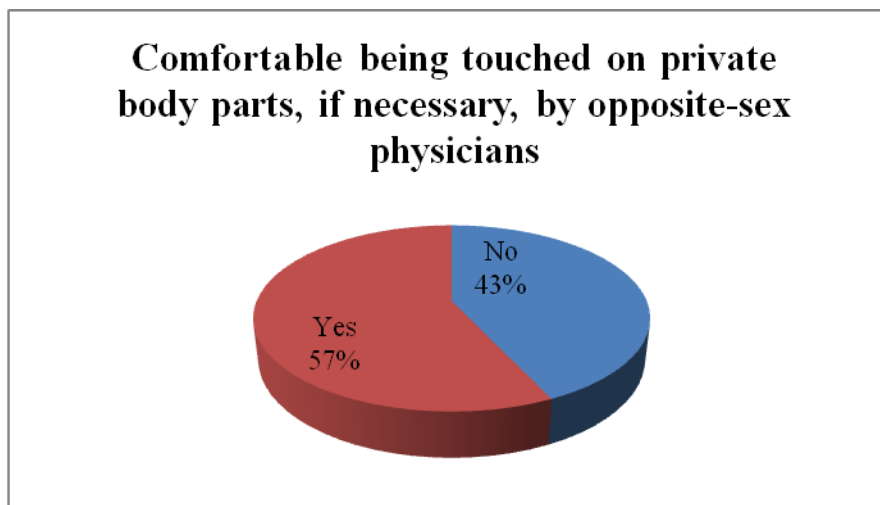
Another cultural phenomenon of the South Asian population is that 56 percent responded that their family members influenced their health decisions (Fig. 33).

Figure 33: Family members' influence on health decisions
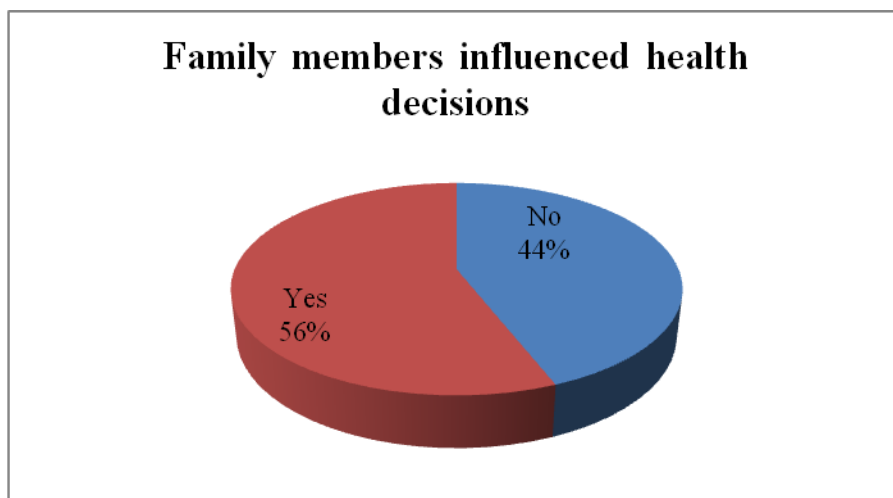
The data shows that 22 percent responded that Canadian allopathic medicines are not adequate to treat their health care needs and services (Fig. 34). They believe that Canadian/allopathic medicines have side effects.

Figure 34: Adequacy of Canadian medicine for health-care needs
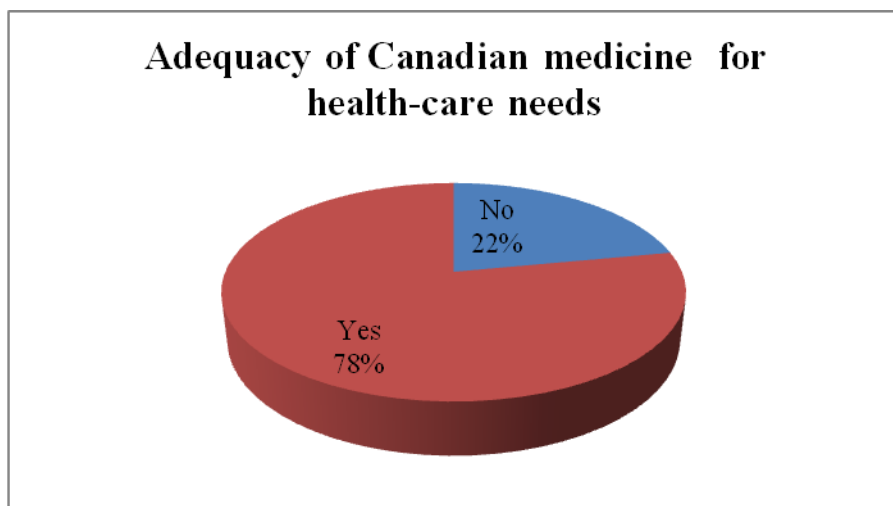
Another 27 percent of the population use culturally-specific (e.g. vaids, homeopaths, naturopaths, unani, and tantric) alternative medicines for their health-care needs (Fig. 35).

Figure 35: Participants' use of culturally-specific medicines
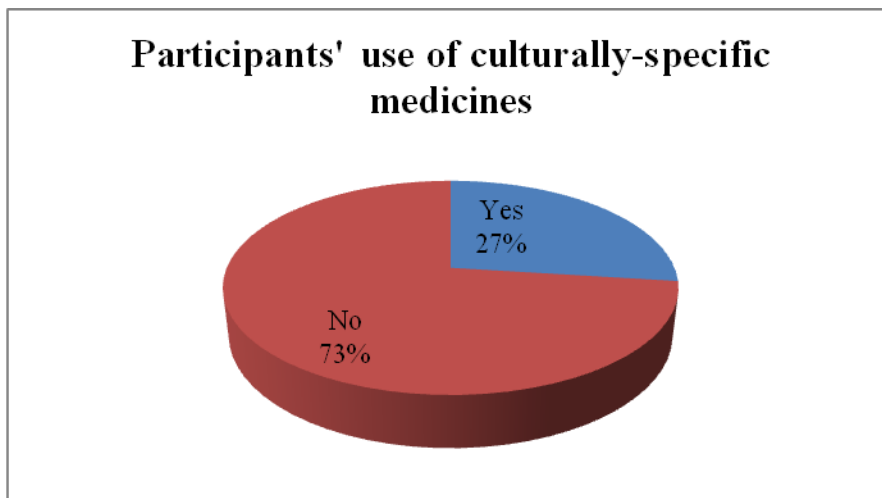
 Participants use culturally-specific medicines because they believe they are harmless and more effective. The research also shows that some people use culture-specific medicine because of easy availability.

The results show that cross-cultural differences, socio-cultural understanding of health care system, cultural perspectives, customs, religious beliefs and traditional norms of the population and their previous experiences acted as barriers to accessing the appropriate health-care services.

5.4.6   Geographic Accessibility

Almost 89 percent of participants have access to health-care services in their neighborhood (Fig. 36) and 31 percent own a personal/family vehicle.

Figure 36: Health services available to participants in their neighborhood
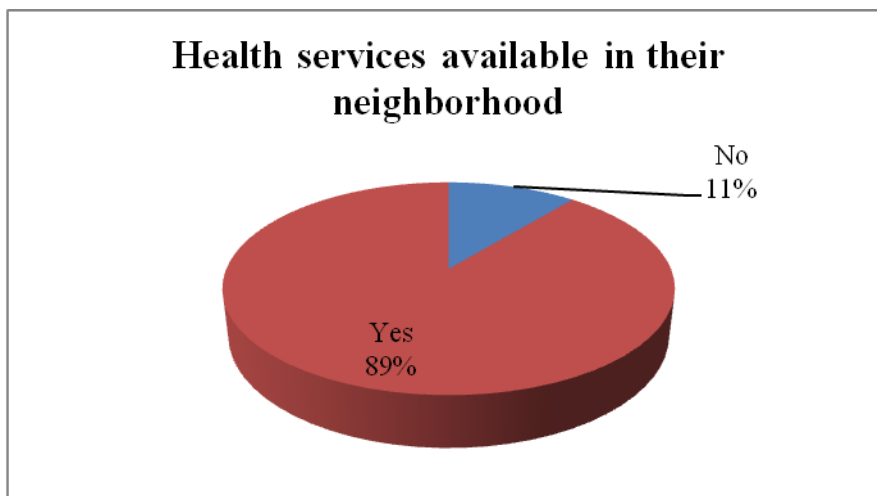
However, it is important to note that 20 percent of the participants responded that transportation difficulties prevent their access to health care (Fig. 37). The data also show that 61 percent use a personal/family vehicle; 29 percent use public transport; 18 percent walk; 8 percent use taxis; and the rest of the population ride with friends/relatives, or use bicycle and other methods.

Figure 37: Participants who faced transportation difficulties in accessing health care
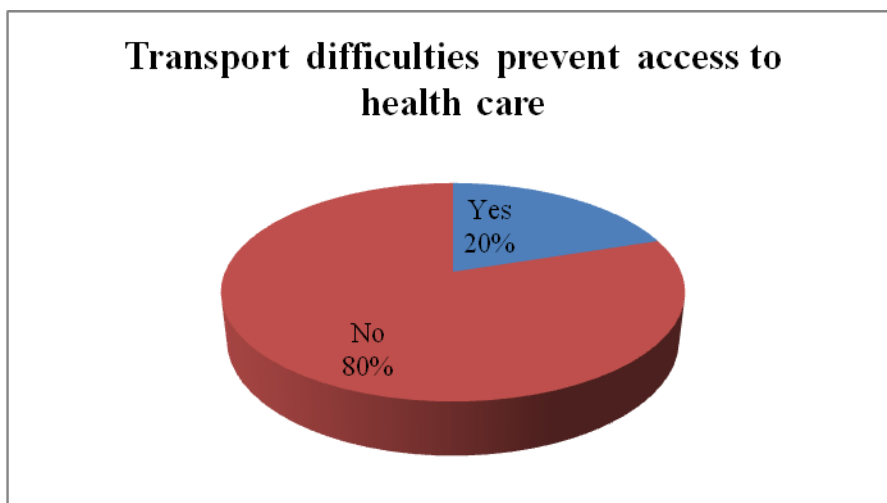
The data shows that geographic accessibility is not a barrier for the majority to accessing health care in the GTA.

5.4.7 Education and Employment

5.4.7.1 Education Status

The participants (n=307) are highly educated. Among the participants 3 percent have PhDs, 5 percent have degrees in Medicine, 33 percent have a Master's, 35 percent have a Bachelor's, 19 percent have diploma/community college diplomas and the other 5 percent have a high school diploma (Fig. 38). The data also show that the women had more general education whereas men had more engineering degrees.

Figure 38: Participants' educational status
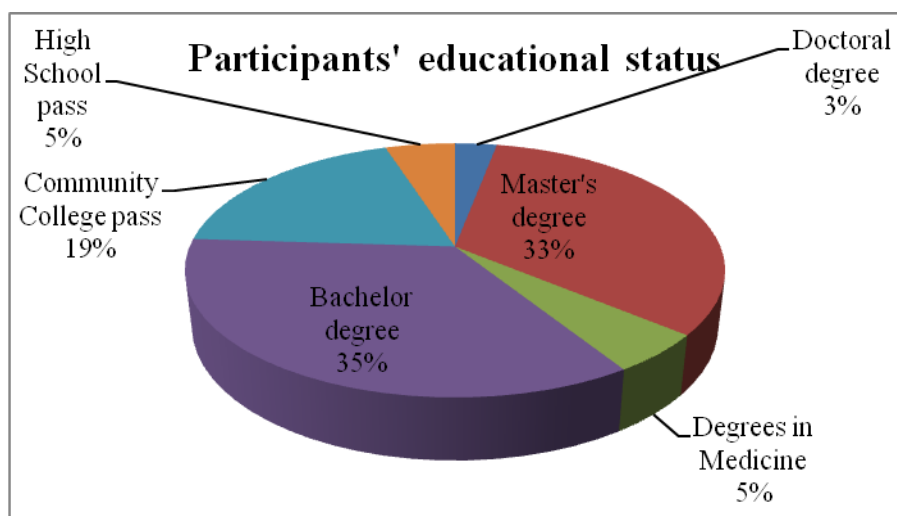
The data also show that 70 percent of the participants obtained their degrees from South Asia; 22 percent from Canada/USA; 5 percent from South Asia and Canada; 2 percent from other countries such as the UK, Russia and Thailand; and 1 percent from other places and Canada /USA (Fig. 39).

Figure 39: Countries where participants obtained degrees
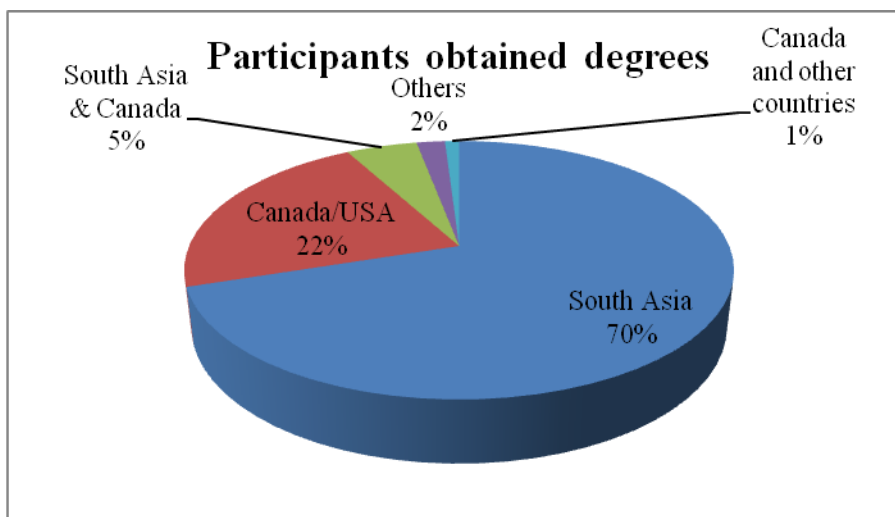
It is very important to note that almost 44 percent of the participants responded that their degrees/diplomas are not recognized in Canada (Fig. 40).

Figure 40: Participants' degrees recognized in Canada
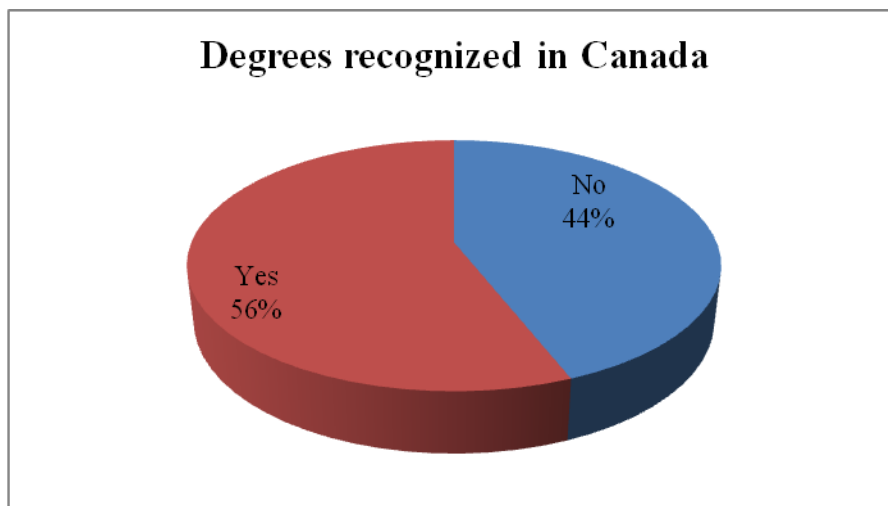
In the case of professional degrees, 57 percent responded that their degrees are not recognized in Canada (Fig. 41) and those who reported that their degrees are recognized also reported that their degrees are not treated as equal to Canadian/USA degrees.

Figure 41: Professional degrees recognized in Canada

Professional degrees recognized in Canada

Yes 43%
No 57%
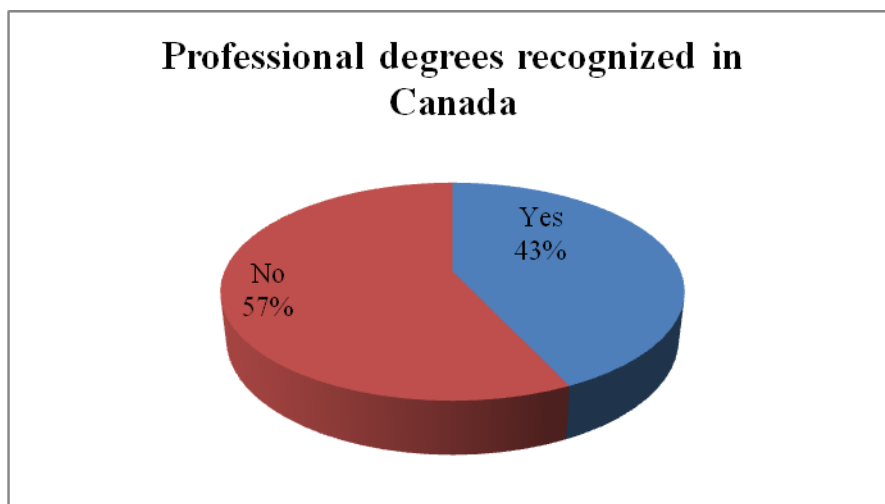
5.4.7.2   Employment Status, Experience and Skills Recognition

As discussed in an earlier section, more than half of the participants' degrees obtained outside Canada/USA are not recognized. In addition, 59 percent responded that the skills and experience they obtained outside Canada/USA are not recognized by the employers in Canada (Fig. 42).

Figure 42: Outside experience and skills of participants recognized in Canada

Outside experience and skills recognized in Canada

Yes 41%
No 59%
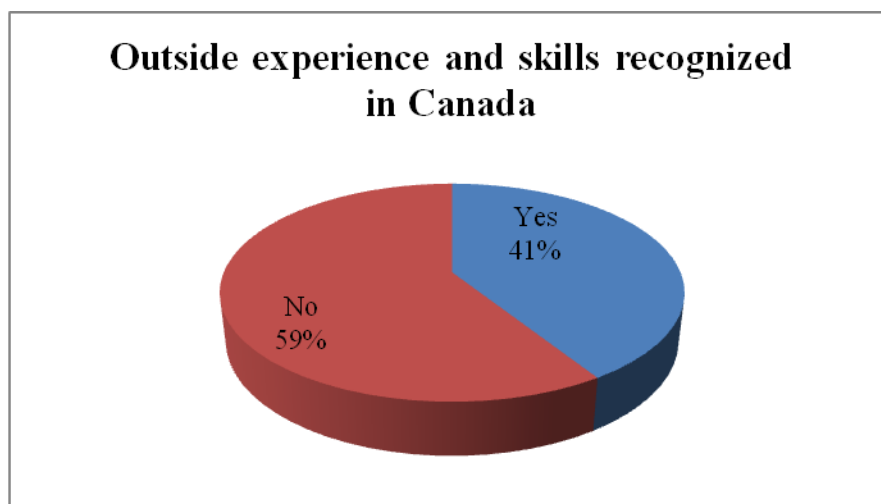
Furthermore, 66 percent experienced difficulties in finding any employment in the GTA

(Fig. 43).

Figure 43: Participants who experienced difficulties finding employment
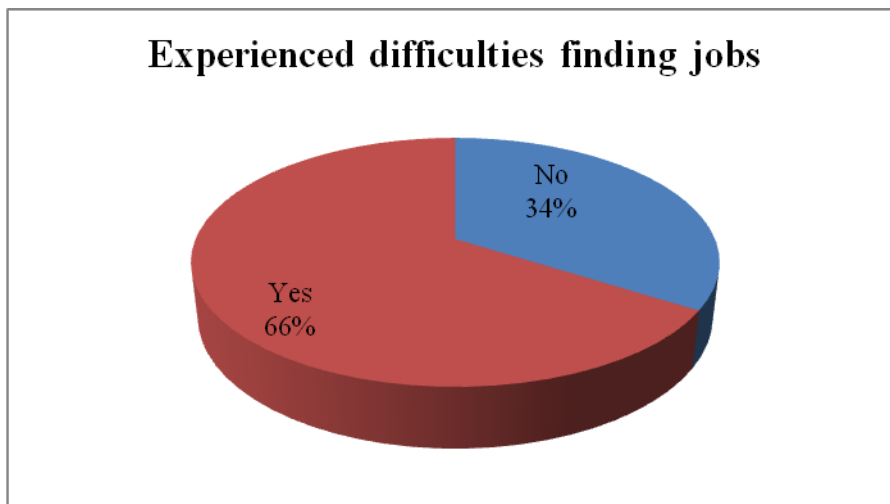
The unemployment rate of the participants (n=307) is very high. Only 48 percent of the participants are working full-time, 16 percent are unemployed, and 14 percent part-time employed (Fig. 44), and their working length mean is 5.57 years. The Median is 4.00, and the Std. Deviation is 5.84. Among them, only 33 percent of women are employed full-time.

Figure 44: Participants' employment status
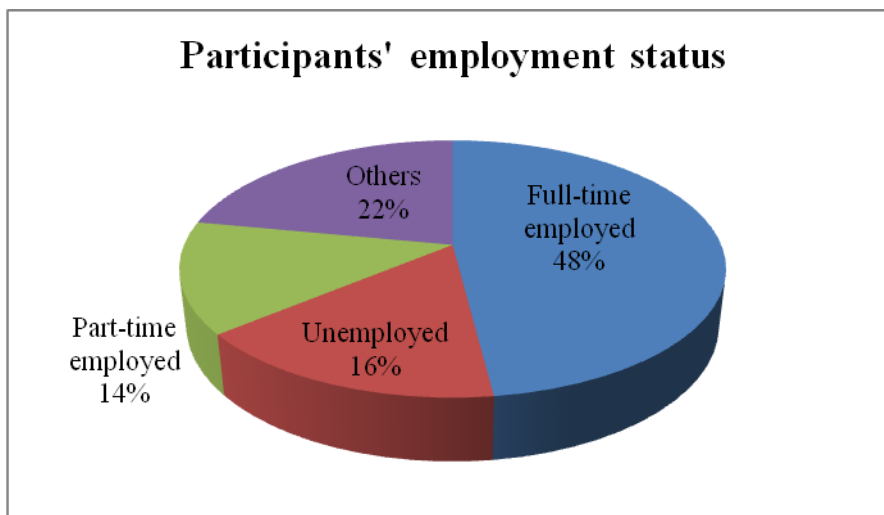
Whereas the Canadian national average of unemployment rate is only 7 percent, almost 16 percent of the South Asian population is unemployed and 14 percent are employed part-time. Among them 21 percent of women are unemployed. Those who are looking for full-time employment are highly educated, under 50 years of age and in good health. They are working part-time because their degrees, experience and skills are not recognized here in Canada. In addition, 50 percent reported that their jobs do not match with their qualifications (Fig. 45).

Figure 45: Participants' jobs do not match with their qualifications
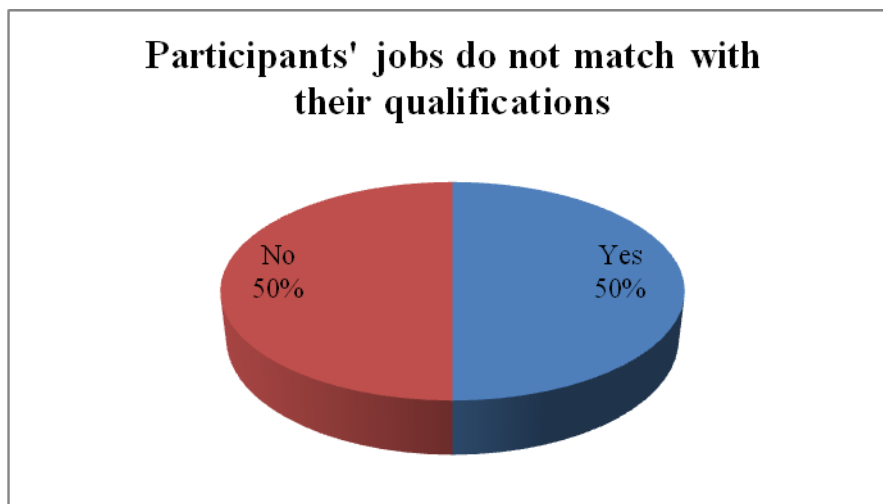
Only 36 percent are working in the same profession/field as they did prior to immigrating to Canada (Fig. 46) and only 25 percent of women are working in the same profession.

Figure 46: Participants working in the same profession after entering Canada
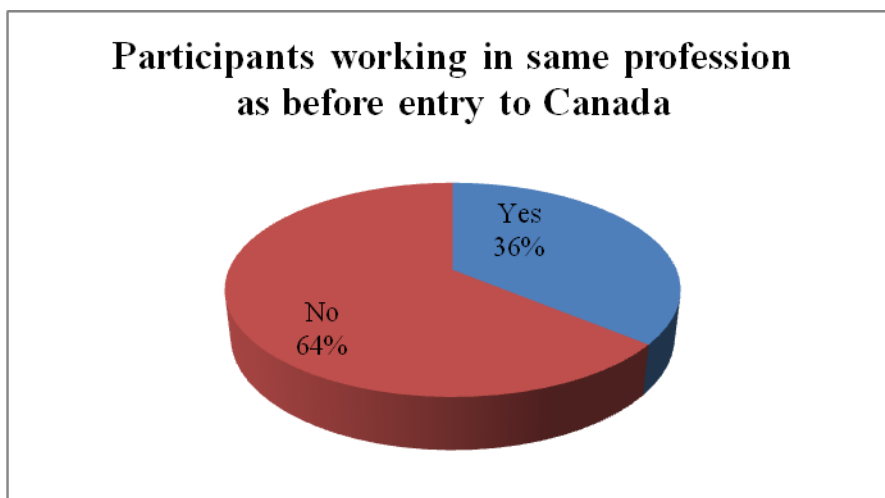
They also responded that almost 63 percent think that their credentials are undervalued by employers (Fig. 47).

Figure 47: Participants' degrees undervalued by employers
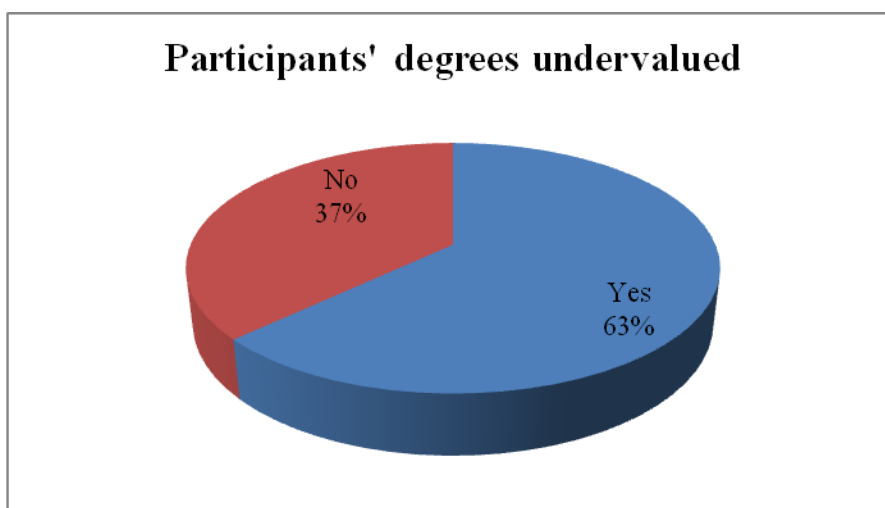
5.4.7.3   Effects of Underemployment

As a result of their underemployment, immigrants are facing tremendous negative consequences that affect their health status directly and their mental health as well. Furthermore, among the population 35 percent reported their dissatisfaction with employment; 23 percent were neither satisfied nor dissatisfied. More than 65 percent of the participants (Table 8) reported that their underemployment has increased their unhappiness, frustration, anxiety, or depression. Among the participants more than 70 percent of women reported unhappiness, frustration, anxiety, or depression regarding their underemployment. This depression, unhappiness, frustration and anxiety affect their mental health and cause further deterioration of their everyday life. The results also show that underemployment affects women more than men.

Table 8: Effects of underemployment

	Effects of underemployment (Yes) %	% Women	% Men
Unhappiness	74.9	79.5	71.3
Frustration	71.1	78	66.1
Anxiety	66.2	73.8	60.6
Depression	64.3	72.8	57.8

5.4.7.4   Income of the Participants

The monthly income of the participants (n=250) is very low. Almost 48 percent of the population responded that they are working full-time; the rest of them are working part-time. The only exception was in cases of the less-than-$1000-per-month category; in this category most were working part-time and others were working full-time; the 10 participants who responded were working full-time. The women's income is far less than the men's: most of the women's income was less than $2000 per month.

Figure 48: Participants' personal monthly income
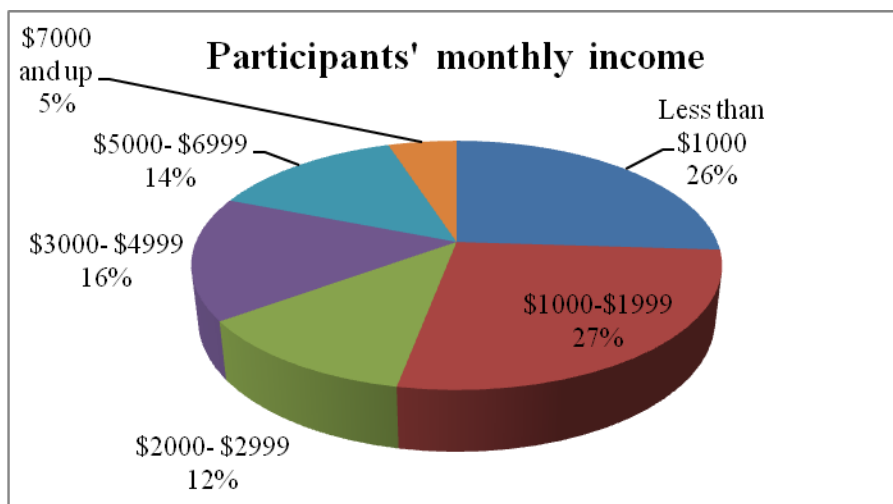
Among the population almost 26 percent of the population earned less than $1000 per month; 27 percent earned $1000 to less than $2000 per month; 12 percent earned from $2000 to less than $3000; 16 percent earned $3000 to less than $5000; 14 percent earned $5000 to less than $7000; and only 5 percent earned more than $7000 per month (Fig. 48).

It is important to note that 65 percent of the respondents have an income of less than $3000 per month. Their situation has improved very little; for those who have lived for less than 1 year in Canada 92 percent's monthly income is less than $3000; 93 percent for those who have lived less than two years in Canada; 89 percent who have lived less than three years in Canada; 77 percent who have lived more than three years in Canada but less than 5 years in Canada and 50 percent, those who have lived longer than 5 years in Canada. The household income of the sample (304) is very low; 53 percent's income is less than $40,000 per annum and 69 percent's income is less than $60,000 per annum; of those who have lived more than 5 years in Canada, almost 55 percent's income is less than $60,000 per annum.

The household data of the population (n=304) show that for 31 percent, household income is less than $20,000 per annum; 22 percent earned from $20,000 to less than

$40,000; 16 percent earned $40,000 to less than $60,000; 12 percent earned from $60,000 to $80,000; and 19 percent earned more than $80,000 (Fig. 49).

Figure 49: Participants' annual household income
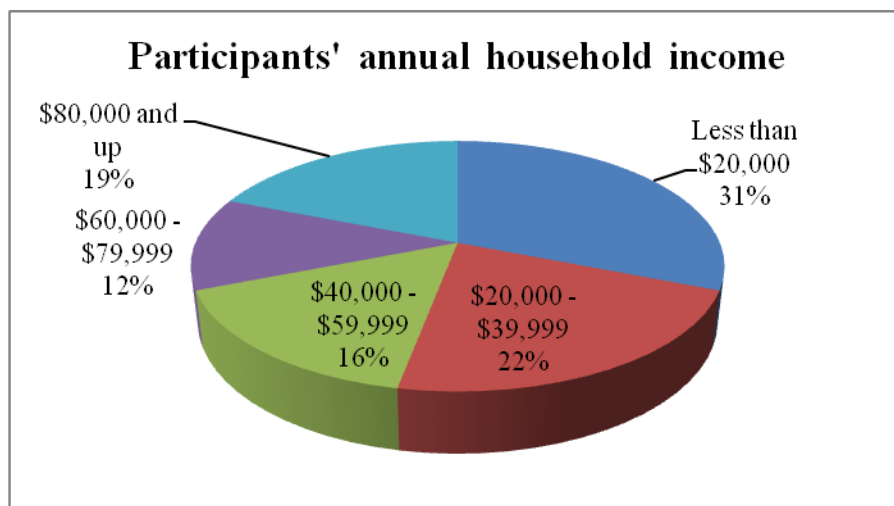
Education and employment are very important elements of better health and well-being. This research suggests that a significant number of the population's degrees, skills and experience obtained outside Canada/USA are not recognized in Canada. They cannot even apply for better employment opportunities, but remain working in minimum wage jobs. Their education and skills are misused and lost. As a result, they are unemployed, underemployed and although wishing to work full-time, can work only part-time. Furthermore, those who have a lower income are not able to obtain extended health care such as dental, eye care, vision care and so on. Therefore, the participants face tremendous pressure regarding their education and employment opportunities, which is reflected in their personal as well as their household income.

5.5   Daily Activities of the Participants

The data show that more than 70 percent of participants reported that their health does not limit their daily activities such as grocery shopping, nor does it limit their social activities such as getting together with family, friends, neighbors or groups; it does not

limit their recreational activities such as hobbies; and it does not limit their household activities such as household chores.

5.6   Capability and Freedom

The data shows that nearly half of the participants are somewhat satisfied with their life in general (Fig. 50); however, women are less satisfied than men.

Figure 50: Satisfaction level of the participants in Canada
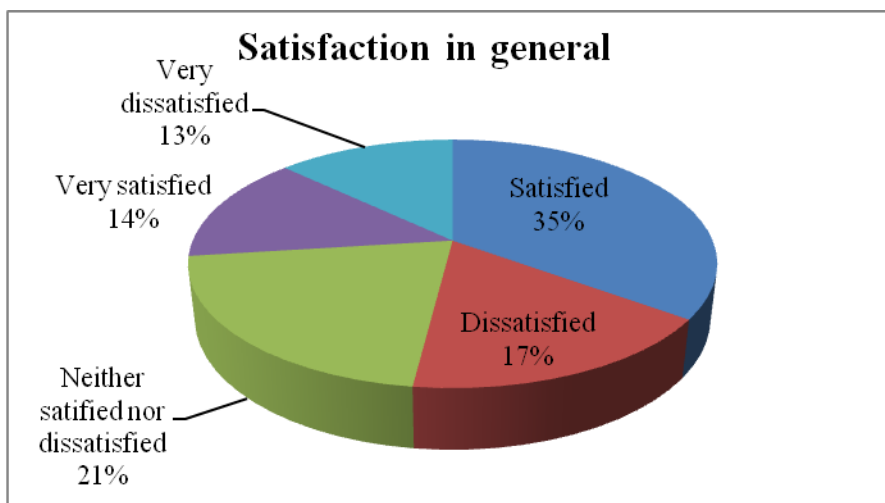
However, 91 percent of the population reported that in everyday life they have stress (Figure 51); among them women have more stress than men.

Figure 51: Everyday stress of the participants

Everyday stress in life

To a great extent 7%
Not at all 9%
Quite a bit 23%
A little bit 20%
To some extent 41%
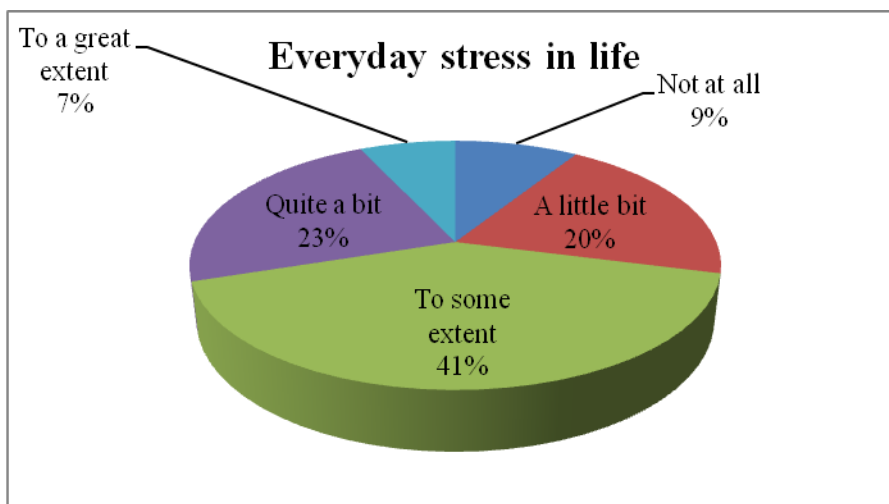
People from different countries immigrate to Canada to live a better life. They want to enjoy culture and society and to achieve the capabilities and freedom of leading the kind of life they have reason to value. However, the barriers to accessing health care and other challenges limit their ability to achieve their quality of life. Among the sample 73 percent (N=307) responded that they are not living the quality of life they were expecting in Canada (Fig. 52).

Figure 52: Expected quality of life participants are living in Canada

Living the quality of life as expected

To a great extent 13%
Quite a bit 14%
Not at all 22%
To some extent 29%
A little bit 22%
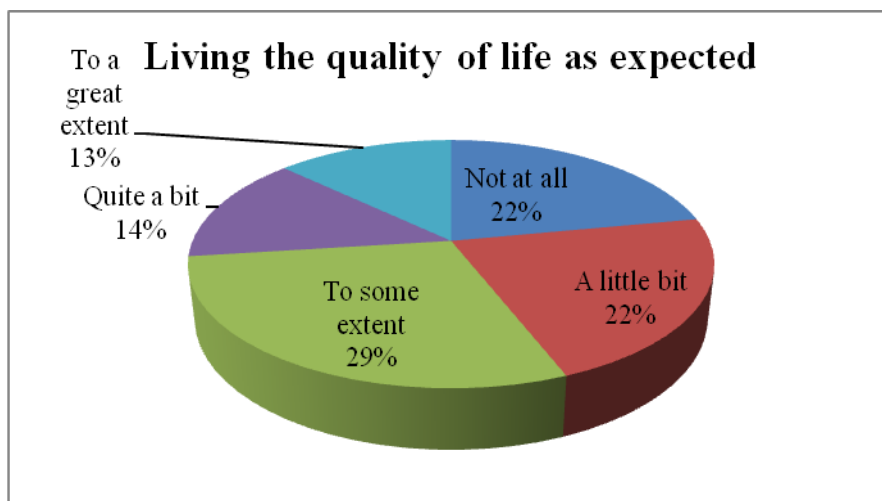
However, the majority of the participants think that their socio-economic situation does not limit their achieving self-esteem (Fig. 53).

Figure 53: Limiting self-esteem
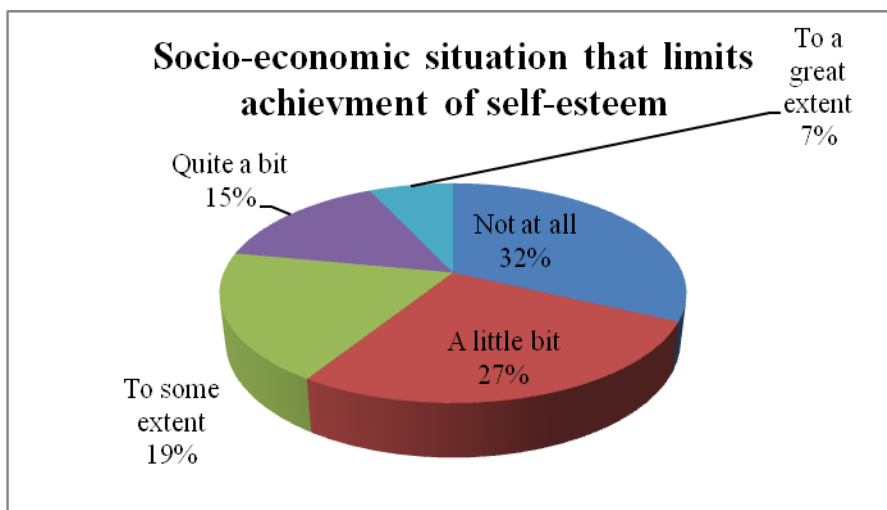
The data also show that among the population, the majority responded that their current situation does not limit achieving the respect of family, groups and community (Fig. 54).

Figure 54: Current situation Limits achievement of respect
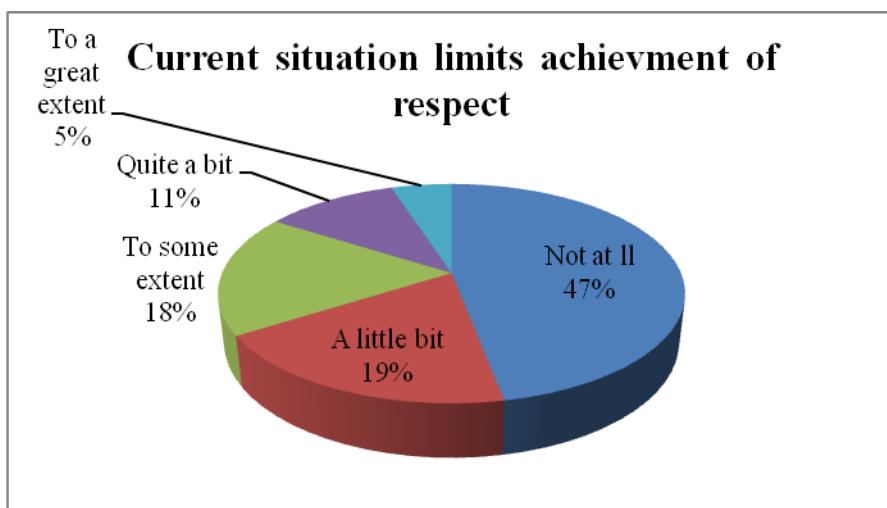
However, it is very important to note that the majority reported that they do not have access to community resources such as education, employment, housing, and so on (Fig. 55).

Figure 55: Participants had access to community resources

Access to community resources

To a great extent 18%
Quite a bit 15%
To some extent 27%
A little bit 26%
Not at all 14%
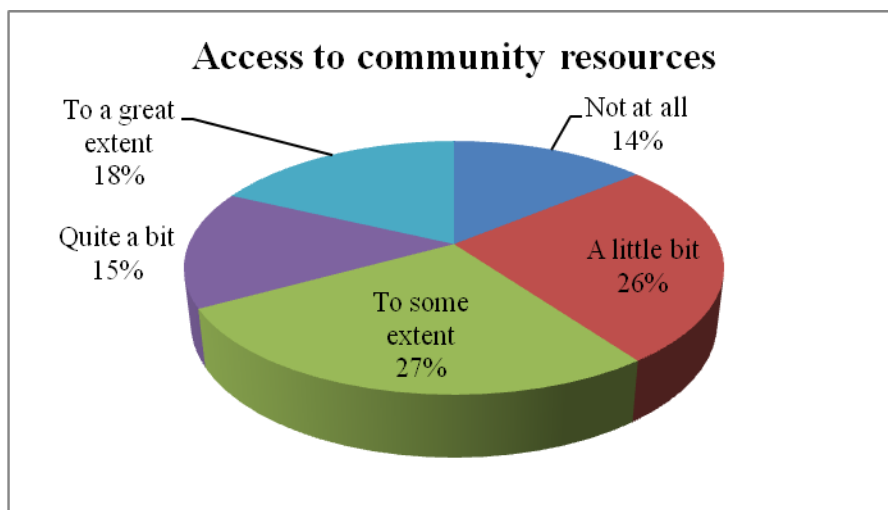
At the same time, Figure 56 shows that it is also a very important barrier to accessing job opportunities that the majority of the participants reported they do not have opportunities for professional development in ways that match their training.

Figure 56: Opportunities for professional development

Opportunities for professional development

To a great extent 15%
Quite a bit 14%
To some extent 18%
Not at all 29%
A little bit 24%
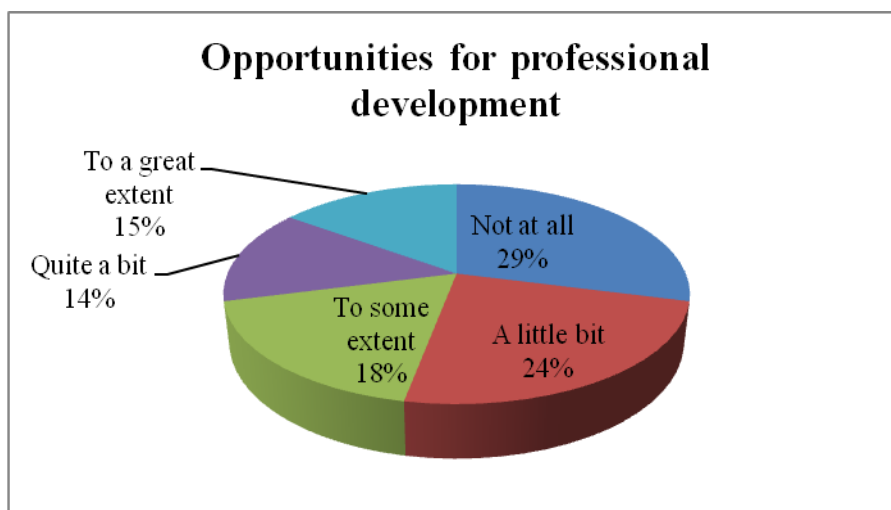
They also responded that they do not have the opportunity to live a full and creative life (Fig. 57).

Figure 57: Opportunities to live a full and a creative life

Opportunities to live a full and creative life

- To a great extent 14%
- Not at all 18%
- Quite a bit 19%
- A little bit 25%
- To some extent 24%
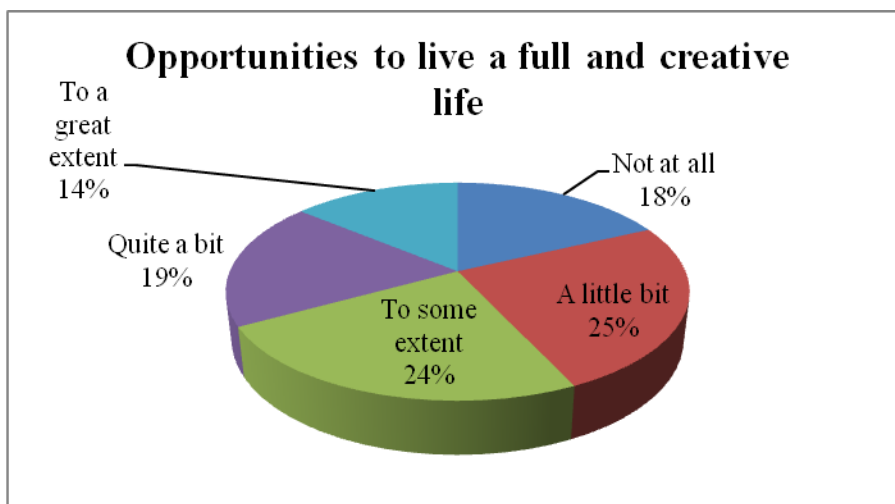
In addition, the participants responded that they do not have the opportunity to live a life that allows choosing among alternatives (Fig. 58).

Figure 58: Opportunities to choose an alternative life

Opportunities to live a life offering choice among alternatives

- To a great extent 12%
- Quite a bit 16%
- Not at all 26%
- To some extent 23%
- A little bit 23%
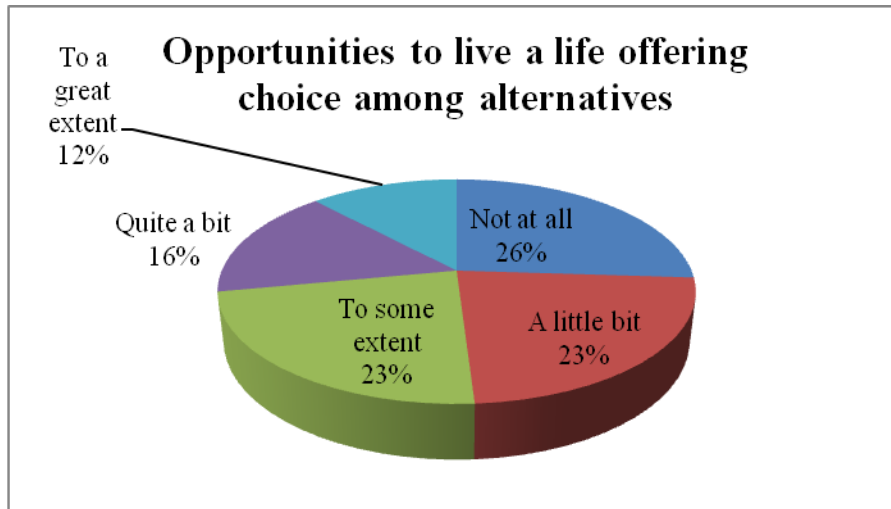
From this response, it can be assumed that the population is facing challenges building their capability and not living the quality of life they were expecting.

5.7   Experience of Barriers to Health Care, Well-Being and Integration

Only 24 percent of the participants rate their health-care services as very good; 39 percent rated them as good, and 27 percent reported a fair quality of health care (Fig. 59).

Figure 59: Participants' rating of the quality of health care they are receiving
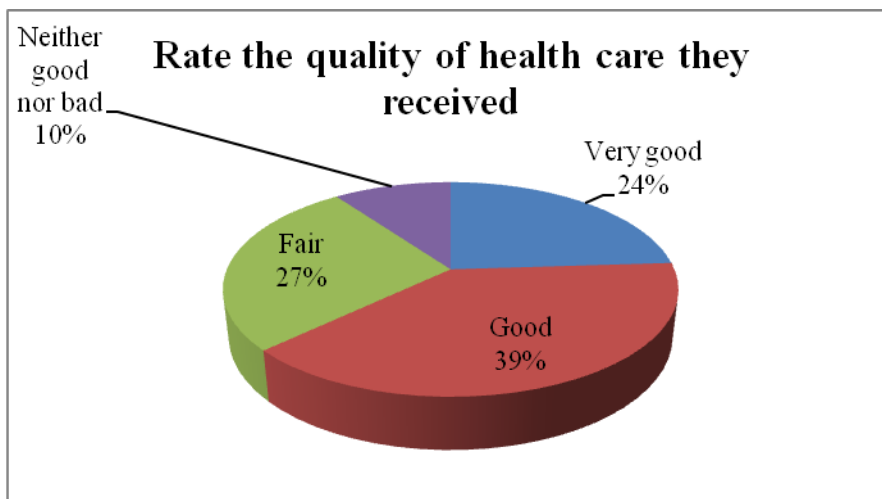
Among the participants, 77 percent responded that their well-being is being compromised by the difficulties they experience in accessing appropriate health care (Fig. 60).

Figure 60: Well-being is compromised because of access barriers
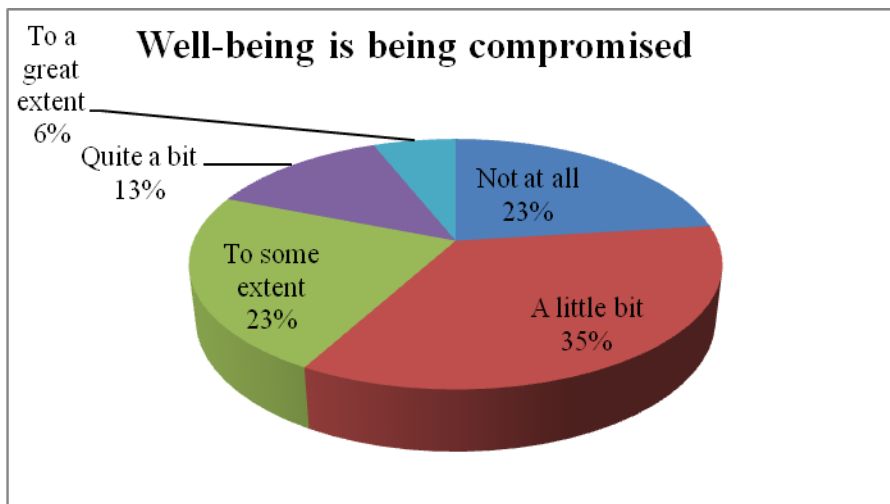
Almost 55 percent reported that their freedom is being compromised by difficulties in accessing appropriate health care (Fig. 61).

Figure 61: Freedom is compromised because of access barriers
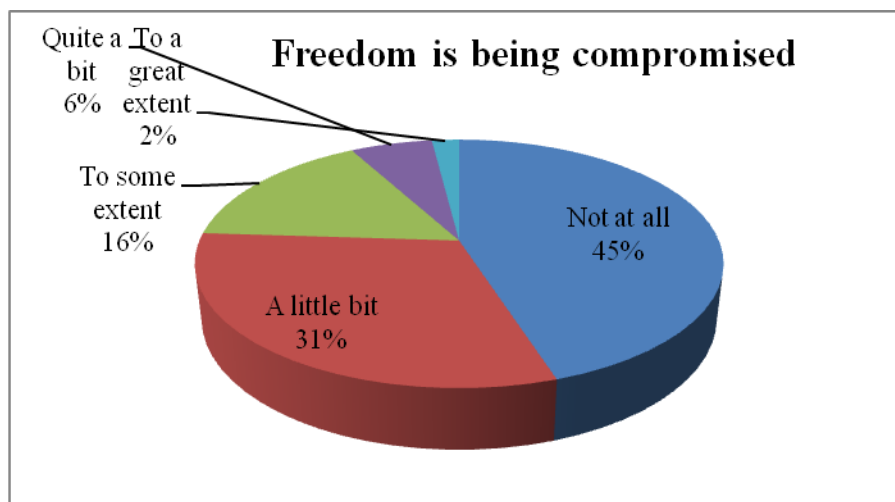
In addition, 61 percent reported that their achievement is being compromised by difficulties in accessing appropriate health care (Fig. 62).

Figure 62: Participants' achievement compromised because of barriers to accessing health care
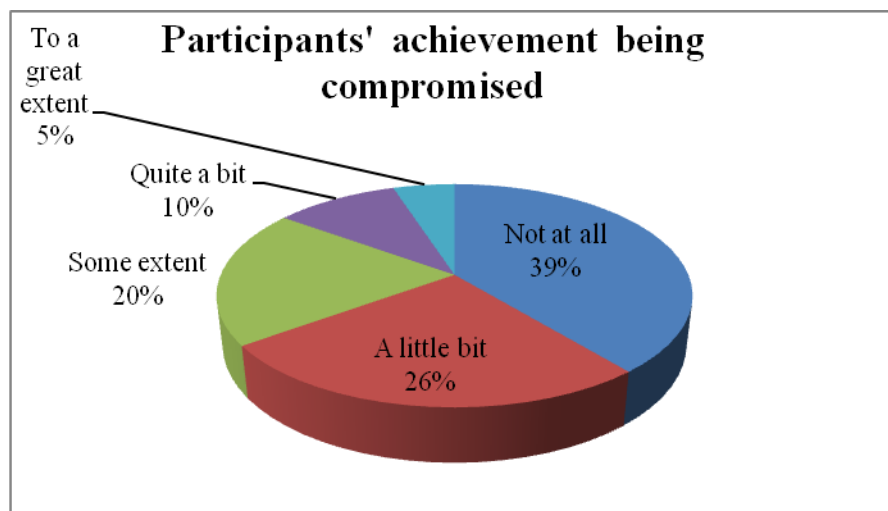
Also, 51 percent responded that barriers accessing health care limit their integration into their new society (Fig. 63).

Figure 63: Barriers to accessing health care limit participants' integration
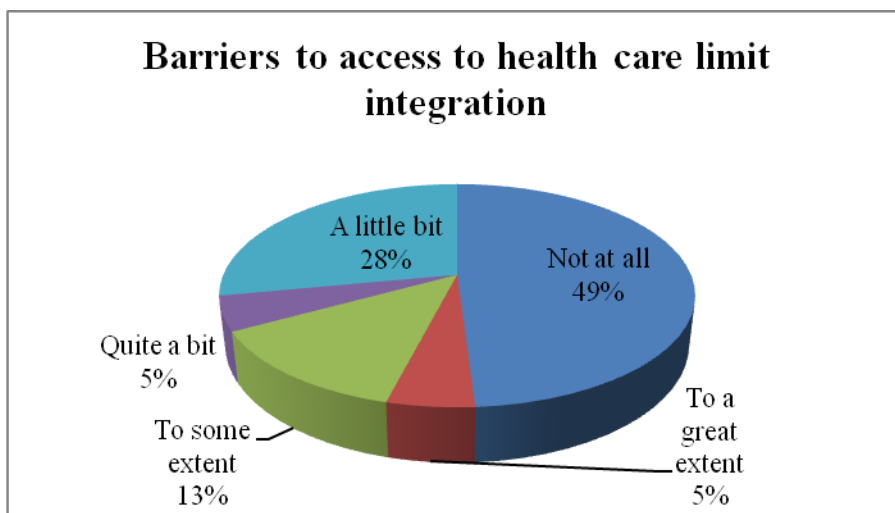
Such a limiting of integration can often result in the unhappiness, frustration, and depression referred to earlier. The results show that the participants' capabilities and freedom are being compromised.

5.8   Overview and Implications

The results of the research show that South Asian immigrants living in the GTA face multiple barriers; lack of health information is one of them. Information on health services, navigating the system, using the system, how the system works and where to go are very important for getting the appropriate and timely services. Almost one-third of the population reported that they did not receive information about available health care services in their area. One-fourth of the population reported that they experienced difficulties getting the health information or advice they needed. In addition, there is a lack of general social support services: 80 percent of the sample population reported that they did not receive any kind of social support services for their resettlement in the GTA. This indicates that there is a lack of social support services in Toronto (GTA) and /or the immigrants are not well informed about the social support services available for them. Among the population the women are more vulnerable than the men.

The results also show that the participants experienced language barriers in accessing health-care services in the GTA. Sixteen percent of the population reported problems in communicating their concern to their physician and 54 percent experienced language barriers when trying to access the routine or ongoing health care services they needed.

Among the population, 20 percent responded that transport difficulties prevented their access to health care in the GTA. Furthermore, the majority (54 percent) of the population believed that different socio-culturally-based understanding about health and health care is a barrier to appropriate health care. In addition, 20 percent of the participants believed that their physicians do not understand their health-related cultural beliefs and traditional beliefs and customs. Another cultural barrier is that 40 percent of the population is not comfortable being touched and examined by the opposite-gender health professionals. Family plays an important role in health decisions; 57 percent responded that family members influenced their health decisions. As well, 22 percent responded that Canadian medicine does not meet their health care needs and services, and 27 percent use culturally-specific alternative medicine for their health. They believe that culturally-specific alternative medicine is side-effect free, effective and accessible.

Education, employment and income significantly affect the population's health in various ways. In the area of employment opportunities, the population faced multiple challenges and barriers. Almost half of the population's general and professional degrees and diplomas, along with the experience and skills obtained outside Canada/USA, were not recognized here in Canada. The unemployment rate of the population is higher than the national average. The population faced difficulties in finding employment: working in the same profession/field as they did prior to immigrating, and securing jobs that match with their qualifications. They also responded that their credentials were undervalued by their employers and they did not have opportunities for professional development in ways that match their training. Therefore, they are facing tremendous challenges with their degrees, skills and experience obtained from South Asia and/or outside Canada/USA. They also face challenges in finding employment in their field of study. In addition, many of those who are employed believe they are underemployed. As a result, their monthly and household income is very low. More than 65 percent responded that

underemployment increased their unhappiness, frustration, anxiety and depression. More than 75 percent reported that their well-being has been compromised and they are not living the quality of life they were expecting in Canada. In addition, 77 percent responded that their well-being is being compromised by the difficulties they experienced in accessing appropriate health care.

This research found that the population is facing multiple barriers in accessing health care services in the GTA. Because of the inability to access the services, they are searching for appropriate health-care services and/or alternative health care services. Furthermore, language barriers, lack of health literacy, and different cross-cultural understanding of health and health care services prevent them from getting the culturally-appropriate services in a timely manner, causing repeated usage of the system without fruitful results. This not only puts pressure on the health-care system, but is also a waste of valuable time and money, resulting in anxiety, unhappiness, depression and frustration. In addition, their education and skills are not recognized and that is also causing a tremendous loss of immigrants' education, training, and skills and waste of their valuable work experience. As a result, their health has declined, they are facing challenges in their growth of capacity and freedom and they are not living the quality of life they were expecting in Canada.

Chapter 6

6   Health and Human Development

This chapter analyses the hypotheses formulated based on the research question of the study. The study aimed at examining factors associated with South Asian immigrants' encountering barriers/challenges to health-care services in the Greater Toronto Area (GTA) and the effects of these accessibility problems on their health and human development. In addition, the chapter analyzes the correlation between the accessibility index and capability indexes and the accessibility index and other variables. Also explored is the association of various perspectives of accessibility challenges and other related variables.

6.1   Research Questions and Hypotheses

Visible minority immigrants enter Canada usually with higher health status because of the Canadian immigration process which screens out anyone who has health problems. However, the literature implies that their health declines after living some time in Canada (Statistics Canada, 2006). Reviewing literature and relevant studies related to immigrants and their health deterioration suggests that their decline in health is caused by various challenges/barriers including those relating to language, culture, lack of employment, and socio-economic factors, as well as a lack of social supports and information (discussed in chapter 3). This study's research question is: What are the challenges that South Asian immigrants face in accessing the appropriate health-care opportunities needed to maximize their human development in the Greater Toronto Area (GTA)? Based on this research question, three hypotheses were formulated:

1) Hypothesis 1: The health status of South Asian immigrants deteriorates after living in Canada for a few years.

2) Hypothesis 2: Visible minority (South Asian) immigrants face significant challenges/barriers in accessing health care in the Greater Toronto Area (GTA).

3) Hypothesis 3*: Health care accessibility challenges are limiting the South Asian immigrants' quality of life and their human development is being compromised.

Cross tabulation and chi-square tests were used to test these hypotheses. Here cross-tabulation compares and finds the trends of the data; the chi-square tests confirm the association between the variables and the significance of the association between them.

6.2   Hypothesis Testing

6.2.1   Self-Reported Health Status of Participants

Hypothesis 1: The health status of South Asian immigrants deteriorates after living in Canada for a few years.

The hypothesis was tested using cross tabulation which compares South Asian immigrants' self-rated health before and after they enter Canada. The chi-Square test was conducted to determine how the two variables were associated. For this research, a chi-square test was conducted and the result shows that there is a statistically significant association between South Asian immigrants' self-rated health before coming to Canada and their self-rated current health after coming to Canada.

Table 9: Participants' current self-rated health

Health on entering Canada * Health Now Cross tabulation

			Health Now			Total
			Good & below	Very good	Excellent	
Health on entering Canada	Good & below	Count	56	6	1	63
		% within Health Ago	88.9%	9.5%	1.6%	100.0%
	Very good	Count	40	54	4	98
		% within Health Ago	40.8%	55.1%	4.1%	100.0%
	Excellent	Count	33	38	75	146
		% within Health Ago	22.6%	26.0%	51.4%	100.0%
Total		Count	129	98	80	307
		% within Health Ago	42.0%	31.9%	26.1%	100.0%

Table 10: Chi-Square test to find association between self-rated health on entering Canada and after living for a few years in Canada (Current).

<div align="center">

Chi-Square Tests

</div>

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	142.591[a]	4	.000
Likelihood Ratio	150.974	4	.000
Linear-by-Linear Association	99.096	1	.000
N of Valid Cases	307		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.42.

The result of bivariate analysis result is χ^2 (4) = 142.59, p<.001; Cramer's V= .482. The chi-square test shows that there are statistically significant associations between self-rated health on entering Canada and after living for a few years in Canada. Cramer's V shows that there is a moderate to strong association between two of the variables. The result of the cross tabulation shows that, among the sample, 146 participants reported their health was excellent before coming to Canada, but after coming to Canada that self-reported health declined. Only 75 participants remained as excellent, 38 participants' health decreased to very good, 33 to good and below category. The health of 98 participants who reported their health as very good also declined, as 54 reported remaining in the very good category, and 40 reported a decrease to good and below category. Among the participants 54 reported their health before as good and 5 participants' health increased to very good while 1 rose to the excellent category; however, 6 participants' health declined below category.

There is a statistically significant association between South Asian immigrants' self-rated health before coming to Canada and self-rated current health after entering Canada and living here for some time. The association between the variables is also strong. In addition, the cross-tabulation shows that the South Asian immigrants' self-rated health declined after entering Canada.

6.2.2   Barriers to Health Care

Hypothesis 2: Visible minority (South Asian) immigrants face significant challenges/barriers in accessing health care in the Greater Toronto Area (GTA).

To test the hypothesis, the association between the South Asian immigrants' current self-rated health status and the variables involved in access to barriers to health care services were tested.

Table 11: **Statistical associations between self-rated health and barriers to accessing health care services**

Hypothesis	Self-rated health after entering Canada					Chi-square
		Good & Below	Very Good	Excellent	Total	
The South Asian immigrants who did not experience any difficulties getting the health information or advice had better health than those who had experienced difficulties.	No difficulties	92	78	73	243	11.91**
	Experienced difficulties	37	20	7	64	
Those who had the information about the health care system in the GTA had better self-rated health than those who did not have the information.	No information	46	14	17	77	14.38***
	Had information	83	84	63	230	
Those who did not have problems communicating their concern to their doctors had better self-rated health.	No problems	98	87	74	259	12.35**
	Had problems	31	11	6	48	
Those who did not have language barriers when trying to get routine or ongoing health care had better self-rated health than those who had language barriers.	No language barriers	42	36	41	119	20.05***
	Had barriers	80	43	18	141	
Those who were familiar with using the Ontario health care system had better self-rated health.	Not familiar	44	19	18	81	7.05*
	Familiar	85	79	62	226	
Those who did not understand basic health information and the services needed to make appropriate decisions about their personal health had worse self-rated health.	Do not understand	39	9	4	52	28.50***
	Understand	90	89	76	225	

Those who were able to communicate effectively with health professionals to get information about their health had better self-rated health.	Not able to communicate	27	9	5	41	11.36**
	Able to communicate	102	89	75	266	
Those who reported that their physicians respected their traditional beliefs and customs regarding their health had better self-rated health.	Not respected	26	16	5	47	7.25*
	Respected	102	82	73	257	
Those who had access to health care in their neighborhood had better self-rated health.	No access	21	2	10	33	11.68**
	Had access	108	93	68	269	
Those who completed their degrees in Canada/USA had better self-rated health.	Not completed	107	66	47	220	15.55***
	Yes completed	22	32	33	87	
Those who completed their degrees in South Asia had worse self-rated health than those who completed their degrees in Canada/USA.	Not completed	16	30	30	76	19.35***
	Yes completed	113	68	50	321	
The South Asian immigrants whose degree(s)/diploma(s) were recognized had better self-rated health.	Not recognized	55	28	16	99	11.51*
	recognized	53	39	34	126	
Immigrants whose professional qualifications were recognized had better self-rated health.	Not recognized	72	32	21	125	11.96**
	Recognized	32	33	28	93	
Immigrants whose skills and experiences obtained outside Canada/USA were recognized in Canada had better self-rated health.	Not recognized	87	51	36	174	10.36**
	Recognized	39	43	40	122	
Those who reported that they did not have opportunities for community resources had worse self-rated health than those who reported that they had opportunities to access community resources.	Not at all	16	9	17	42	
	A little bit	37	24	20	81	
	Moderate	44	26	14	84	15.59*
	Quite a bit	17	17	12	46	
	Excellent	15	22	17	54	
Those who were satisfied with their life in general had better self-rated health than those who were not satisfied with their life in general.	Not at all	15	12	13	40	
	A little bit	19	11	21	51	
	Moderate	37	18	10	65	26.21***
	Quite a bit	50	37	21	108	
	Excellent	8	20	15	43	
Those who reported that they lived a better quality of life had better self-rated health than those who did not.	Not at all	28	16	23	67	
	A little bit	28	24	14	66	
	Moderate	47	28	15	90	16.05*
	Quite a bit	14	18	12	44	

	Excellent	12	12	16	40	
Those who reported that their self-esteem was not limited had better self-rated health than others.	Not at all	34	32	32	98	
	A little bit	36	27	20	83	
	Moderate	32	22	5	59	18.22*
	Quite a bit	20	13	13	46	
	Excellent	7	4	10	21	
Those who reported that they did not have opportunities for professional development in ways which matched their training had worse self-rated health than those who reported that they had opportunities.	Not at all	47	18	24	89	
	A little bit	25	30	19	74	
	Moderate	30	16	10	56	27.10***
	Quite a bit	15	21	7	43	
	Excellent	12	13	20	45	
Those who reported that they were not living a full and creative life had worse self-rated health than those who reported that they were living a full and creative life.	Not at all	27	12	17	56	
	A little bit	38	20	18	76	
	Moderate	35	25	13	73	19.25*
	Quite a bit	20	24	14	58	
	Excellent	9	17	18	44	
Those who did not have the opportunity to live a life with alternative options had worse health than others.	Not at all	41	16	24	81	
	A little bit	32	27	13	72	
	Moderate	34	18	17	69	27.46***
	Quite a bit	15	24	9	48	
	Excellent	7	13	17	37	
Those who thought that their well-being had been compromised by the difficulties they experienced in accessing appropriate health care had worse self-rated health than those who thought that their well-being being was not compromised.	Not at all	15	28	28	71	
	A little bit	59	32	15	106	
	Moderate	31	24	13	68	29.97***
	Quite a bit	18	9	12	39	
	Excellent	6	5	8	19	
Those who reported that their achievement had not been compromised by difficulties in accessing appropriate health care had better self-rated health than those who reported that their freedom had been compromised by difficulties in accessing appropriate health care.	Not at all	36	43	40	119	
	A little bit	39	25	15	79	
	Moderate	35	16	10	61	16.91*
	Quite a bit	12	11	8	31	
	Excellent	7	3	3	13	

P value, * <.05, ** <.01, *** p<.001

Some of the findings from Table 11 are discussed here. The findings in Table 11 show that those who had the information about the health care system in the GTA had better self-rated health than those who did not have the information (χ^2 = 14.38, p<.001). Those who did not have language barriers when trying to get routine or ongoing health care had better self-rated health than those who had language barriers (χ^2 = 20.05, p<.001). In addition, those who understood basic health information and the services needed to make

appropriate decisions about their personal health had better self-rated health than those who did not understand basic health information and the services (χ^2 = 28.50, p<.001).

Those who reported that their physicians understood their health-related cultural beliefs had better self-rated health than others who reported that their physicians did not understand their health-related cultural beliefs (χ^2 = 10.27, p<.05). In addition, those who were comfortable being touched and examined by an opposite-gender health professional had better self-rated health than others who reported that they were not comfortable being touched and examined by an opposite-gender health professional (χ^2 = 12.10, p<.05).

Those who completed their degrees in South Asia had worse self-rated health than those who completed their degrees in Canada/USA (χ^2 = 19.34, p<.000). Similarly, those who completed their degrees in Canada/USA had better self-rated health than those who completed their degrees in other areas (χ^2 = 15.55, p<.001). In addition, immigrants whose professional qualifications were recognized had better self-rated health than those whose professional qualifications were not recognized here in Canada (χ^2 = 11.96, p<.01). In the same way, immigrants whose skills and experiences obtained outside Canada/USA were recognized in Canada had better self-rated health than those whose skills and experiences obtained outside Canada/USA were not recognized in Canada (χ^2 = 10.36, p<.01).

Those who reported that they did not have opportunities for professional development in ways which matched their training had worse self-rated health than those who reported that they had such opportunities (χ^2 = 27.10, p<.001). In addition, those who thought that their well-being had been compromised by the difficulties they experienced in accessing appropriate health care had worse self-rated health than those who thought that their well-being being was not compromised (χ^2 = 29.97, p<.001).

The findings show that there are significant statistical associations between South Asian immigrants' current self-rated health status and the variables involved in accessing barriers to health care services.

6.2.3   Associations between Barriers to Health Care and Human Development

Hypothesis 3**:** Health care accessibility challenges/barriers are limiting the South Asian immigrants' quality of life and their human development is being compromised.

Table 12: **Statistical association between barriers to accessing health care services and capability index (quality of life)**

Hypothesis		Achieved expected quality of life						Chi-Square
		Not at all	A little bit	To some extent	Quite a bit	To a great extent	Total	
Among the sample population, males had better quality of life.	Male	13	42	53	47	8	163	**11.80***
	Female	15	51	51	19	8		
Those who had better self-rated health had better quality of life.	Good & Below	11	45	52	17	4	129	**34.43***
	Very good	4	27	32	33	2	98	
	Excellent	13	21	20	16	10	80	
Those who have experienced problems getting health information had a lower quality of life.	No problems	23	66	79	60	15	243	**12.16***
	Experienced problems	5	27	26	6	1	64	
Those who had information about the Ontario health care system had lived a better quality of life.	No information	10	29	27	11	0	77	**11.41***
	Informed	18	64	77	55	16	230	
Those who did not have problems communicating concerns to physicians had lived a better quality of life.	No problems	27	72	83	64	13	259	**16.20***
	Had problems	1	21	21	2	3	48	
Those who had extended health insurance lived a better quality of life.	No insurance	19	56	58	25	6	164	**12.34***
	Had insurance	9	37	46	41	10	143	
Those who had no language problems had a better quality of life	No language problems	12	32	31	35	9	119	**24.66***
	Had problems	8	52	57	21	3	141	

Statement	Category						Total	χ^2
Those who were not familiar with how to use the Ontario health care system had lived a lower quality of life.	Not familiar	7	38	28	8	0	81	**22.72*****
	Familiar	21	55	76	58	16	226	
Those who understood basic health information to make appropriate decisions about personal health had lived a better quality of life.	Not understood	4	25	21	2	0	52	**19.80*****
	Understood	24	68	83	64	16	255	
Those who could not communicate effectively with health professionals had lived a lower quality of life.	Problems communicated	3	20	16	2	0	41	**14.42****
	Able communicated	25	73	88	64	16	266	
Those who thought that differences in socio-cultural-based understanding about health and health care is a barrier to culturally appropriate health care had lived a lower quality of life.	Not barrier	9	34	50	40	7	140	**10.96***
	Considered barriers	18	59	54	26	9	166	
Those who were not comfortable being touched on private body parts by opposite-gender physicians lived a lower quality of life.	Not comfortable	12	44	50	26	1	133	**10.93***
	Comfortable	16	49	54	40	15	174	
Those who used a family vehicle to go to their doctors/hospitals lived a better quality of life.	No vehicle	12	42	47	11	6	118	**18.43****
	Family vehicle	16	47	56	55	10	184	
Those who completed their degrees/ diploma in Canada lived a better quality of life.	Not in Canada	20	70	86	38	6	Total	**22.47*****
	Canada	8	23	18	28	10	87	
Those who completed degrees in South Asia lived a lower quality of life.	Not South Asia	6	24	17	21	8	76	**11.41***
	South Asia	22	69	87	45	8	231	
Those whose degrees were not recognized in Canada lived a lower quality of life.	Not recognized	7	39	40	13	0	99	**11.80***
	Recognized	15	31	47	28	5	126	
Those whose professional degrees are recognized here in Canada lived a better quality of life.	Not recognized	10	46	53	16	0	125	**18.35*****
	recognized	12	19	33	24	5	93	
Those whose skills and work experiences were not recognized lived a lower quality of life.	Not recognized	16	65	61	31	1	174	**26.09*****
	Recognized	12	23	42	32	13	122	
Those who did not find difficulties/ barriers in finding employment in	No difficulties	6	25	30	27	11	99	**13.88****

Canada had a better quality of life.	Experienced difficulties	21	64	68	38	5	196	
Those who are working in their same profession of training had a better quality of life.	Not same profession	21	66	60	27	7	181	21.51***
	Same profession	5	19	35	33	8	100	
Those who thought that their credentials were undervalued by the employers lived a lower quality of life.	Not undervalued	6	23	31	30	8	98	12.57*
	Undervalued	16	58	63	27	6	170	
Those who thought that underemployment increased their frustration lived a lower quality of life.	Not considered	3	18	13	20	9	63	20.33***
	Yes considered	18	46	56	32	3	155	

P value, * <.05, ** <.01, *** p<.001
» For computing chi-square, this table was compressed (quality of life categories were reduced) to meet the assumption of having a minimum of 5 expected values in each cell.

A discussion of some of the findings from Table 12 follows: the findings of Table 12 show that those who have experienced problems getting health information had a lower quality of life ($\chi^2 = 12.16$, p<.05). Those who had information about the Ontario health care system had lived a better quality of life ($\chi^2 = 11.41$, p<.05). In addition, those who are not familiar with how to use the Ontario health-care system lived a lower quality of life ($\chi^2 = 22.72$, p<.001). However, those who had extended health insurance lived a better quality of life ($\chi^2 = 12.34$, p<.05).

Those who did not have problems communicating concerns to physicians lived a better quality of life ($\chi^2 = 16.20$, p<.01). However, those who could not communicate effectively with health professionals lived a lower quality of life ($\chi^2 = 14.42$, p<.01); however, those who understood basic health information to make appropriate decisions about personal health lived a better quality of life ($\chi^2 = 19.80$, p<.001). Those who thought that difference in socio-cultural-based understanding about health and health care is a barrier to culturally appropriate health care lived a lower quality of life ($\chi^2 = 10.96$, p<.05). In addition, those who were not comfortable being touched on private body parts by opposite-gender physicians lived a lower quality of life ($\chi^2 = 10.93$, p<.05).

Those who had completed degrees in South Asia (outside Canada/USA) lived a lower quality of life ($\chi^2 = 11.41$, p<.05). Similarly, those whose degrees/diplomas are not

recognized in Canada lived a lower quality of life ($\chi^2 = 11.80$, p<.05). In addition, those skills and work experiences are not recognized here in Canada lived a lower quality of life ($\chi^2 = 26.09$, p<.001). However, those who completed their degrees/diploma in Canada lived a better quality of life ($\chi^2 = 22.47$, p<.001). In addition, those whose professional degrees/diplomas are recognized here in Canada lived a better quality of life ($\chi^2 = 18.35$, p<.01). In the same way, those who are working in the same profession or training had a better quality of life in Canada ($\chi^2 = 21.51$, p<.001).

The results show that there are significant associations between South Asian immigrants' barriers to accessing health care services and their quality of life and human development. The barriers to accessing health-care services are limiting the quality of life and human development of immigrants in the Greater Toronto Area.

6.3   Correlation Analysis

6.3.1   Capability Index vs. Accessing Barriers Index:

The previous section of the study analyzed the individual variables and their association and significance. This section of the study shows the results of a two-tailed bivariate correlation analysis between collective indexes of barriers and capability. Assumptions of correlation were checked. The correlation analysis between the capability index and accessibility barriers index, length of time working in Canada, and monthly personal and household income was conducted.

Table 13: Correlation coefficient between capability index and working length and monthly income

Variables	Correlation
Capability Index & Working duration	**.250****
Capability Index & Respondents Monthly Income	**.268****
Capability Index & Annual Household Income	**.316****

** Correlation is significant at the 0.01 level

The correlation coefficient analyses show that there is a significant relationship between capability index and working length (years); as working length rises, capability also rises. However, the strength of the relationship (.250) is weak. In addition, there are significant relationships between the capability index and monthly and household income. The findings show that if the monthly income or household income rises, the capability also goes up. The strength of the relationship between monthly income capability incomes (.268) is weak and the strength of the relationship between annual household income and capability index (.316) is medium.

6.3.2   Barrier Index and Other Variables

This section of the study involved computing a collective index of barriers and other variables related to the study. The two-tailed bivariate correlation analysis between accessibility barriers index, length of time living in Canada, and respondents' monthly personal and household annual income was conducted. Assumptions of correlation were checked.

Table 14: Correlation coefficient between access barriers index and length of stay in Canada

Variables	Correlation
Access Barriers Index & living long (duration of living)	-.322**

   **Correlation is significant at the 0.01 level

In the correlation analysis between access barriers and length of time living in Canada, the result shows that the longer immigrants live in Canada the fewer access barriers they face. The strength of the relationship (-.322) is medium.

6.4   Additional Associations Tested

6.4.1   Association between Employment Status and Accessing Health Care

Table 15: **Statistical association between employment status and access barriers**

Association between variables	Chi-square	p-value	Cramer's V
Those who are employed had extended health care insurance.	41.59	.000	.368
Those who had higher employment rate had more information about the Ontario health care system.	10.06	.018	.181
Those who were familiar with the use of Ontario health care system had a higher employment rate.	15.72	.001	.226
Those who had a higher employment rate were able to communicate effectively with health professionals.	8.68	.034	.168
Those who had a higher employment rate were comfortable being touched by opposite-gender physicians.	23.98	.000	.279
Those who had a higher employment rate had neighborhood access to health-care facilities.	13.98	.003	.215
Those who had a higher employment rate had a family vehicle.	30.11	.000	.315
Those who had a higher employment rate used a family vehicle to go to their doctors/hospitals.	46.35	.000	.392
Those whose degrees/diplomas were recognized in Canada had a higher employment rate.	11.24	.010	.224
Those whose degrees/diplomas were evaluated equal to Canadian degrees had a higher employment rate.	16.05	.001	.329
Those whose skills and work experiences were recognized here in Canada had a higher employment rate.	17.76	.000	.245
Those who did not find difficulties/ barriers in finding employment in Canada had a higher employment rate.	16.73	.001	.238
Those who were working in their same profession of training had a higher employment rate.	29.28	.000	.323
Those who had a higher employment rate think that underemployment did not increase their unhappiness.	15.46	.001	.261
Those who had a higher employment rate think that underemployment did not increase their frustration.	13.07	.004	.245
Those who had a higher employment rate think that underemployment did not increase their depression.	7.93	.047	.193

The association of employment status and access barriers shows that those whose education achievement is recognized an equal to Canadian degrees had a higher employment rate although the strength of the association (Cramer's V = .329) is medium. Also, those who are working in their profession had a higher employment rate and the strength of the association (Cramer's V= .323) is medium. In addition, those who were employed had extended health care insurance and were not experiencing the health-care access barriers. The strength of the association (Cramer's V= .368) is medium.

6.4.2   Association between Monthly Income and Accessing Health Care

Table 16: **Statistical association between monthly income and access barriers**

Association between variables	Chi-square	p-value	Cramer's V
Those who had lower income attended language proficiency classes.	14.43	.013	.240
Those who had lower income they were more likely experience difficulties getting the health information.	16.97	.005	.261
Those who had lower income were less likely to have extended health insurance.	54.53	.000	.467
Those who had lower income were less likely to have information regarding Ontario's health care system.	16.21	.006	.255
Those who had lower income were less familiar with how to use Ontario's health care system.	30.47	.000	.349
Those who had lower income were less likely to understand basic health information and services to make appropriate decision about their personal health.	15.47	.009	.249
Those who had lower income were not able to communicate effectively with health professionals.	15.42	.009.	.248
Those who had lower income thought that socio-culturally-based understanding about health and health care is a barrier.	16.30	.006	.255
Those who had lower income were not comfortable being touched by physicians of opposite-gender.	20.58	.001	.287
Those who had lower income were not comfortable being touched on their private body-parts, if necessary, by opposite-gender physicians.	13.90	.016	.236

Those who had higher income had a family vehicle.	34.57	.000	.373
Those who had higher income used their family vehicle to go to their doctors/hospitals.	34.70	.000	.374
Those who had lower income used public transportation to go to their doctors/hospitals.	25.02	.000	.318
Those whose degrees/diplomas were not recognized in Canada had lower income.	14.92	.011	.287
Those whose professional degrees/diplomas were not recognized here in Canada had lower income.	23.32	.000	.362
Those whose degrees/diplomas were not evaluated as equal to Canadian degrees had lower income.	11.57	.041	.305
Those whose outside skills and work experiences were not recognized here in Canada had lower income.	28.68	.000	.344
Those who had difficulties/ barriers in finding employment in Canada had lower income.	13.80	.017	.235
Those who were not working in their same profession of training had a lower income.	51.67	.000	.464
Those who thought that their credentials were under evaluated had a lower income.	12.36	.030	.234
Those who believed that their job did not match with qualifications had a lower income.	29.69	.000	.354
Those who had a lower income thought that underemployment did increase their unhappiness.	12.40	.030	.253
Those who had a lower income thought that underemployment did increase their frustration.	11.165	.048	.244
Those who had a higher employment rate thought that underemployment did increase their depression.	12.37	.030	.261
Those who had full-time employment had a better income.	86.43	.000	.588

The association between respondents' monthly income and access barriers shows that those who had lower income had experienced barriers to accessing health care. This may be happening because their lives are not stable and having a lower level of employment for living also makes their lives unstable. They are not in a settled, stable condition with their career, employment and other accessibility which is a precarious situation leading to many uncertainties. For example, those who had lower income did not have extended health insurance. The strength of the association (Cramer's V= .467) is medium. In addition, those who were not working in their same profession of training had a lower income and the strength of the association (Cramer's V= .464) is medium. Those who

had full-time employment had a better income and the strength of the association (Cramer's V= .588) is medium-strong.

6.4.3 Association between Information about the Ontario Health Care System and Barriers to Access to Health Care

Table 17: **Statistical association between information about Ontario health-care system and barriers to access**

Association between variables	Chi-square	p-value	Cramer's V
Those who got jobs in the GTA and chose to live there were better informed about the Ontario health-care system.	5.64	.018	.135
Those who had internet access when they first came to the GTA were better informed about the Ontario health-care system.	9.90	.002	.180
Those who had information regarding the availability of Ontario health care services were better informed about the Ontario health-care system.	27.46	.000	.299
Those who had contacted their doctors' office frequently for their health information were better informed about the Ontario health-care system.	6.62	.010	.147
Those who did not visit walk-in clinics were better informed about the Ontario health-care system.	5.17	.023	.130
Those who did not experience problems getting health information were better informed about the Ontario health-care system.	12.59	.000	.203
Those who required health information for their own or family members were better informed about the Ontario health-care system.	3.96	.047	.114
Those who had family doctors were better informed about the Ontario health-care system.	8.90	.003	.171
Those who were better informed about the Ontario health care system had better familiarity with how to use the Ontario health-care system.	63.55	.000	.455
Those who had extended health insurance were better informed about the Ontario health-care system.	15.40	.000	.224

Those who did not have language barriers to getting routine or ongoing health care were better informed about the Ontario health-care system.	14.98	.005	.240
Those who did not have problems communicating with physicians were better informed about the Ontario health-care system.	10.55	.000	.185
Those who understood their physicians' instructions and directions were better informed about the Ontario health-care system.	15.22	.000	.223
Those who understood basic health information to make appropriate decisions about personal health were better informed about the Ontario health-care system.	24.00	.000	.280
Those who were able to communicate effectively with their health professionals were better informed about the Ontario health-care system.	47.02	.000	.391
Those who thought that their physician understood their health-related cultural beliefs were better informed about the Ontario health-care system.	25.74	.000	.291
Those who believed that their physician respects their traditional beliefs and customs regarding their health were better informed about the Ontario health-care system.	20.84	.000	.262
Those who were comfortable being touched and examined by opposite-gender physicians were better informed about the Ontario health-care system.	13.01	.000	.206
Those who responded that Canadian medicine fulfilled their health care needs and services were better informed about the Ontario health-care system.	3.83	.050	.112
Those who had access to health care services in their neighborhood were better informed about the Ontario health-care system.	13.66	.000	.213
Those who had a family vehicle were better informed about the Ontario health-care system.	10.86	.001	.189
Those who used a family vehicle to go to their doctors/hospitals were better informed about the Ontario health-care system.	6.39	.011	.146
Those who did not use public transportation to go to their doctors/hospitals were better informed about the Ontario health-care system.	4.67	.031	.124
Those who were employed full time were better informed about the Ontario health-care system.	10.06	.018	.181
Those who had the highest monthly income were better informed about the Ontario health-care system.	16.21	.006	.255

Those who had access to community resources were better informed about the Ontario health-care system.	11.60	.021	.194
Those who had an opportunity to have a full and creative life were better informed about the Ontario health-care system.	14.12	.007	.214
Those who thought that they were living the quality of life they were expecting in Canada were better informed about the Ontario health-care system.	11.46	.022	.193
Those who were very satisfied with their life in general were better informed about the Ontario health-care system.	21.78	.000	.266
Those who had the opportunity to choose among alternative life options were better informed about the Ontario health-care system.	23.09	.000	.274
Those who were better informed about the Ontario health-care system had been living a higher quality of life (capability index).	11.41	.022	.193

Association between information about the Ontario health care system and access barriers variables show that those who did not experience problems getting health information were better informed about the Ontario health care system, although the strength of the association (Cramer's V=.203) is weak. Those who did not have language barriers to getting routine or ongoing health care were better informed about the Ontario health-care system, and the strength of the association (Cramer's V=.240) is weak. Those who had an opportunity to have a full and creative life were better informed about the Ontario health care system; however, the strength of the association (Cramer's V=.214) is weak. Those who thought that they were living the quality of life they had expected in Canada were better informed about the Ontario health-care system, and the strength of the association (Cramer's V=.193) is weak. In addition, those who were better informed about the Ontario health-care system had better familiarity with how to use the Ontario health-care system. The strength of the association is also medium (Cramer's V= 4.55). The associations among variables show that the participants are better informed about their health-care information when they have gone through their settlement periods successfully.

6.5   Discussion

The results of the chi-square tests show that there is a statistically significant association between participants of South Asian immigrants' self-rated health before coming to Canada and self-rated current health after coming to Canada. The results of the chi-square tests also show that there are significant associations between South Asian immigrants' current self-rated health status and the variables involved in barriers to accessing the health-care services. The results of the chi-square test further confirm that there are statistically significant associations between South Asian immigrants' barriers to accessing health-care services and their quality of life and human development.

This study also conducted correlation analyses between the capability index, length of time lived in Canada, and immigrants' monthly and annual household income. The correlation analyses results show that there is a significant relationship between the capability index and length of time working in Canada, and the capability index and participants monthly and annual household income. The correlation analyses further confirmed the correlation between access barriers and length of time living in Canada. Here the result shows that as long as they live in Canada their access barriers are reduced.

In addition to these hypotheses and correlation analyses, this study conducted additional chi-square tests to investigate the relationship between employment status and access barriers, monthly income and access barriers, information about the Ontario health-care system and access barriers and using the Ontario health care system and access barriers. The results show that there are significant relations among these variables.

6.6   Summary

The results of the statistical analyses confirmed the hypotheses: the self-rated health status of South Asian immigrants deteriorates after living in Canada for a few years; South Asian immigrants living in the GTA face significant challenges/barriers in accessing health care; and health care accessibility challenges/barriers are limiting the South Asian immigrants' quality of life and their human development is being

compromised. The result of the correlation analyses shows that there are significant relationships between the capability index and monthly and household income and if the monthly income or household income rises, the capability also goes up. Another correlation analysis between access barriers and length of time living in Canada shows that the longer they live in Canada, the fewer access barriers they face. In addition, the associations among variables show that the participants are better informed about their health-care information when they have gone through their settlement periods successfully.

Chapter 7

7 Discussions of the Barriers to Accessing Health Care

This chapter analyzes the focus group discussions of South Asian immigrants living in the Greater Toronto Area (GTA). Among the focus groups' participants there were professionals, students, and homemakers, as well as settlement support services workers who were South Asian immigrants, also working for South Asians. There were two groups of participants—one group who were South Asian immigrants living in the GTA and another group who were South Asian immigrants living in the GTA as well as working in the immigration settlement services in the GTA. Three focus groups were in the first category and two in the second category.

The focus group discussions' open-ended questions reflected the shared concern of the visible minority immigrants' access to health care. The participants had the opportunity to describe their own as well as their clients, friends, and families experiences in the settlement process in the GTA. The themes of the focus groups emerged, focusing on access to care in the form of settlement services to immigrants in the GTA, available information regarding the Ontario health-care services, access barriers/challenges to health care in general, appropriate health-care services, barriers/challenges of professional development, how professional and social status in Canada affects their physical health, and how professional and social status in Canada affects their mental health.

For this research, quantitative and qualitative methods were chosen to enhance the reliability and validity of the findings. The focus groups' open-ended questions provided better explanation through exploration of the survey questionnaires of this study. The findings of the focus groups, which have immediate face validity, were triangulated with the relevant questions of the survey questionnaires.

7.1   Settlement Services

In the focus group discussions, the participants expressed their concern about the services available to them. Many believed that although they were never received, the services are not enough or the services they want are not available in these settlement services agencies. Many of the immigrants who visited these agencies had mixed reactions. Some of them complained that they were wasting time. The settlement service providers were providing very primary-level services; they needed more specialized appropriate real-life services. Here are some comments by the participants

> **Man**: In the college they only try to change my resume that's it. They did not find my specific; they did not pointed out where I should go, connect with the right person.

> **Man**: I never visited any of them. Next day my wife is going for neighborhood workshop, 9 days workshop

> **Man**: It is just wasting time. I do not think it will help to get right job. They gave us book and theoretically but how many people getting help. Immigrants people helping immigrants.

> **Man**: We are helping each other, advising each other.

In these comments, the participants showed their discomfort with and disbelief in the existing settlement services.

 In the focus groups, there were participants who are South Asian as well as working in the settlement services offices, working for South Asian immigrants living in the GTA. They believed that there are opportunities to get services, but the newcomer immigrants do not know what kind of services are available that could help them in their transition. One participant commented:

> …the important intervention here is how many of these newcomers really access the social services there available for them like we are providing. A lot of our clients have said that had they known they could access these services when they

were new to Canada first in the few weeks, they wouldn't have to come back now. The sad thing is that a lot of services, a lot of services are available for newcomers within their first few years 3 to 5 years until they get their citizenship, afterwards they do not get these services, and They may or may not know about the services one thing they know is that they should apply for citizenship as soon as they are eligible and as soon as they become citizen they cannot access these services.

The South Asian settlement workers also think that the immigrants' pre-arrival mindset is different from the reality here in Canada. The immigrants are not taking informed decisions. They take decisions based on popular sayings or the immigrant consultants' oversimplified information. Here is a short conversation between participants:

Man: It has to start before the person come in Canada. The mindset you are talking of, this kind of information should be given to the immigrants before they come to Canada.

Woman: There are lot of information in the website but the immigration consultant who are sitting there who are charging a lot of money as middle man they do not want the clients to access these information, because you know they are creating these dreams. They go to the beaches, they go to the nice pictures of the CN Towers and lake and they say ok where you belong right and they tell all the success stories, they plant seed in their mind.

Man: How would they tell their clients the realities of Canada?

From these comments, it is very clear that newcomer immigrants are not taking informed decisions about immigrating to Canada. They think that when they are in Canada, life will be very easy and rewarding. They come with an impression that when they are here in Canada everything is easy and ready for them such as health-care services, employment and other opportunities. They will soon be living a better quality of life. They are coming to their dreamland with high hopes about the quality of life. As soon as they face the reality, they are lost, depressed, and anxious:

One of the barriers is I think also you know when the immigrants come here they have this mindset that you know they are immediately going to get a good job, they are going to immediately settled, like they have this things ok we have to start from scratch but how long is that going to take and what is the procedures going to be and how frustrating it can be that they are not ready for that. So they, the result weeks after they land here days after they land here most of them get deep frustration, depression, they do not want to talk, they do not want to go out. They keep blaming themselves, keep blaming Canada which is likes takes a lot of time them to get out of that to be a normal functioning person and then come back to terms and reality and start working again.

The focus group participants' concern is that the settlement services provided by various organizations are helpful, but not sufficient for immigrants' resettlement. Those who have used the services are not happy because they think that the kinds of services they want are not available there. Those who never received the service or never visited a settlement service office reported that it is not worth going there and it is a waste of time. They want more real-life specific and specialized services which could help them to access the opportunities directly.

7.2   Newcomer Immigrants' Access to Health-Care Services

According to Ontario health care policy, newcomer immigrants have to be residents of Ontario and stay and live here for a minimum of 90 days to be eligible for OHIP coverage. Although in the GTA there are community health-care services, they are not fully equipped to provide sufficient services to the immigrants in their need for health-care services. In addition, the sponsored immigrants cannot go to the community health centre for free services during their 90-day waiting period. One participant described the situation:

There are community health centers right but those have barriers and restrictions, long waiting list. They are not accessible to all of them. They do not have doctors,

if you are sponsored you stay detachment area. So there are many restrictions to them which people cannot afford to go there as well. They do not have all the services, especially for the pregnant ladies, talk about the insurance. If you buy private insurance is not covered for pregnant ladies. For pregnant lady pre-existent condition is not covered.

In the 90-day waiting period without OHIP coverage vulnerable populations such as pregnant women, seniors and children face significant challenges in access to care. One of the women described her experience regarding the 90-day waiting period, community health centre, and private insurance:

Most of the diseases are not covered. If you pay extra then they cover. When I was expecting my little one, what happened to me it was a nightmare. Every single day I use to make so many calls with directory who is accepting and who is not. Even the doctors after paying fees they did not check my blood pressure. I used to go to the pharmacy take my own blood pressure but I did not know what is my glucose level. I was so weak I do not know what I will have to eat. I did not know my sugar level. So, I bought a glucometer then I used to it but I do not know. There are so many things only doctors can advice it upset me. I wanted to go back (South Asia) but by that time I realized I made an effort may be today may be next week by that time I was as advanced my pregnancy I could not even travel. Finally after three months when I got my OHIP card that was the happiest day.

From this comment, it is clear that although it is said that newcomers' health care services are free and covered by community clinics in the GTA, in reality it is different for vulnerable populations such as those who have pre-existent conditions and sponsored immigrants.

7.3   Culturally Appropriate Health-Care Services

The immigrants desire easily accessible, fast, timely, culturally appropriate health-care services. They are also worried about the dental and vision-care services. According to them, for women female physicians are very important:

> Culturally appropriate health care is very important especially for the people who come from South Asia many of them they do not speak English and they have some cultural issues as well, for example, ladies who wear hijab. They want the person should understand their culture. Because you go with a hijab then other person who are not aware of the culture they start saying if you do not remove your hijab then I cannot treat you with your hijab on. The other thing is gender. They need to have female person. Female doctor is very important for us. Female patient should have a female doctor. It is culturally appropriate thing. It also helps them to communicate well and understand each other.

One of the settlement services worker women who shared her South Asian immigrants' experience:

> You know, I have at least seen 3 to 4 clients there is lot of male gynecologist in Canada and ladies first of all who are from our community, will not like to go to the male gynecologist and at times they do not have option. It was the (Name) hospital they said ok they have this doctor we do not have anybody else for you. What you do? So they have to go to the male gynecologist.

The participants also reported that if you are not comfortable with opposite sex physicians or participants have any complaint, they cannot do that because before they get treatment, they will have to sign the form. In addition, they made it clear that they are a culturally distinct community and they have their own way of life. Many South Asian women who wear a veil faced challenges getting appropriate services. The South Asian community also has distinctive eating and food habits.

> At the same time also about the food, food is very important. Eating habits. So, if you are diagnosing something and the person who are doctor is from same culture

then she/he can understand what their backgrounds are. What are they eating? What is their food habit? What are causes of it? What they should restrict in order to get proper treatment?

The participants also reported on how they can get culturally appropriate health care services:

I do agree we South Asians need culturally appropriate health care services, I have family doctor who is from Sri Lanka and she knows my lifestyle, what's are the food I eat what are my habits and we have different habit we are not into fitness and Gym, we are sedentary and potato eater and you our we have a intensity for high cholesterol all that you know syndromes are more in South Asia, she know that but I am going to other doctors they would not understand my lifestyle. So I do agree, I am willing to pay for culturally appropriate health care services, if I require.

Another participant's concerns about the vision and dental care which are not covered by the OHIP and those who are not working full-time had to pay for those services which are very expensive also:

South Asians have their own way of eating food. We have our own of cooking that food and the especially oil and all that's when we talk to another doctors it does not work this and that why not send us to the dietician that suit my South Asian food my roti, my chapti, dhal but they tell which I cannot manage eat broccoli raw vegetables, it does not, people does not do it…. Why have South Asian healthy healthy food. At the same time I want to add that about eye care and dental care. They can manage MRI, Bi-pass, and other expensive surgery; why not include eye and dental care? This is big question, everything is free…. but paying a lot.

The South Asian community desperately looks for culturally appropriate health-care services and to get the culturally appropriate health-care services, they are ready to pay if it is affordable. They think that if the health professionals understand their cultural

perspectives then they will be able to provide appropriate services. To get the culturally appropriate health care services, they are even ready to get services from non-licensed South Asian health professionals:

> I am willing to pay and I have crazy idea always that let people choose between two systems ok I should have a choice: either I go for current system or you have thousands of immigrants doctors who are very intelligent and very experience and they are unemployed they can be a parallel health care system and people like us who believe in them and things that they do not need any license practice they already had practiced in India, Pakistan or Sri Lankan. I will prefer going to them for diagnosis because their diagnosis is much more accurate, they know our lifestyle and our food habits and what are you know good. They give us some prescription and tips and they know what we are going to do. Even they do not have license I am comfortable to go them.

The focus group participants recognized that they are a different cultural community; they have different cultural and religious perspectives, food habits and traditional values which warranted culturally-appropriate health-care services. As Canada has adopted multicultural policy, they expect there should be appropriate measures for culturally appropriate health-care services.

7.4   Barriers/Challenges to Professional Development

Most of the immigrant populations are worried about their professional development in their new society. In most cases, South Asian educational degrees, work experiences and skills are not recognized. The employers also overemphasize language and communication skills and have a negative mind-set about colored people. The participants widely discussed that there is a mind-set that the South Asians cannot communicate, do not know either English or French and are culturally different. Many immigrants want to go back to school but education is costly and they have family so need money/income immediately. They also think that cultural barriers play a role:

People who are coming from South Asia he or she is Master degree holder coming to this country submit their resume different organization they do not find job six month or one year. He/she is frustrated then went to college or university degree somehow, sometimes might be diploma and diploma is greater than your Master degree or diploma is less than your master degree, so the degree is undervalued. Their skill is undervalued in Canada. After finishing their diplomas when you knock the door again for job no no no nothing, because why? You have the communication problem. That guy again goes to another diploma, in the meantime, who are the immigrants' population in this country they are not their age of 19. Their age between 30 and 49. …. Those people are doing their more three four five diplomas but eventually no job. Outcome is that the knock the door for social assistance. They are frustrated you know. This is why 1) communication is a matter 2) your religious sentiment is a matter and cultural barriers very important in professional development.

The above quote clearly demonstrates that Canadian employers unnecessarily place more weight on language and communication. Immigrants think that in many jobs communication is not necessary and at the same time they have basic Canadian official language proficiency. However, still they face language and communication challenges to access to employment:

As we who have come here we have basic communication skills, may we have some oral communication lack. If we get 3 month training and give me a job for 3 months and my understanding is that I will be able overcome the oral communication problem within three months.

Another participant said:

There are some jobs where communication skills are essential like customer care service, but when I will go to customer service job I will go there with sufficient fluency. But as an accountant what's' my job accounting bookkeeping, so in this case I you do not need higher communication skills. But, when I am going to the job market as federal skilled worker I have fulfilled all of my l pre-requirement-

my education, my job experience, I have to fulfilled all the requirements But when I come here I fulfilled all the requirements as a skilled immigrants and when I come here. After coming here when I am going to enter the job market for me there is no jobs, Even though accounting clerk. But may be in my home country I worked in a multinational company as a supervisor that's a managerial position, ok and with my experience and education but coming here I have nothing.

Although immigrants believe that getting Canadian education may help to get access to employment, they are here for living a life, not for education. At the same time, everyone is not ready to go back to school considering their age, expenses and family. One South Asian man stated that "Getting admission is not difficult at all. Main things come again is you know how to kind of manage time between studies and to meet your expenses."

In addition to education, skill recognition and overemphasis on language and communication, the regulated professionals face systematic barriers to access to their profession of training:

Other thing is that which profession they are coming from it is regulated or not regulated. If regulated then you need to meet the regulations to take those courses. If it is not regulated like say administration, accounting or IT those kind of professions does require good communications skills, good attitudes, good interpersonal skills, so some of the clients we get high technical skill low soft skills and they feel to understand that in Canada like 80 of your soft skills and 20 of your technical skills, so they think oh my goodness I do not have technical education that the reason I am not getting jobs. So they end up going to back to school again to gain more technical knowledge. So the technical ladder become higher and softer remains the same and again they are ones who do not get jobs.

Most of the participants were concerned about their professional development in their field of study, the experience and skills they achieved in their home country. They have the understanding that the Canadian government recognized their education, skills and experience and based on that they are allowed to immigrate to Canada; then why are they not getting a job with that? They are immigrating to Canada to live a better life, not for

studying, so why will they have to get a Canadian degree to get a job in here? They are very unhappy with employment opportunities and many of them looked for a job for a long time with no luck. According to one participant,

> Whereas 80 percent or more than 80 percent people are immigrants and this is multicultural country. So we have to set up the system that immigrant people will get the benefit from the migration as per their education, qualification and skills.

7.5 How do Profession and Social Status in Canada Affect Health?

The focus groups' discussions reveal that immigrants lead a very stressful life. There is no peace, always insecurity, stress, which leads to unhappiness, frustration, and depression, which directly affect health. In addition, loss of identity and social status also provide pressure on everyday life. It is widely discussed by concerned immigrants that as soon as they are in Canada they go from the top of the hill to the bottom of the hill, hero to zero, and they will have to start from the beginning. Here is a conversation:

> **Man 1**: Those people especially from South Asia, After coming here all these expression going down, dream broken, frustrated, depression and all those frustration depression makes you diabetics, etc. etc. blood pressure, so what this is shows that you are getting properly things and health decline.

> **Man 2**: Not only jobs, but high expectation. It will happen. It is happening. That is the bylaw of the migration. Nobody can from the ancient time do the same thing. Migration, first generation have to suffer, ok now you can overcome that one how can overcome them. Good thing, people are going to ESL school, it helping…. They are helping a lot. You know everyone say, after coming here you have your rent, TTC pass, where is the money coming from, that is important.

> **Man 3**: You have to bring lot of money for six months.

Man 2: Six month is not enough, come on, **we are new born baby**, it is enough for six months.

Man 3: After six month you can apply for OSAP. You can go for social…

Man 2: That's not a got thing. This is not solution. Government should give proper education relevant to their skills and experience.

Man 2: In Toronto there is only problem that is job problem. Everything comes with the money. If you can solve the job problem everything solved. If you have money you will be able solve all of any problem. So you do not have to come, No one want to come to home at 2am, of course I want good life that does not mean ok one year, two years, three years, how long I will have to struggle, I want to mind to struggle 10 years after 10 years I want the assurance, like I am going to the right track. **I what about life what I expect not 100%, maybe I can get 50%, I do not want to come by blue nights after 10 years 3 o'clock in the morning with snowing everything. I don't mind to work like 3, 4 or 5 years hard job of course I understand.**

Those who are approved to immigrate to Canada as an economic category/independent category had a stable life with personal status and dignity in their home country. They were provided immigration based on their education, employment and overall personal achievement. However, as soon as they are in Canada, they face challenges with their previous achievement of education, skills and experience. They think that their social status and identity are lost and after being underemployed for a long time they become frustrated, which directly affects their personal health status. Many times, they do not even seek support from health professionals for their recovery.

7.6 How do Profession and Social Status in Canada Affect Mental Health?

Not getting a job in their profession and losing social status not only affects their physical health but also their mental health. In addition, it reduces their encouragement for employment and education. Not having a job also affects their food intake, for example: less food intake, less nutritious food which eventually brings health problems. One of the South Asian immigrant settlement workers working for South Asian in the GTA described a case a South Asian immigrant experienced:

Depression frustration and mental health issue are increasing. We have many clients with mental health issue. I had a client who could not find a job. First time I met he came to me very happy. He is from Bangladesh. He came to me very happy. He was in the IT field in Bangladesh. I told him we have ELT program and these and these and job search workshop programs. He told me that I do need that program. He told me that I have good English, good experience I will find a jobs very fast. I said good luck. He had a resume and I asked can I see your resume. He came for child tax application. I have resume and already send it to the employers' office, I said ok. I said good luck! He was very confident very happy. He comes back to me after 7 months, depressed, totally changed personality. Very happy go like …he is in tears. He said he is not getting jobs. He does not know what to do. I am losing my house. I have spent all of my resources, all my money. What to do. First thing I have to deal with his finances status I said ok deal with …. Now but he said shameful I said I understand you are not that situation but you know told him you need money desperately otherwise you might be out of your house, you will be homeless, and he says it is ok at least he agreed to that then we job search program. He attended the job search programs and workshop and attended the coop programs and now what to do, still he cannot find a job. It just few months over one year now…. He finished his placements and everything but not getting a job. Now he is having mental health issue. He is going under depression, he is doubting everybody, he is suspicious of everyone, his health is really being affected now. His wife is working though but they are

saying what to do what to do, like they very confuse now. He is panicking, he is starting panicking now.

The above quote provided a general case of a South Asian immigrant having tremendous challenges to access to services which are very important for their expansion of capability and freedom. This is not an isolated case; it is the common phenomenon that the visible minority immigrant community faces in the GTA.

Participants who faced challenges getting employment have a severe affect on their mental health which eventually leads to family problems. Here is a comment from one participant:

That affects whole family, specially the children, you know. They cannot meet the needs of the children and they become frustrated easily, they quickly get angry and then they show the harsh word to the children at that time they cannot control their anger the relationship is affects children.

The immigrants also face challenges because they are afraid of losing their identity or self-esteem. Here is a conversation between settlement workers that reveals the truth:

Woman: When we asked them not to mention their executive level experience on the resume when they are looking for an entry level position, they feel that a part of their identity has lost. They had put a lot effort reaching there, you learn so many things being there now you want to show them you are only high school student or only a year experience they do not like that. They do not want to do that and get a job.

Man: I always tell my customers be flexible and if you want to live Canada leave your previous designation back home. They have to come back later.

Woman: You have to start from scratch.

Numerous participants reported that they faced discrimination in their way to access to health-care services, education, and employment opportunities. Here is the quote:

I am a college student. Last semester when I was looking my placement although my GPA everything is much better than the Canadian students so I went to the group interview for community agency with my one friend also she is also from India post graduate so we went for interview there and then they called us back actually they called to my friend and told him that you know what you overqualified for our position so we cannot take you as a student here and they did not respond me so when I called they said ok you know what we are looking for someone who have Canadian experience and you are new this country so we cannot take you as a student as well. So we both were rejected from there and went back to my college practicum coordinator…. They manage one for me.

It is widely discussed and emphasized by most of the participants that outside job experience is not accepted here and without Canadian experience getting a job is impossible. Therefore, here is the vicious circle of getting Canadian experience. Here is a relevant conversation:

Woman: You are actually talking about the vicious circle, you do not get a job unless you have Canadian experience, you do not get Canadian experience if you do not have a job.

Woman: For professional license exam, you need to have certain numbers of paid hours as a technician to be eligible for exam and again the same thing if do not have the Canadian experience you cannot go for the exam and you cannot get the paid hours because you do not have the license, so either ways.

Man: Most of the professional.

These conversations provide the very delicate issue of various professionals who are looking for a license in Canada based on their back home education and employment. As they mentioned, it is a vicious circle: they will have to start from the very beginning and how is this possible for immigrants aged 35 to 50 years old? Since the regulatory structure is unchanged, any changes of the immigration policy will not help them at all.

7.7   Summary

The focus group discussions provided an unpleasant picture of what the South Asian participants are experiencing in their settlement process. Their expectations are lowered and they are fighting for survival, losing their education, relevant experience and the skills they achieved in their home country. The participants were not well informed about their new destination. They have an idea of a "dreamland," but when they arrive in Canada the reality they face is different. They do not know what steps they must take to overcome the challenges they encounter and how they can build their capability. In the new society, they face tremendous challenges to access health care in the form of lack of support services, lack of appropriate health-care services, access to education and employment opportunities; they also face discrimination.

The focus group participants are urgently pressing the issue that their barriers to accessing health care, education and employment opportunities not only frustrate them but also isolate them from their family members. They are even hiding from their close ones because of their inability of getting a better job, providing family members a better quality of life. This issue eventually creates mental health problems, which culminates in chaos in the family, affecting youth members of the family very adversely.

Chapter 8

8   Summary, Limitations and Implications

While income and material things might be necessary to facilitate a good quality of life, the capability approach recognizes that it does not automatically follow that there will be a strong link between income and access to resources and the ability to achieve valuable capabilities which are necessary for full participation in society and state (Sen, 2001). This capability approach considers people at the centre of the development process, with people regarded as the primary ends as well as the principal means of development. The goal of development is the promotion and expansion of capabilities, and the social opportunities make a direct contribution to the expansion of human capabilities. Access to health care is one of the very important social opportunities which directly contribute to the expansion of human capabilities (Sen, 2001).

The primary goal of this research was to determine the challenges/barriers experienced by the South Asian immigrants living in the Greater Toronto Area (GTA) and how these challenges/barriers are affecting their expansion of valuable human capabilities and limiting their quality of life in their host society. This chapter analyzes the key findings of this research, notes limitations, and discusses the implications of the findings for future policy, practice, and recommendations.

8.1   Key Findings

8.1.1   Access to Health Care

Almost one-third of the participants reported that they did not receive information about available health-care services in their area. The results also show that the participants experienced language barriers in accessing health-care services in the GTA. Sixteen percent of the participants reported problems in communicating their concerns to their physician and 54 percent experienced language barriers when trying to access the routine or ongoing health-care services they needed (discussed in section 5.4.1).   The South

Asian immigrants come from different health-care systems, and understanding the Canadian health-care system and information is not easy for them. As soon as the immigrants are here, they become busy with their employment and careers; they need money to feed their families. They have very little time to get information regarding health and the health-care system. Only when they need services do they start looking for where to go, how to go and how the systems work - and they face challenges. This should be the role of settlement services agencies, but they have very few programs to educate immigrants regarding health-care systems and services. As well, general language proficiency and the health-related vocabulary or health literacy are different; thus, they face tremendous health literacy or health-related language problems even when they have some proficiency in the English language (discussed in section 5.4.4).

Culture and tradition play important roles in getting appropriate health-care services (discussed in section 5.4.5). If the physicians and nurses understand the patient's traditions and cultural values, it becomes comfortable for both sides to communicate effectively with respect. This helps to understand the health concerns and provide the appropriate services. It is important to mention that 54 percent of the sample population thought that different socio-culturally-based understanding about health and health care is a barrier to culturally appropriate health care. Another cultural barrier is that 40 percent of the sample population is not comfortable being touched and examined by opposite-gender health professionals. Family plays an important role in health decisions; 57 percent responded that family members influenced their health decisions.

As a distinct cultural community, the South Asian immigrants' community faces very strong challenges because of cultural differences (discussed in section 5.4.5). Culturally South Asians are not open and comfortable about sharing with and providing health-related information to the opposite sex. In the case of women, it becomes very difficult to share their problems with opposite sex health care professionals, not only for religious reasons but also from cultural perspectives. Sometimes professionals do not understand and respect these patients' cultural perspective, which is another fear of South Asian women. In the focus group discussions, many women made it clear that only same-sex professionals understand their health-related problems and a lot of health-related

problems and issues are very difficult for a professional with a different cultural background to understand (discussed in section 7.3). For example, many doctors refuse to serve if women do not open their veil.

In the case of employment opportunities, the participants faced multiple challenges and barriers. Almost half of the participants' general and professional degrees and diplomas, experience and skills obtained outside Canada/USA were not recognized here in Canada (discussed in section 5.4.7.2). The unemployment rate of the sample population is very high. Only 48 percent of the sample population is working full-time, and only 33 percent of women are employed full-time. In 2012, however, the employment rate for men was 65.8 percent and for women, 57.9 percent (Ministry of Employment and Social Development of Canada, 2014). The immigrants' employment rate is below the national average. They also responded that their credentials were undervalued by the employers and they did not have opportunities for professional development in ways that matched their training. More than 65 percent responded that underemployment increased their unhappiness, frustration, anxiety and depression.

When immigrants decide to immigrate to Canada, they have an expectation and plan for their future career. They think that as the Canadian government is accepting and recognizing their education and experience for the immigration point system, they will get a similar professional job in Canada. That pre-arrival assumption of visible minority immigrants simply does not come true. Although the Canadian government recognizes the immigrants' credentials for their immigration application processing, that recognition does not work inside Canada. Here, there are regulatory bodies for professionals and they have their own recognition policies and procedures (discussed in section 7.6). At the same time, although the government or credentials evaluator provides immigrants with equivalency certificates, the employers do not respect or count them and there is a communication and understanding gap between the employers' and immigrants' communities. In addition, many immigrants complain about the mindset of foreign education and experiences. They look for a job relevant to their education and experience and they try year after year, but they are forced to start working at whatever is available

to them and at the end they become stuck there with frustration and mental health problems and their health eventually declines (discussed in section 5.4.7.2, 7.4 & 7.6).

The monthly personal and household incomes support their stories (discussed section 5.5.7.9). Among the sample population almost 26 percent of the population earned less than $1000 per month; 27 percent earned $1000 to less than $2000 per month; 12 percent earned from $2000 to less than $3000; 16 percent earned $3000 to less than $5000; 14 percent earn $5000 to less than $7000; and only 5 percent earn more than $7000 per month. It is important to note that 65 percent of the respondents have an income of less than $3000 per month. Their situation has improved very little; for those who have lived less than 1 year in Canada 92 percent's monthly income is less than $3000; 93 percent for those who have lived less than two years in Canada; 89 percent for those who have lived less than three years in Canada; 77 percent for those who have lived more than three years in Canada but less than 5 years in Canada and 50 percent, those who have lived longer than 5 years in Canada. In Canada in 2011, real GDP per capita was $ 39, 370 and in Ontario in 2010 it was $46, 304 (Ministry of Employment and Social Development of Canada, 2014). That means that 89 percent of immigrants living in Canada less than three years, and 50 percent of immigrants living here more than five years were far behind the Ontario per capita income (discussed in section 5.4.7.9).

The annual household income of the sample is very low; 53 percent's income is less than $40,000 per annum and 69 percent's income is less than $ 60,000 per annum; of those who have lived more than 5 years in Canada, almost 55 percent's income is less than $60,000 per annum. For the participants with university degrees, almost 33 percent's household income is less than $20,000 per annum, 20 percent's income is less than $40,000 per annum, and 16 percent's income is less than $60,000 per annum. In 2011 in Canada, families living one of the large urban areas such as Toronto, the median after-tax income were $72,600 (Ministry of Employment and Social Development of Canada, 2014). Therefore, it is clear that an immigrant family living in Canada more than five years falls far behind the income of a large city's family income. These personal and household incomes provide very grim pictures of immigrants' standard of living.

Therefore, as soon as the immigrants enter Canada and begin to look for jobs they see the situation and become depressed and start panicking. In this position, they need a very personalized evaluation of their education and experience and how that can be transferred in the Canadian perspectives with relevant training, education, volunteering and upgrading.

From the above discussion, it is not surprising that more than 75 percent reported that their well-being has been compromised and they are not living the quality of life they were expecting in Canada (discussed in section 5.6). In addition, 77 percent responded that their well-being is being compromised by the difficulties they experienced in accessing appropriate health care. The majority of participants, 55 percent, reported that their freedom is being compromised by difficulties in accessing appropriate health care. In addition, 60 percent reported that their achievement is being compromised by difficulties in accessing appropriate health care. Half of the population, 51 percent as well, responded that barriers accessing health care limit their integration into their new society.

8.1.2   Health and Human Development

The chi-square analyses and cross tabulation supported the hypothesis that the health status of South Asian immigrants deteriorates after living in Canada for a few years (discussed in 6.2.1). Although not hypothesized, it was found that male immigrants' health is better than female immigrants'. For those who are highly educated, although working full time but not in their field of study, their health had declined rapidly. In addition, those aged between 30 and 65 and living in Canada more than 5 years have a worse health status than others.

There are statistically significant associations between South Asian immigrants' current self-rated health status and the variables involved in accessing barriers to health-care services (discussed in section 6.2.2). The South Asian community initially faces the challenges to enter into health-care services and information and how to use the system.

The system is different from back home; therefore, they need information on where to go, how to get appropriate health services in their community. South Asian immigrants' distinctive cultural perspectives also contribute to their barriers to accessing health-care services (discussed in section 7.3). Their understanding of health and the healthcare, symptoms, and help-seeking approach is different. For example, South Asian women are not comfortable sharing their health concerns with a male health professional.

The study findings also confirm that the South Asians face tremendous challenges to building their career in Canada. Their education, employment and skills are not recognized; even when those degrees are recognized, it is very difficult to get employment in their field of interest. Most importantly those who are immigrating to Canada have families and they do not have enough time and money to start education again after having the highest level of education and extensive experience and skills in their home country.

The chi-square analyses supported the hypothesis that health-care accessibility challenges are limiting the South Asian immigrants' quality of life and their human development is being compromised (discussed in section 6.2.3). They also confirmed that there are statistically significant associations between South Asian immigrants' accessing barriers to health care services and their quality of life and human development.

8.1.3   Discussion of Barriers to Accessing Health Care

It is very clear from the discussion that newcomer immigrants are not taking an informed decision about immigrating to Canada (discussed in section 7.1). From their home country they think that when they will be in Canada, life will be very easy and rewarding. They come with an impression that as soon as they are in Canada everything is readily available for them such as health-care services, employment and other opportunities as required for the growth of capabilities and freedoms. On arriving here, they face the reality which is not similar to their dream and they become puzzled, lost, depressed,

anxious and panicky. Obviously, they are not informed about the available settlement services and other services which could help them in their resettlement period.

At the same time they face health care accessibility challenges such as health information, how to use those services, language problems, health literacy problems and cultural problems. They understood how important culturally appropriate health care is for them and that they need to get the culturally appropriate health care services; they are even ready to pay if it is affordable (discussed in section 7.3). They think that if the health professional understands their cultural perspectives then he/she will be able to provide appropriate services. To get the culturally appropriate health care services, they are even ready to get services from non-licensed South Asian health professionals.

Almost all of the immigrants' populations were worried about their professional development (discussed in section 7.4). Their South Asian degrees, work experiences and skills are not recognized here in Canada. According to them Canadian employers put overemphasis on language and communication, and have a negative mind set about colored people. They also think that there is a mind-set that South Asians cannot communicate, do not know either English or French. Although many immigrants want to go back to school, education is costly and they have family, so need an income immediately. At the same time, they are not well informed, do not know procedures, cultural transition, credentials assessment, and are not informed of how to capitalize and translate outside credentials and experience into Canadian. They are not informed about their career opportunities here and do not get appropriate counseling for professional development, which is very crucial for the settlement.

This discussion again makes it clear that they are not getting sufficient, appropriate and timely career development information and counseling regarding where they will start and how long it will take and where to stop. In addition, what will be the best match with their previous education and experience and how can they get relevant education or training to build successful professional development? This kind of settlement service is rare, so the immigrants are not informed about issues. In addition, loss of identity and social status also provides pressure on everyday life.

The focus group discussions provided information that not getting a job in their profession and losing social status not only affects their health but also creates mental health issues (discussed in section 7.4 and 7.5). The participants noted that mental health problem become worse as time goes on and directly affect family, especially younger members of the family. In addition, it reduces their enthusiasm for employment and education. Not having a job also affects their food intake: less food intake of less nutritious food eventually brings health problems.

The focus groups' discussions provided a harsh picture of the South Asian community coping with their settlement process. They have a mindset but they do not know how to get out of it, what the processes and procedures are and how long it will take to get back their hope. Who will help them with personalized care? The settlement services could be the best way to get help but the question remains: are they able to provide appropriate services with their existing structure?

The focus group discussions provided the very real situation of the community who are looking for appropriate cultural health-care services and personalized career counseling for their full settlement in Canada. They do not want 'one size fits all' services; they want personalized appropriate settlement services for their health, well-being and the building of human capabilities and freedom. They need more individualized counseling and a support system to translate their knowledge and skills into a Canadian perspective and arrange to have some job experience, education upgrading and help in learning the Canadian style of communication, knowledge and training for entering into the job market.

Figure 64: **Analytical model of human development**
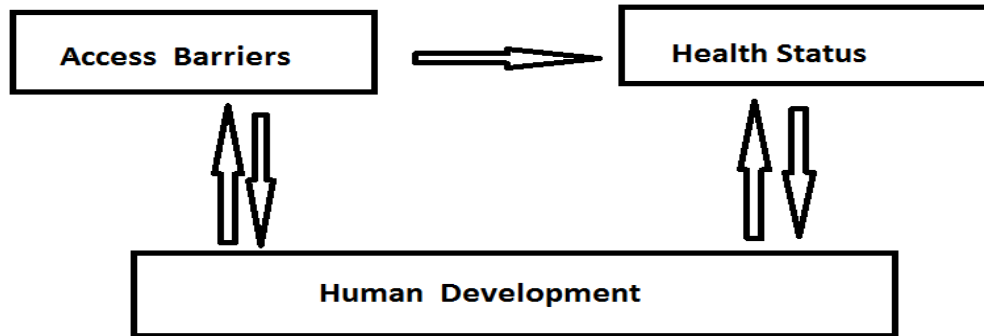
Both quantitative and qualitative research indicates that the South Asian immigrants living in the Greater Toronto Area face barriers to access to health care:

- ➢ The newcomer immigrants' 90-day waiting period is a barrier to accessing to health-care services.
- ➢ They face challenges getting information on available health care services and how to navigate the Ontario health-care system.
- ➢ There are challenges in waiting time in the hospitals as well as finding family doctors.
- ➢ They face language and health literacy barriers to receive their ongoing and routine health-care services and make health decisions.
- ➢ Culturally appropriate health care is one of the main barriers immigrants face in the GTA.
- ➢ Cultural perspectives such as family members influencing the decision making may also delay their access to care.
- ➢ Cultural as well as religious beliefs sometimes play a major role in accessing health-care services.
- ➢ Almost all of the immigrants are facing professional development challenges in their field of education and experience.

> ➢ South Asian immigrants are also facing challenges in getting employment in their field of training and experience.

Almost all of these challenges/barriers are influencing immigrants' health in the GTA. The findings also confirmed that there are significant associations between access barriers and health status, quality of life and human development. The results of the statistical analyses confirmed that their health is deteriorating. Health care accessibility challenges in the form of access to health, education and employment opportunities are limiting the South Asian immigrants' expansion of capabilities, eventually affecting their quality of life and their human development. The findings also confirmed that those who had a better self-rated health had a better quality of life. The analytical model is therefore supported and confirmed by these research findings.

8.2   Limitations of the Study

On the advice of his thesis committee, the researcher was trying to collect around 200 samples of South Asian immigrants living in the Greater Toronto Area (GTA). As the researcher mentioned in chapter 4, to get help collecting data he communicated with organizations that are providing services to the newcomer immigrants in the GTA. Although many of the organizations agreed to help, after a long time they expressed their helplessness. At that time, talking to the thesis supervisory committee members and others in the GTA, the researcher came to the decision that if he did not provide any honorarium it would be difficult to collect the desired data. Thus, the researcher applied to the Laurentian University Research Ethics Board to allow him to provide some honorarium to collect data. Another issue the researcher faced in collecting data is that some of the South Asian immigrants were afraid of providing information. Their understanding is that if they provide information then they will be in trouble. For that reason, many South Asians, although willing, refused to provide information, and thus it took a long time to collect research data.

As the research is a cross-sectional research design, analyzing the access barriers to health care services, employment and educational opportunities, it is very important to conduct focus group discussions for in-depth understanding of the issues, better explanation of the survey data, analyzing and getting participants' feedback about the findings of the survey questionnaires. However, it was very difficult to arrange focus groups with all of the South Asian community proportionately.

No sample frame is available to get random sampling data for a particular ethnic community in a large area like the GTA. For that reason, the researcher chose convenience sampling and therefore, results cannot be generalized. However, the researcher tried to maintain a representation from all the nations of South Asia, small communities, gender, age groups, professionals and language speakers of South Asian living in the GTA. For inclusiveness of the representation, the researcher also translated questionnaires into six major South Asian languages.

8.3   Implications of the Study

Canada needs immigrants and the government is trying to spend vigorously on settlement services for their successful settlement and participation in our process; however, the question remains whether these are sufficient for an effective, appropriate settlement service, which eventually could lead to the immigrants' integration into their host society. Debbie Douglas, executive director of the Ontario Council of Agencies Serving Immigrants said this about the services and integration:

> We have probably the most developed settlement and integration sector in the world. From coast to coast, there are a myriad of services from employment support to language classes, general settlement adaptation supports and organizations working on issues of racism through public education and other interventions. (cited in Ryan, 2014, p. 53)

Although government is spending, however, the study findings raise the questions of whether the settlement services programs are appropriate for the visible minority

immigrant populations, as well as cost effective, or do they lack funding to better serve the immigrants? In addition, this study's findings suggest that only a very small number of immigrants are receiving settlement support services. Furthermore, the immigrants are not informed about the programs. According to the immigrant populations, these programs are very limited, not the kind of service they need to reach their full potential and growth of human capability and freedom.

The settlement services for immigrants should be relevant to immigration policy, employment policy, health policy and education policy. The settlement services and a delivery system should be designed based on these policies. In addition, the repeated changes in immigration policy will not help until we understand and identify the real problems and the kind of policy we should formulate; according to that we can design our settlement services programs and their delivery.

The study findings assert that the participant immigrants desperately want help for their settlement and future career in Canada; they want:

- ➢ Ontario Health Insurance Program (OHIP) services from the very first day of their entering into Canada; they reported that community health services and/or private insurance are not enough.
- ➢ Culturally appropriate health-care services; they are ready to pay for them.
- ➢ Specific directions and counselling regarding their skills and experience, relevant employment and education.
- ➢ Vigorous English language services for not only everyday life but also for attending university/colleges.
- ➢ Very specific and in-depth and rigorous assessment of their education, experience and skills and counselling to convert their credentials into Canadian ones, which will help them in their new society. They reported that current services are ineffective and insufficient and not specific.

Immigrants' full participation is only possible when they have opportunities to have equal and appropriate access to health care, education, and employment opportunities. For this, to happen, appropriate policies and programs appropriately targeted to the immigrants

must be in place. To do so, a coordinated effort to change the policies of the relevant ministry would be required for real change in immigration policy, employment and social development policy, health policy and education policy. Other than effective changes and reforms, below are some temporary/permanent measures that could be taken as a best practice settlement service model:

➢ Informed decisions: As soon as they apply for Canadian immigration they will be informed of Canadian society, employment, education and the hurdle waiting in front of them for settlement.

➢ Pre-arrival orientation and counselling: the Canadian embassy will arrange mandatory pre-arrival orientation and counselling on the Canadian way of life and settlement services' importance and how and where they will have to get those services as soon as they arrive in Canada.

➢ Arrival/Entry point orientation: As soon as the immigration officer accepts and welcomes them to Canada, the officer will make sure that where they are going to stay is close to where the one-stop settlement services office is located and they will within a certain time report to the one-stop service centre and will make an appointment for future career counselling and other services required and essential for their successful settlement in Canada.

➢ For better settlement and integration services there will be a region-based, one-stop immigration services office where every immigrant will report and there will be highly trained counsellors to assess and frame their future career and needs such as health, education and employment, guidelines relevant to their previous education, experience and skills; they will be sent to a specialized settlement services agency according to their need and prioritization.

➢ Every support services agency will be highly trained and specialized in only one aspect of settlement services. They will not provide all kinds of services, but particular specialized support services. For example, some neighborhood centers will specialize in language training only; some will be highly specialized for health care services; some will provide services only for educational needs; some will provide services only for employment-related services; some may help to build soft skills, and some may work for immigrants' technological skill building

services. These services will be practically oriented and appropriate for their needs.

➢ The immigration officers will make sure that when immigrants are entering Canada they will receive information to get ready to spend at least six months learning communication ways, building relevant skills and experience, learning the Canadian way of communicating, cultural perspectives, technological skills and making their plan for their future life in Canada before they enter employment, education or whatever is appropriate for them.

➢ This model could be implemented with current resources and promoting best practices in settlement services based on immigrants' real-life needs.

➢ Creating a vibrant forum for ongoing discussion and research with community partners, immigrants, the business community, colleges and universities, health care service providers, and representatives of relevant ministries. Their dialogue should focus on immigrants' needs, realities, and challenges to find solutions that recognize immigrants' contributions and validate their human capital.

8.4   Conclusion

People from different countries are migrating to Canada for a better, secure, easier and professional life with fully developed capability and freedom. This is not only for a secure professional life, but also the hope for Canadian multicultural policy which also encourages migrants to choose Canada as their destination. However, the research findings did not confirm the visibility of multicultural policy effects on immigrants' access to culturally and linguistically appropriate health-care services. The participants reported that they are not getting culturally appropriate health-care services in the GTA. As a result, as soon as they enter Canada, they face a grim reality, which most of them are not ready to embrace.

However, within this reality, immigrants' populations are trying to build up their asset base, working for a better life and trying to integrate into their host society. A Conference Board Report of 2010 on Immigrants as Innovators: Boosting Canada's Global

Competiveness stated that immigrants are the seekers of a better future and quality of life. In a knowledge-based economy immigrant populations try to maximize their opportunities for better quality of life with their higher education and skills, comprehensive experience in Canada and abroad, knowledge of diverse culture and languages, and understanding of wider market opportunities from different perspectives, which lead them to be the best innovators in Canada (Downie, 2010). Releasing the report, Dianna MacKay, the Conference Board Director for Education and Health, said that, "At every level we examined—individual, organizational, national and global—immigrants were associated with increased innovation in Canada" (The Conference Board of Canada News Release 11-37, 2010). Not only are they contributing to our population growth; they are also contributing to the economy. Spitzer (2011) confirmed that "immigrants contribute significantly to Canada. We rely on immigration to sustain our population and our economy; thus, even in the most utilitarian sense, good migrant health benefits us all" (p. 249). From this perspective, immigrants' access to health, education and employment should be considered a priority for their health, well-being and growth of capabilities and freedom which will eventually lead to their human development; then they can contribute and fully participate in our society. For that, a very effective, real-life best practice settlement support services system is essential, one that can help immigrants' access to health care, education and employment opportunities significantly.

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Appendix 1

Human Development Focusing on Access to Health Care of South Asian Immigrants
Living in trhe Greater Toronto Area (GTA)

Research Questionnaire
(Please tick the appropriate box and/or write answers)

Name:……………………………………………………
Telephone:…………………………………………
Gender: …………………………………..
Age: …………………………………
Marital Status: (Tick the one that describes your current situation best)   □ Married   □ Single   □ Separated   □ Divorced   □ Widowed   □ Common law partner
In what country were you born?   □ Bangladesh   □ Bhutan   □ India   □ Maldives   □ Nepal   □ Pakistan   □ Sri Lanka
When did you first immigrate to Canada?   Year………………   Month………

General Settlement Support

1.	Did you have any relatives in Canada when you moved here?	Yes □	No □
2.	Did you have any friends in Canada when you moved here?	Yes □	No □
3.	Did you receive any social support services (such as settlement, housing and other basic need) for resettlement after coming to Canada?	Yes □	No □
4.	Did any person or any organization inform you about the support services available here for you?	Yes □	No □
5.	Did you attend any information session regarding available support services for settlement in Canada?	Yes □	No □
6.	Why did you choose to live in Toronto? □ Got a job □ Employment opportunities □ Friends □		

	Relatives □ Community people □ Other (specify)……………….		
7.	Did you attend any language proficiency classes after coming to Canada?	Yes □	No □
8.	Did you have internet access when you came here?	Yes □	No □

Health Information

9.	Did you receive any information about available Ontario health care services?	Yes □	No □

10.	Whom do you contact most often when you need health information or advice for yourself or a family member?
	    □ Doctor's office □ Community health centre □ Walk-in clinic
	    □ Telehealth Ontario □ Emergency room □ Other
	(specify)…………..		

11.	Did you ever experience any difficulties getting the health information or advice you needed?	Yes □	No □

12.	What type of difficulties did you experience getting the information or advice you needed?
	
	    □ Difficulties contacting a physician or nurse □ Did not have a telephone number
	    □ Could not get through (i, e. no answer) □ Waited a long time to speak to someone
	    □ Did not know where to go/call/uninformed □ Did not get adequate information
	    □ Other………………………….		

13.	When you emigrated from your country, how good was your health? □ Poor □ Fair □ Good □ Very Good □ Excellent		
14.	In general, how is your health now? □ Poor □ Fair □ Good □ Very Good □ Excellent		
15.	In the past 12 months have you required health information or advice for yourself or a family member?	Yes □	No □
16.	During the past 12 months for your own health how many times did you seek or talk to a Times None Family doctor or general practitioner? ………. ……………. Medical specialist? ….…… ………… Dentist? ………... ………… Optometrist or optician? ………... …………		

	Nurse (excluding making appointment)? ……….. …………. Chiropractor? ……….. …………. Psychologist, Social Worker, or Counselor? ……….. ………… Physiotherapist? ……….. ………….. Any other health care professional? (Specify)………… ………… …………. If you have never visited a doctor, a clinic or a hospital, what is the reason?...........................		
17.	Do you have the information you need about the Ontario health care system?	Yes □	No □
18.	Do you have extended health benefits/insurance (e. g., prescription drugs, eye care and glasses, dental care, chiropractor and so on)?	Yes □	No □
19.	Do you think that costs of extended health benefit act as a barrier to accessing health care?	Yes □	No □
20.	Do you have a family doctor? (If your answer is no, then skip questions 21 & 22, go to question 23)	Yes □	No □
21.	Did you have to wait to get a family doctor in this city? If yes, how long did you wait for a family doctor? (Complete the followings) □Year….. □Month(s)..... □Days……….	Yes □	No □
22.	Does your family doctor know your mother tongue?	Yes □	No □

Language

23.	What language did you first speak in childhood?	□ English	□ French	□ Other (specify)…
24.	What language do you speak most often at home?	□ English	□ French	□ Other (specify)…
25.	Do you have any problem communicating your concerns to your doctor?	Yes □		No □
26.	Do you need a translator or help to communicate with your doctor?	Yes □		No □
27.	How often did you experience any language barriers when trying to get the routine or ongoing health care you needed? □ Always □ Usually □ Sometimes □ Rarely □ Never □ Not applicable			

Health Literacy

28.	Are you familiar with how to use the Ontario health care system?	Yes □	No □
29.	Do you understand your physician's instructions and directions?	Yes □	No □
30.	Do you understand basic health information and the services needed to make appropriate decisions about your personal health?	Yes □	No □
31.	Are you able to communicate effectively with health professionals to get information about your health?	Yes □	No □

Culture and Tradition

32.	Do you think your physician understands your health-related cultural beliefs?	Yes □	No □
33.	Do you think your physician respects your traditional beliefs and customs regarding your health?	Yes □	No □
34.	Do you think that different socio-culturally-based understanding about health and health care is a barrier to culturally appropriate health care?	Yes □	No □
35.	a) Are you comfortable being touched and examined by a male/female doctor/nurse?	Yes □	No □
	b) Are you comfortable being touched on your private body parts, if necessary, by a health provider of another gender?	Yes □	No □
36.	Do your family members influence you in your health decisions?	Yes □	No □
37.	Does Canadian medicine fulfill your health care needs and services?	Yes □	No □
38.	Do you use any cultural-specific (e.g., vaids, homeopaths, naturopaths, unani, and tantrik) alternative medicine?	Yes □	No □

Geographic Accessibility

(If you have never visited a doctor, a clinic or a hospital, please skip questions 39, 41 & 42)

39.	Do you have access to health care services (such as hospitals) in your neighborhood?	Yes □	No □
40.	Do you/your family own a vehicle?	Yes □	No □

41.	What kind of transportation do you usually use to go to your doctor/hospitals? □ Your own/family vehicle □ Bus □ Taxi/Cab □ Walk □ Bike □ Ride with friends/relatives □ Other (specify)............................		
42.	Do transportation difficulties prevent your access to health care?	Yes □	No □

Education & Employment

43.	What is the highest level of education that you have attained? □ Doctoral (Ph.D., D. Phil., D.Sc., D. Ed.) □ Masters (M.A., M.Sc., M.Ed., ME, M. Eng.) □ Degree in Medicine, Dentistry, Veterinary Medicine, or Optometry (M.D., D.D.S., D.M.D, D.V.M., D.D.) □ Bachelor or undergraduate degree in Engineering (e.g. B.E., B. Eng., B. Tech. B.Sc. Eng., B. arch) □ Bachelor or undergraduate degree, or teacher's college (e.g. B.A., B.Sc., B.A. Sc., LL.B) □ Diploma or certificate from community college, CEGEP or Nursing school □ Diploma or certificate from trade, technical or vocational school or Business College □ Some university □ Some community college, CEGEP or nursing school □ Some trade, technical or vocational school or Business College □ Other……………………………………………		
44.	Where did you complete your degree(s)/diploma (s)? (Tick/write as many as applicable to you) □ Canada /USA □ South Asia □ Other (specify)……………… (If your answer is Canada /USA, please skip questions 45 & 46)		
45.	Are your degree(s)/diploma(s) recognized here in Canada?	Yes □	No □
46.	a) Are your professional qualifications recognized here in Canada?	Yes □	No □
	b) If your answer is yes, do you think that your degree/diploma outside Canada/USA is evaluated as being equal to Canadian/USA degree/diploma?	Yes □	No □
47.	Have the skills and experiences you obtained outside Canada/USA been recognized in Canada?	Yes □	No □
48.	Which of the following describes you best? □ Employed full-time (including self-employed) □ Unemployed and looking for job		

	□ Employed part-time (including self-employed) □ Full-time student □ Unable to work due to long-time sickness or disability□ Looking after home/family □ Retired from paid work □ Other ……………………… If you are not employed, can you explain the reasons?		
49.	Did you face difficulties/barriers in finding employment in Canada?	Yes □	No □
50.	Are you working in the same profession/field as you did prior to immigrating to Canada?	Yes □	No □
51.	Do you think that your credentials (obtained from outside Canada/USA) are being undervalued by employers? (If you have obtained your degree in Canada /USA, please skip this question)	Yes □	No □
52.	Do you believe that your job does not match with your qualifications? If yes, do you know why? ………………………...	Yes □	No □

53.	Do you think that underemployment (your job does not match your qualifications) increases your (please respond whom applicable):
	            a) Unhappiness Yes □ No □
	            b) Frustration Yes □ No □
	            c) Anxiety Yes □ No □
	            d) Depression Yes □ No □		

54.	How satisfied are you with your job or employment?
	    □ Very dissatisfied □ Dissatisfied □ Neither satisfied nor dissatisfied
	    □ Satisfied □ Very satisfied		

55.	a) For how long have you worked in Canada? Year(s)……………. Month(s)………		
	b) What is your personal monthly income? □ Less than 1,000 □ 1,000 to less than 2,000 □ 2,000 to less than 3,000 □ 3,000 to less than 5,000 □ 5,000 to less than 7,000 □ 7,000 and more		
56.	What is your best estimate of your family/household income from all sources, before deductions during the past 12 months? □ Less than 20, 000 □ 20,000 to less than 40,000 □ 40,000 to less than 60,000 □ 60,000 to less than 80,000 □ 80,000 and more		

Daily Activities

57.	Does your health limit your daily activities, such as grocery shopping? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
58.	Does your health limit your social activities such as getting together with family, friends, neighbours or groups? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
59.	Does your health limit your recreational activities such as your hobbies? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
60.	Does your health limit your household activities such as household chores? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Capabilities and Freedom

61.	How satisfied are you with your life in general? ☐Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied
62.	Thinking about the amount of stress in your life, how would you describe most of your days? ☐ Not at all stressful ☐ Not very stressful ☐ A bit stressful ☐ Quite stressful ☐ Extremely stressful
63.	Do you think you are living the quality of life you were expecting in Canada? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
64.	Does your socio-economic situation limit you in achieving self-esteem? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
65.	Does your current situation limit you in achieving the respect of family, groups and community? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
66.	Do you have access to community resources such as education, employment and housing? ☐ Not at all ☐ A little bit ☐ Moderately

	□ Quite a bit	□ Extremely	
67.	Do you have opportunities for professional development in ways which match your training? □ Not at all	□ A little bit □ Extremely	□ Moderately
	□ Quite a bit		
68.	Do you have the opportunity to have to live a full and creative life? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately
69.	Do you have the opportunity to choose among alternative options to live your life? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately

Experience of barriers to health care

70.	How do you rate the quality of health care that you receive from the family physician or general practitioner or from the hospital staff you rely on most for your health? □ Poor □ Good	□ Fair □ Very good	□ Neither good nor bad □ Not applicable
71.	Do you think that your well-being is being compromised by the difficulties you experience in accessing appropriate health care? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately
72.	Is your freedom being compromised by difficulties in accessing appropriate health care? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately
73.	Are your achievements being compromised by difficulties in accessing appropriate health care? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately
74.	Do barriers to accessing to health care limit your integration into your new society? □ Not at all □ Quite a bit	□ A little bit □ Extremely	□ Moderately

Appendix 2

Focus Group Discussion/Interview Questions

1. a) What do you understand by appropriate health-care services?

   b) How important it is to have culturally appropriate health-care services available?

   c) What type of culturally-appropriate services is required by your community?

   d) If appropriate health care is not available, how is that going to affect you?

   e) If you have to pay to get culturally appropriate health care services, will you do that?

2. a) Are some traditional health and healing services (e.g., vaids, homeopaths, naturopaths unani, tantrik) available here in Toronto?

   b) Have you ever used traditional health and healing services (i.e., vaids, homeopaths, naturopaths unani, and tantrik)?

   c) If so, how effective are they?

3. What are the barriers to health care for your South Asian community?

4. a) Are there barriers in getting job-oriented education?

   b) If so, what are the barriers?

5. a) Are there barriers to professional development in South Asian immigrants' field of training?

   b) If so, what are the barriers?

   c) Do they affect South Asian immigrants' health?

6. a) How does immigration to Canada affect South Asian immigrants social status?

   b) Does it affect South Asian immigrants' health?

   c) If so, how?

7. a) Are there freedoms and opportunities to choose one kind of life over another?

   b) If not, what are the barriers?

   c) If yes, how do they help immigrants from South Asia?