THE EXPERIENCES OF NEW IMMIGRANTS SEEKING EMERGENCY HEALTHCARE IN THE CITY OF KELOWNA

by

Emad Awad

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

THE COLLEGE OF GRADUATE STUDIES

(Interdisciplinary Studies)

THE UNIVERSITY OF BRITISH COLUMBIA

(Okanagan)

March 2016

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The undersigned certify that they have read, and recommend to the College of Graduate Studies for acceptance, a thesis entitled:

The Experiences of New Immigrants Seeking Emergency Healthcare in the City of Kelowna

Submitted by Emad Awad in partial fulfillment of the requirements of

The degree of Master of Art - IGS

Dr. Jose Carlos Teixeira, Irving K. Barber School of Arts & Sciences
Supervisor, Professor (please print name and faculty/school above the line)

Dr. Joan Bottorff, Faculty of Health and Social Development School of Nursing
Supervisory Committee Member, Professor (please print name and faculty/school in the line above)

Bernard Momer, CCGS, Irving K. Barber School of Arts & Sciences
Supervisory Committee Member, Professor (please print name and faculty/school in the line above)

Wendy Andrews, Faculty of Health and Social Development School of Nursing
University Examiner, Professor (please print name and faculty/school in the line above)

Bruce Newbold, School of Geography & Earth Sciences, McMaster University
External Examiner, Professor (please print name and university in the line above)

April 7, 2016
(Date submitted to Grad Studies)
Abstract

Several studies acknowledge that immigrants encounter barriers when accessing health care in large Canadian cities. Little is known about new immigrants’ access to emergency health care in mid-sized cities. This study explores the barriers faced by new immigrants when accessing emergency health care in the city of Kelowna, a mid-sized Canadian city, and the strategies new immigrants use to deal with these barriers.

The data for this study were collected between April and August of 2015 through a survey of 40 new immigrants in Kelowna and follow-up interviews with a subsample of eight of the survey respondents.

The results indicate that new immigrants face several barriers when accessing emergency health care in Kelowna: long wait times, perceived inadequacy of care, language barriers, lack of knowledge about the emergency care system, culturally incongruent care and perceived discrimination, and financial burdens.

Additionally, the study demonstrates that a large proportion of new immigrants are not prepared to obtain health care during their first three months in Kelowna, primarily because they are unfamiliar with the emergency care services and provincial insurance policies. The province of British Columbia does not extend its health insurance coverage to immigrants during their first three months of residency and a large proportion of immigrants do not enroll in private medical insurance.

Depending on the nature of the barriers to accessing emergency care, new immigrants use three main coping strategies: silence, help-seeking, and personal initiatives. Silence or non-action is a common response to system related barriers, while help-seeking is a common coping technique for non-system related barriers. Personal endeavors, such as using
alternative care are commonly used by medically uninsured immigrants during their first three months in Canada while waiting for provincial insurance coverage.

The results of this study yield policy and practice recommendations aiming at improving new immigrants’ access to emergency health care. Recommendations derived from the findings of this study are to reduce the wait time in emergency departments, reevaluate the policy of a three-month wait for provincial insurance coverage, educate new immigrants about the emergency care system, and improve the quality of care provided in emergency departments.
Preface

This thesis is an original intellectual product of the author, Emad Awad. The fieldwork reported in chapters four to eight was covered by Behavioural Research Ethics Board Okanagan Certificate number H15-00462.
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Acknowledgements

I offer my enduring gratitude to my supervisor, Professor Carlos Teixeira, for his guidance and support throughout the process of completing this thesis. Professor Teixeira has always provided extraordinary support during this veritably profound experience. To my committee members, Professor Joan Bottorff, who continuously provided incredibly precise and constructive feedback that has greatly assisted me in performing this work, and Associate Professors Wendy Andrews and Bernard Momer, who supported me with their constructive feedback and their sincerity throughout all the stages of my research.

My sincere thanks go to all the new immigrants who trusted me to do justice to their responses to both the questionnaires and the interviews. I truly appreciate the efforts of the administrators and gatekeepers of all the organizations that assisted in the success of this study, including the Kelowna Community Resource, Kelowna Islamic Centre, Sikh temple, and Kelowna Friendship Society.

I am thankful to my fellow graduate students, friends, and relatives in Canada and outside of Canada. Special thanks to my sister, Hala Awad, who always kept me reinforced and focused on my life goals and how to achieve them.

To my parents, my wife, my brothers, and my children, Mohammad, Omar, Yousef, and Ryan, who are my greatest blessings. Thank you for all your love and laughter – God bless you all.
Dedication

To the virtuous, principled, and noble humanitarians and freedom fighters in the world
Chapter 1 Introduction to the Study

1.1 Overview

International migration has been progressively increasing over the past 50 years. The number of cross-border immigrants increased three-fold between 1960 and 2010, from 75 million in 1960 (United Nations, 2006) to almost 214 million in 2010 (International Organization for Migration [IOM], 2010). To illustrate, one out of every 33 persons, lives in a country other than his/her country of birth. This cosmopolitan migration phenomenon is traditionally explained by “push and pull factors” (Kobayashi, Li, & Teixeira, 2012, p. xix), that is, residents are ‘pushed’ by political conflicts, human rights violations in some of the Middle East countries as well as poverty in countries like the Philippines, while immigrants are attracted to host countries that offer better education, higher income, political freedom, and quality health care.

Wealthy, developed countries such as the United States, Australia, Germany, New Zealand, and Canada, seek to attract immigrants to fill their labour shortages and strengthen their economies, whereas immigrants move to these countries in search of a better life (Kobayashi, Li, & Teixeira, 2012). Thus, the migration process is frequently mutually beneficial for immigrants as well as host countries. With the global economic political changes of the last decade, the number of migrations to developed countries has continued to increase, jumping from 214 million in 2010 (IOM, 2010) to 232 million in 2013 (United Nations, 2013).

Canada is well-known as one of the more desirable destination countries and often called “the land of immigrants” (Citizenship and Immigration Canada [CIC], 2011). Over the past century, more than 13 million immigrants moved to and settled in Canada (Employment and Social Development Canada, 2015).
The proportion of immigrants in Canada continues to rise, from 14.7% in 1951 to 16.1% in 1991 (Statistics Canada, 2011a). During the period from 1991 to 2000, Canada was one of the highest immigrant-receiving countries in the Western world. The total number of immigrants entered Canada during that period was 2.2 million (Hou & Bourne, 2006, p. 1506). From 2006 to 2011, nearly 1,163,000 immigrants entered Canada (Statistics Canada, 2015a). More recently, the total number of people who immigrated to Canada was 257,894 in 2012, and 258,953 in 2013 (Statistics Canada, 2015a), and 260,404 in 2014 (CIC, 2015a), matching the governmental admission target plan to accept a quarter million immigrants every year (CIC, 2012). The immigrants have indeed participated prosperously in the development of the Canadian economy and contributed to the Canadian way of life.

1.2 Immigrant Settlement

New immigrants\(^1\) in Canada often choose to live in the large cities. The top cities in terms of receiving immigrants are Montreal, Toronto, and Vancouver, with 61% of total immigrants dwelling in these three largest Canadian Cities (Statistics Canada 2011a; Hiebert, 2015). However, according to the data from Statistics Canada, the number of immigrants who choose to live in small and mid-sized cities over the last decade has been noticeably increasing (Statistics Canada, 2008, CIC, 2013a).

At the early stage of settlement, immediately after arrival to Canada, immigrants encounter many challenges and difficulties. These include finding a suitable place to live that is affordable, securing employment, using a new language, adapting to a new culture, and accessing health care services (Teixeira, 2008; Kobayashi, Li, & Teixeira 2012). The last of

\(^1\)Statistics Canada (2012) defines new immigrants as those who have been in Canada for five years or less. For the purpose of this study, ‘new immigrants’ are defined as those who were born outside Canada and arrived in Canada within the previous five years (i.e., arrived in Canada after January 2010).
these can be a critical problem that may have a significant impact on immigrants’ health.

Immigrants’ access to health care has been studied in the major Canadian cities such as Toronto and Montreal, as will be noted in Chapter 3. However, relatively little is known about immigrants’ access to health care in smaller Canadian cities.

1.3 Immigrants’ Access to Health Care in Canada

Recent research suggests that newly arrived immigrants face some difficulties in their settlement and integration in new host countries (Teixeira, Li, & Kobayashi, 2012). Some of these difficulties are related to fundamental human needs, such as the basic needs outlined in Maslow’s hierarchy model (Maslow, 1982). The essential human needs include but are not limited to the need for food, housing, relationships, and health and wellbeing. In the developed countries, people meet some of these needs with the aid of services provided by government programs and agencies as well as non-governmental organizations. For example, the educational needs can be met by the availability and the quality of educational institutions, and health needs can be met through not merely the availability of health care facilities, but the accessibility to care in these facilities, and the quality of service provided. Accessing health services is fundamental to maintaining good quality of life for the new immigrants. Accessing health care can vary from a simple visit to a walk-in health clinic to a visit to an emergency department (ED) when there is a serious and urgent need for care. In the case of an emergency, quick and unhindered care should be provided; any obstacle may have a very serious impact on patients’ lives. It may also be considered a violation of patients’ rights and dignity. All individuals should, therefore, be able to access emergency health services without barriers.

Unemployment, poverty, social isolation, and stress may negatively influence individuals’ health (Wilkinson & Marmot, 2003). These factors are commonly experienced by immigrants after arrival in Canada and put this particular group of people at risk of
possible health issues or disease (Hyman & Dussault, 2000; Dean & Wilson, 2009; Wang, Chacko, & Withers, 2012). Accordingly, their need to seek medical care and utilize health care facilities may increase. Unfortunately, there is evidence revealing that recent immigrants in Canada encounter impediments when attempting to access health care services to meet their health needs (Wu, Penning, & Schimmele, 2005; Asanin & Wilson, 2008; Sanmartin & Ross, 2006; Long, 2010; Wang, Chacko, & Withers, 2012). Therefore, special attention and priority should be given to new immigrant health and access to health care in order to achieve equitable access to health services. The concept of “equitable access” was stressed in a report published in 2009 by the Norwegian Directorate of Health report, entitled “Migration and health – challenges and trends”. The report argues that, as immigrants are at higher risk of certain health issues, special resources and prioritization are required for this group. “The aim is therefore not to offer equal services, but rather equitable services which take into account the differing pre-determinants and requirements among citizens” (Norwegian Directorate of Health, 2009, p. 11).

Under the Canada Health Act (CHA), the Canadian health care system adheres to five principles “Public Administration, Comprehensiveness, Universality, Portability and Accessibility” (Health Canada, 2012a, para. 21). The primary purpose of these principles is to provide the country’s residents with access to essential medical services without barriers (Health Canada, 2010). Despite these principles and their objectives, studies have confirmed that new immigrants in Canada face numerous barriers when they attempt to access health services, including financial problems, language barriers, lack of culturally incongruent care, lack of knowledge about health services, unawareness of availability of health services, difficulties in finding family doctors, and discrimination (Glazier et al., 2004; Wu, Penning, & Schimmele, 2005; Reitmanova & Gustafson, 2007; Asanin & Wilson, 2008; Long, 2010; Ngwakongnwi et al., 2012; Bell et al., 2013).
Barriers to accessing health care have become an important concern in Canada because they pose serious settlement challenges for newcomers and may impair their integration into their new society (Bollini & Siem, 1995; Asanin & Wilson, 2008). More importantly, difficulties in accessing health services may act as a source of psychological distress, and may have serious consequences on morbidity and mortality (Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007; Rousseau et al., 2008). Furthermore, health service accessibility barriers may delay necessary care, and the delay may put immigrant patients’ safety and lives at risk, especially when medical emergency care is needed, and lead to deterioration of their health. This could, subsequently, create health disparities between immigrants and non-immigrants in the country (Wilkinson & Marmot, 2003; Rousseau et al., 2008).

Problems in accessing health care in general and emergency health care need to be explored further in different geographical regions in Canada, including small and mid-sized cities, in order to get an in-depth understanding of the nature and causes of these problems. Further steps may then be taken to find solutions. Potential solutions may include modifying the existing health services to overcome the accessibility barriers (Long, 2010) and providing newcomers with education and orientation programs about the health care system in Canada.

Relatively little is known about immigrants’ access to health care service in small and mid-sized Canadian cities. Much less is known about new immigrants’ access to emergency health care service. This study explores the barriers and difficulties new immigrants experience when seeking emergency health care in Kelowna, a mid-sized Canadian city. The number of immigrants has increased over the last two decades in Kelowna (Statistics Canada, 2015b), and no previous studies have addressed new immigrants’ experiences with emergency health care services.
1.4 Study Objectives and Research Questions

This study explores the barriers that new immigrants in the city of Kelowna\(^2\), a mid-sized Canadian city, face when they attempt to access emergency health care in a hospital emergency department (ED). The primary objectives of this study are to: (1) identify what hinders new immigrants from receiving appropriate emergency health care when needed; (2) determine how prepared new immigrants are to obtain any needed urgent health care during the first three months after arrival in British Columbia, when they are not covered by the provincial health plan; (3) identify the coping strategies that new immigrants use to deal with any accessibility barriers to emergency health care; (4) inform policy makers and health care providers (HCPs) about the main barriers new immigrants experience in accessing emergency health services and provide them with recommendations for achieving improved access to emergency health care.

In order to achieve these objectives, this study was guided by four main research questions: (1) What are the major barriers that new immigrants face in accessing emergency health services during the first five years after arrival in Kelowna? (2) How prepared are new immigrants to obtain any needed emergency health care during the first three months in British Columbia when they are not covered by the provincial health insurance plan? (3) What coping strategies do new immigrants use to overcome the accessibility barriers to emergency health care services in Kelowna? (4) What recommendations can be made to improve new immigrants’ access to emergency health care services in Kelowna?

1.5 Structure of the Thesis

This thesis is divided into eight major sections. Following this introduction (Chapter 1), Chapter 2 provides an overview of the structure and function of the Canadian health care

\(^2\) “Kelowna” and “city of Kelowna” are used interchangeably in this thesis to refer to the city of Kelowna.
system. Chapter 3 reviews the literature concerning new immigrants’ access to health care services in Canada. Chapter 4 outlines the area of study and the methodology, including sampling technique and data collection. The chapter also highlights the study’s limitations.

Chapters 5, 6, and 7 present the data analysis and research findings as per the research questions. Chapter 5 addresses the barriers new immigrants encounter when accessing emergency health care. Chapter 6 focuses on the new immigrants’ experiences with emergency care during their first three months in British Columbia. Chapter 7 discusses the coping strategies used by new immigrants to deal with the barriers and challenges they face when accessing emergency health care services. Chapter 7 also provides policy recommendations for addressing the identified barriers, from the immigrants’ points of view. The final chapter (Chapter 8) concludes with a summary of the research findings, policy recommendations, and suggestions for further research.
Chapter 2 The Canadian Health Care System

2.1 Overview

It is critically important to understand how the Canadian health system functions prior to delving deeper into immigrants’ access to health care in this system. This chapter describes the structure and function of the Canadian health care system, provides a critical review and analysis of temporary issues within this system, explains how health care is delivered to Canadians, and highlights the structure of health care system in British Columbia. A description of the major healthcare services available in the city of Kelowna will be presented under the study area section in Chapter 4. The useful knowledge that the researcher gained about the health system in Canada and British Columbia avoids potential health system-misunderstanding bias during the data analysis stage and indeed boosts the researcher ability to analyze the research data for this study.

2.2 Health Care System in Canada

Under the principle of federalism, Canada is divided into two levels of government, the federal government and provincial-territorial governments. Both have certain roles and responsibilities in various fields in the country such as education, agriculture, and health. The complex health system in Canada is managed by those two levels of governments, in collaboration with Health Canada.

The federal government contributes by funding the provincial heath care systems to assist them in covering the cost of health care. The funding comes from taxes and other programs, and it is estimated that “tens of billions of dollars annually” are paid through Canada Health Tax program (CHT) (Fierlbeck, 2011, p.18).
The federal government participates in funding and supporting the provincial health care systems aiming to implement policies and programs that are consistent with federal government objectives. Provincial and territorial governments are practically in charge and responsible for managing, organizing and delivering health care services to their citizens (Fierlbeck, 2011). Health Canada's responsibilities include delivering health care services to vulnerable populations (e.g., Inuit and First Nations), and working in partnership with provinces and territories to support the health care system through innovations and interventions in domains such as health human resources planning, adoption of new technologies and primary health care delivery (Health Canada, 2012a).

Roles and responsibilities for Canada's health care system are shared, in various proportions, among the federal government, provincial-territorial governments, and Health Canada. The federal government, the ten provinces, and the three territories play important roles in the health care system under the Canada Health Act (CHA). CHA is “Canada's federal legislation for publicly funded health care insurance” (Health Canada, 2012b, para.9). The primary objective of this act is to promote and maintain the Canadian residents’ physical and mental health and wellbeing, and to facilitate providing them with reasonable access to health care services without obstacles. This objective is achieved by setting and administering national principles for the health care system through the CHA (Health Canada, 2012b).

The Canadian health care system has many advantages, which can be inferred from the five principles of the CHA: “Public Administration, Comprehensiveness, Universality, Portability, and Accessibility” (Health Canada, 2012a, para. 21). According to the CHA, public administration means a public authority performs on a non-profit basis all administration of provincial health insurance. Comprehensiveness means all essential health care should be ensured. Universality is defined as equal health care services among insured residents. Portability means residents who move from their province to another province or
territory are still eligible for care. Their home province is responsible for their coverage until they settle down in the new province, usually a three-month period. The last principle (accessibility) is defined as reasonable access to “primary, secondary and tertiary” care without barriers. The primary purpose of these principles is to provide the country’s citizens with access to essential medical services on the three levels of health care on a prepaid basis (Health Canada, 2010; Health Canada, 2012a).

Based on the aforementioned principles, a conclusion can be drawn that financial barriers in accessing health care should not exist in Canada, nor should inequity-related barriers. This contrasts with some other countries like the USA and some European countries. In the USA, financial problems and insurance issues were found to be major barriers to accessing health services (Woolf et al., 2013). In many European countries, discrimination and inequality were found to be critical issues reflecting negatively on immigrants’ health (European Union Agency for Fundamental Rights, 2013).

It is important to note that health care affairs in Canada fall under the domain and control of the provincial authorities. The provincial governments pass laws, govern, finance and deliver health services to their citizens. Thus, Canada has thirteen health care systems, not just one national system for the entire country. As such, the lack of a standardized national health system may lead to disparities and discrepancies in health care delivery among different provinces and territories. Consequently, this may create health inequities among Canadian residents. Fierlbeck, (2011) suggests that because Canada has several health systems that differ in their structures and operations, there is a potential for inequity to occur. The Province of British Columbia, for instance, has levied health care premiums and provides an income based Pharma-Care program. The Province of Alberta, in contrast, eradicated its levied premium and does not offer a Pharma-Care program (Fierlbeck, 2011). Another example of the discrepancies in provincial services is that in Ontario, Quebec, and British
Columbia, newly landed immigrants have to wait for three months to be enrolled in the provincially insured care, but they do not have to do so in other provinces or territories (Fierlbeck, 2011).

2.2.1 Health Authorities in British Columbia

In the province of British Columbia, there are five regional health authorities, in addition to the Provincial Health Services Authority (PHSA). PHSA is responsible for managing and coordinating a variety of services and programs across the province. These include the services of specialized programs that are provided through the following agencies: BC Mental Health Addiction Services, BC Cancer Agency, BC Provincial Renal Agency, BC Centre for Disease Control, BC Transplant, and BC Emergency Health Services (provides ambulance services across the province). The five regional health authorities are Island Health Authority, Fraser Health, Northern Health, Vancouver Coastal Health, and Interior Health. Each of these authorities is responsible for managing and delivering a high standard of specialized health care services to the residents within a specific geographical area in the province (BC Ministry of Health, 2013). The Interior Health authority is responsible for ensuring health services are provided in the Southern Interior region for more than 742,000 residents. Interior Health covers a geographical area of approximately 216,000 square kilometers. Kelowna is the central city in this geographical area (Central Okanagan Economic Development Commission, 2012; Interior Health, 2015c).

2.2.2 How is Health Care Delivered to the Residents of Canada?

There are three levels of health care in Canada, through which residents can obtain care when needed. These are primary, secondary and tertiary care. When a patient needs health care in a non-urgent condition, most often she/ he goes to primary health service which is often called first-contact service (Stanhope, Lancaster, Jessup-Falcioni, & Viverais-Dresler, 2011). Examples of these services include visits to family physicians, visits to nurse
practitioners, telephone calls to health information lines and appointments to receive immunizations (Health Canada, 2012a). The patient’s health issue could be resolved within this level. If not, the patient is referred to a higher level of care called secondary health care. Secondary health care is defined as the medical care provided by physicians with specialized medical training that focuses on a specific medical field (Health Canada 2012a). Cardiology, oncology, orthopedics, and gynecology are examples of these specialties. The medical care provided at the secondary care level may include special diagnostic and therapeutic procedures such as tissue biopsy or kidney dialysis. However, patients may need more advanced care such as having surgery or receiving intravenous medication. In these cases, tertiary health care will be provided. Thus, tertiary health care is medical care delivered by health care providers in advanced health care facilities such as a hospital with advanced and specialized diagnostic and treatment technologies (Crisp et al., 2013). A tertiary health care center usually has a specialized coronary care service and an intensive care unit. The tertiary care is usually obtained after a referral from a primary or a secondary care provider. In a situation where urgent care is needed, a patient visits an emergency room and after a quick assessment by an emergency triage nurse, a decision is made about his/ her urgency level. The decision regarding priority for treatment is decided based on the Canadian Triage Acuity Scale (CTAS) (Canadian Association of Emergency Physicians [CAEP], 2015).

Ostensibly, health care services in Canada are exemplary compared to the health system in some other countries like the USA. However, many Canadians are concerned about the state of the Canadian health care system and do not feel that the health care in place is sustainable (Soroka, 2007). In fact, the Canadian health care system is facing several complex issues and impediments. The section below addresses some of these issues.

2.2.3 Contemporary Issues within the Canadian Health Care System

In addition to the discrepancies in the health care services delivery and management
among the Canadian provinces, there are other impediments and unresolved issues within the health care system in Canada. For instance, the health system does not cover treatments such as physiotherapy, dental care, optometry and chiropractic (CIC, 2015b). However, many residents acquire coverage for such services from their work, but this is not applicable to new immigrants who come to Canada without job offers (CIC, 2015b). Additionally, in the provinces of Ontario, Quebec, and British Columbia, newly landed immigrants have to wait for three months to be enrolled in the provincial insurance plan, but they do not have to do so in other provinces or territories (Fierlbeck, 2011). They are advised to buy private medical insurance to cover for the first few months until the provincial insurance is issued (Fierlbeck, 2011). The three-month wait policy seems contradictory with the CHA’s principles and objectives as this policy itself may be a serious obstacle that hinders new immigrants’ access to health care.

In fact, the Canadian health care system encounters problems that are more complex. One of the significant problems is the lengthy wait time to receive care (Soroka, 2007; Barua & Esmail, 2012; Canadian Institute for Health Information [CIHI], 2012). Long wait time is a major dilemma in Canada because it is a long-standing problem that has not been completely resolved despite the effort and financial resources that have been directed to solve this problem. The Ministry of Health in British Columbia, for instance, invested $400 million in expanding, renovating and improving patient flow in 35 emergency rooms throughout the province to reduce wait times in emergency rooms (BC Ministry of Health 2013). In 2010, 16.5 million dollars were devoted to patient-focused funding in order to reduce patient wait times in emergency departments in British Columbia (BC Ministry of Health, 2013). All Canadian provinces initiated incentives and projects (e.g., human resources management, use of technology) aimed at reducing the ED wait times. In general, because of the huge investment in these projects, the wait times to receive care in EDs in Canada have decreased
since 2005 (CIHS, 2012). However, more improvements need to be achieved, especially in relation to care management within the health facilities (CIHS, 2012).

Data from a survey assessing Canadians’ perceptions about the health system, which has been reported to Canadian Health Council, showed that timely access to services is perceived as the highest health care priority for Canadians (Soroka, 2007). The average waiting time for a “65-year-old man who requires a routine hip replacement” is six to 12 months and the wait time in emergency departments is two to four hours (Soroka, 2007, p.15).

Furthermore, according to a survey that was conducted by the Fraser Institute, a public policy research institute, specialist doctors across ten provinces reported that there is an approximately 18 week wait time between seeing a doctor and a referred specialist. As well, patients wait almost 40 weeks for elective orthopedic surgeries and wait up to four weeks for medical oncology treatments. Additionally, the operation list in Canada has over 870,000 surgeries waiting to be performed, and the total waiting times to receive care in 2012 was 91% longer compared to 1993 (Barua & Esmail, 2012).

The long-standing wait time problem is not only limited to referrals and surgeries but also routine and emergency care. According to a report released in 2012 by CIHI, Canada ranks the lowest among 11 developed countries in terms of wait times for primary or secondary health care (waiting to be seen by a doctor, a nurse, and a specialist). The majority of Canadians (nearly four out of five) wait an average of two days to see their family doctor for routine care (CIHI, 2012). Additionally, the wait times to see a specialist doctor exceeded three months for 14 % of Canadians. The report also reveals that, while 41% of the Canadian patients wait two months to see a specialist, only seven percent of patients in Germany wait that long. Moreover, when Canada was compared with 11 other developed countries in 2010, statistics showed that almost half of Canadian patients wait for more than four hours during
emergency room visits. In contrast, less than 5% of emergency room patients in Germany, United Kingdom, and the Netherlands wait more than four hours (CIHI, 2012).

Long wait times have very significant repercussions on the economy of Canada. The economic cost of excess wait times is estimated to be billions of dollars annually (Canadian Medical Association, 2008). More importantly, long wait times to receive care put patients’ safety at risk and may lead to delays in necessary medical care, especially in cases of emergencies. Such delays could cause serious consequences that may include death (Trzeciak & Rivers, 2003; Sprivulis, Da Silva, Jacobs, Frazer, & Jelinek, 2006).

Linked to wait times, the physician referral process is another critical problem in Canada’s health care system. The referral process is time-consuming because there is a vast defect in the communication among physicians for referral purposes; they do not have a standardized communication strategy (Canadian Medical Association, 2010). The referral processes seem to be disunited and diversified as the methods of contacting one another differ not only by city or region but also within regions (Canadian Medical Association, 2010).

Finally, one of the significant challenges that the Canadian health care system encounters is the health issues related to vulnerable groups such as indigenous people and immigrants. It is evident that the health of indigenous people is poorer than the health of the general population (Stanhope, Lancaster, Jessup-Falcioni, & Viverais- Dresler, 2011). Indigenous people have a higher rate of infectious disease and chronic disease, and lower life expectancy in comparison to the general population (Stanhope, Lancaster, Jessup-Falcioni, & Viverais- Dresler, 2011). New immigrants are the second group that needs the attention of the decision makers in the Canadian health system. New immigrants encounter serious barriers when they attempt to access health services (Wu, Penning & Schimmele, 2005; Sanmartin & Ross, 2006; Long, 2010). Barriers to accessing health care is an important concern in Canada because they interfere with the process of integration into the new society (Bollini & Siem,
Additionally, barriers to accessing care, if faced by certain groups, such as immigrants, could create disparities among different populations living in the same country (Marmot & Wilkinson, 2003; European Union Agency for Fundamental Rights, 2013).

2.3 Summary

Management of Canada’s health care system falls under the two levels of governments (federal government, provincial-territorial governments). While the federal government is mainly responsible for financial assistance, the provincial governments have almost all control over the health services for their residents.

Based on these principles, one can conclude that financial barriers in accessing health care should not exist, nor should inequity-related barriers. However, there is evidence that some barriers to accessing the Canadian health services exist in different geographical regions. First nations and new immigrants are a vulnerable population encountering impediments in obtaining health services.

Canadians have access to a wide range of health services, provided under the framework of primary, secondary and tertiary care. While the Canadian health care system is seemingly exemplary, there are some concerns and defects in this system. Important concerns include the lack of national standardized health care services and management for the entire country, long wait times to receive care, unclear and fragmented patients’ referrals process, and the need for equitable access to health services especially for vulnerable groups such as new immigrants.

There is a variety of health services provided for the residents of British Columbia. Management of these services falls under the responsibility of Ministry of Health in coordination with the six health authorities. Health services in the city of Kelowna falls under the responsibility of the Interior Health authority.
The province of British Columbia imposes a three-month wait period before new immigrants can enroll in the provincial insurance plan. Relatively little is known about how newly arrived immigrants obtain medical care if needed during this uninsured period.
Chapter 3  Literature Review

3.1  Overview

The aim of the current chapter is to identify major significant trends within the literature dealing with immigrants’ health in Canada, particularly those addressing immigrants’ access to health care. This chapter provides a critical review and analysis of the main studies that address immigrants’ health and their access to care in Canada, then discusses the common barriers faced by new immigrants in accessing health care, and finally concludes with identifying a gap in the literature and the points that this study takes into account to fill this gap.

3.2  New Immigrants’ Health

Peer-reviewed studies have confirmed that, in Canada, recent immigrants are in better physical health than non-immigrants, but their health status tends to drop over time (Ali, McDermott & Gravel, 2004; Newbold, 2005; Newbold, 2009a; Fuller-Thomson, Noack & George, 2011; Gushulak et al., 2011, Ng, 2014). Newbold (2009a) applied multivariate methods to analyze data drawn from Statistics Canada’s Longitudinal Survey of Immigrants to Canada (LSIC). In particular, the multivariate methods were used to assess the health status of recent immigrants in six months, two- years and four- years post arrival. The results of this study reveal that new immigrants’ health begins to decline immediately after arrival in Canada (Newbold, 2009a). De Maio (2010) conducted a systematic review of 51 empirical studies and concluded that the overall physical, clinical, and mental health of new immigrants in Canada is better than the health of their Canadian counterparts. However, the findings of this review indicate that this health advantage declines over time (2 to 10 years) (De Maio, 2010). De Maio’s review is not without limitations; it focused on immigrants’ health outcomes and did not examine the association between access to health services and health
outcomes. Additionally, De Maio (2010) excluded all studies that were published in a language other than English, and also excluded qualitative studies in her review.

New immigrants’ psychological and mental health also seems to be overall better in comparison to their native-born counterparts. This conclusion is based on three indicators: a quantitative study provides significant evidence that the suicide rate among immigrants is 50% less than in non-immigrants (Malenfant, 2004); immigrants are less likely to suffer from depression compared with the Canadian-born population (Stafford, Newbold, & Ross, 2011); the lifetime prevalence of bipolar disorder is significantly lower among immigrants than non-immigrants, according to a regression analysis of data from the Canadian Community Health Survey-Mental Health and Well-Being (Schaffer et al., 2009).

It is believed that the new immigrants are generally healthy because of the application process imposed by CIC, by which economic immigrants are selected based on a point system that includes health screening (Ali, McDermott & Gravel, 2004). The point considers an applicant’s age, education, language skills, and work experience as well as a mandatory medical examination that the applicant must pass prior to being issued a landing visa. Applicants who have serious medical illnesses may be excluded (Beiser, 2005; CIC, 2013b). However, post-arrival, many factors can contribute to the deterioration of immigrants’ physical and mental health. Unemployment, poverty, social isolation, discrimination, and stress experienced by immigrants after arrival in Canada put them at risk of developing avoidable physical and mental health problems or illnesses, leading to a decline in their health status (Hyman & Dussault, 2000; Dean & Wilson, 2009; Fuller-Thomson, Noack, & George, 2011; Wang et al., 2012). The deterioration of immigrants’ health could also be partially explained by the “acculturation hypothesis” (Wang et al., 2012, p. 173), which posits that immigrants alter their lifestyle over time and become accustomed to an unhealthy Canadian lifestyle such as being inactive and eating unhealthy food.
It appears that recent immigrants use health services less frequently than the native-born population (Ali, McDermott & Gravel, 2004; Long, 2010). This seems consistent with the fact that new immigrants are healthier than non-immigrants. Over time, immigrants use health care services more often (Newbold, 2005), perhaps reflecting a decline in their health. However, this increase in the utilization of health care by immigrants may not adequately counterbalance the decline in their health (Newbold, 2005; Long, 2010).

3.3 Settlement Stress

As mentioned above, recent immigrants in Canada encounter many difficulties that may hinder their integration into the Canadian society. These include difficulties in finding affordable housing, securing employment, using the language, adapting to the new culture, and accessing health care (Li, Kobayashi, & Teixeira, 2012; Anne-Marie & Tara, 2012). These difficulties may contribute to the deterioration of immigrants’ health. For example, when examining the correlation between employment and health variables, evidence suggests that there is a positive association between steady employment and good physical and psychological health and wellbeing (Frankish et al., 2007). Unemployment, moreover, was found to be associated with poor health outcomes such as depression, anxiety, heart disease, and musculoskeletal disorders (O’Campo, Eaton, & Muntaner, 2004). Overall, the integration and settlement period is considered very stressful, and this itself is a significant risk factor that has a potential negative impact on the immigrants’ health (Hyman, 2000; Beiser, 2005). In addition to mental illness, long-term stress has detrimental health effects; it could contribute to heart disease, sleeping disorders, gastrointestinal problems, anxiety, depression, and memory weakness (American Psychological Association, 2015). It is plausible that settlement stress can, in turn, be exacerbated by a lack of proper health care services, or difficulties in obtaining appropriate health care.
3.4 Barriers to Accessing Health Care

3.4.1 Most common barriers

Although the Canadian health system is universal, peer-reviewed studies confirm that new immigrants in Canada encounter numerous barriers when they attempt to access health services. These barriers include financial problems, languages difficulties, receiving culturally incongruent care, lack of knowledge about health care services, exposure to discrimination, and difficulties in being accepted by family doctors (Wu, Penning, & Schimmele, 2005; Asanin & Wilson, 2008; Sanmartin & Ross, 2006; Long, 2010; Wang Lu., Chacko, & Withers, 2012; Ngwakongnwi et al., 2012).

The UBCO electronic database and search engines including Google Scholar, Geo-base, Summon, and Academia Search Complete were searched in March 2014 and in December 2014 for articles that included the terms: immigrants, Canada, small and mid-sized city, access to health care, and emergency health services. A total of 98 peer-reviewed papers published between 2000 and 2014 were found; 33 of them were identified as relevant. The methodology and results of these 33 articles were critically reviewed and analyzed. Non-peer-reviewed articles and gray literature reports were also reviewed and examined for data relevant to immigrants’ access to health services.

As already noted, peer-reviewed studies have established that immigrants’ health starts to decline after arrival in Canada. To inquire about the factors associated with the decline in immigrants’ health, Fuller-Thomson et al. (2011) conducted a study based on data collected by CIC and Statistics Canada. These data were initially collected from new immigrants who participated in the LSIC that was conducted between 2001 and 2005. In this survey, participants were interviewed three times: six months, two years, and four years following immigration. With a random sample of 7,716 respondents who participated in the LSIC, Fuller-Thomson et al. applied bivariate statistics and logistic regression models to
examine the effects of socio-demographic factors, perceived discrimination, and social network as predictors (explanatory variables) on the decline in immigrants’ health. The findings of this study reveal that 15% of new immigrants reported “a two-step decline in health (e.g., from excellent to good and from good to fair on a five points self-reported scale) four years after arrival in Canada, compared to only 5.7% of Canadian-born group reported a two-step decline in health during the same period in a PHNA analysis” (Fuller-Thomson et al., 2011, p. 273). Some socio-demographic factors, such as marital status, language, country of origin, age, and sex, were associated with the decline in the new immigrants’ health. For example, women had 27% higher odds of reporting a decline in health than men, and immigrants with language insufficiency had 19% higher odds of reporting a decline in health compared to those with good language skills. The study findings also demonstrated that social networks, education, and income had no significant effects on immigrants’ health. Immigrants from Eastern Europe, South Asia, China, and India had 200% greater odds of reporting a decline in health than those from Oceania and North America. Exposure to discrimination was also associated with a decline in health. In regards to accessing health services, this study revealed that approximately 25% of all respondents faced barriers in accessing health care services, and among those who reported a decline in health, 27% encountered barriers in accessing health services (Fuller-Thomson et al., 2011).

A study by Lai and Chau (2007) is helpful in understanding the nature of barriers to accessing health care. They gathered data from 2,214 Chinese immigrants aged 54 years or more, using a structured questionnaire to assess 21 potential barriers. They found that older Chinese immigrants experienced numerous barriers, of which the most common were difficulties in communication with care providers, long wait times to see a doctor, deficit of knowledge about the availability of services, and unawareness of health care professionals
about Chinese cultures (Lai & Chau, 2007). The limitation of this study is that its results may not be generalized to other ethnic groups or younger groups.

Sociocultural, geographical and economic barriers to accessing health service by recent immigrants were reported in a study that was carried out in Mississauga, Ontario by Asanin and Wilson (2008). The data were collected from the participants through focus group discussions. Although the results of this study cannot be generalized to the entire immigrant population, this exploratory study was helpful in understanding the nature of the obstacles that immigrants encounter when accessing health services. The findings of this study highlight sociocultural, geographical and economic barriers immigrants experience in accessing health care. The reported sociocultural barriers included language barriers and receiving care incongruent with cultural norms and religious beliefs. The geographical barriers included unavailability of family doctors near the immigrants’ residential locations, long wait times to find a family physician, and transportation problems. The economic barriers included financial problems related to the cost of prescription medication and the cost of care in the first three months after arrival in Ontario when newcomers are not covered by provincial health plan, in addition to lacking coverage for extended health benefits (Asanin & Wilson, 2008).

Sanmartin and Ross (2006) used univariate and logistic regression in a secondary analysis of data from the Canadian Community Health Survey (CCHS) and Health Services Access Survey (HSAS). This study identified immigration status as one of the factors associated with experiencing difficulties accessing urgent care in physicians’ clinics and hospital emergency rooms. They found that recent immigrants (in Canada for five years or less) were 250% more likely to report difficulties accessing immediate care, and new immigrants “were 10 times more likely than Canadian counterparts to identify barriers primarily related to personal circumstances, such as transportation, language, cost or lack of
information about where to go for care” (Sanmartin & Ross, 2006, p. 116). Notably, in this study, immediate care was defined as the health care needed for non-life threatening medical problems such as skin laceration and fever. The study did not examine barriers in accessing emergency departments with serious medical problems.

Another study that was useful in understanding the obstacles and challenges immigrants and refugees encounter when accessing health care services in Canada was conducted by Thomson, Chaze, George, and Guruge (2015). They used a scoping review of Canadian literature to examine obstacles that immigrants encountered in accessing mental health care services. This study demonstrated the main barriers immigrants face include knowledge deficits about mental health problems and availability of mental health services, receiving culturally inappropriate care, social isolation, limited transportation and mobility, experiences of discrimination, and language barriers.

In a qualitative study conducted in Toronto, Sadavoy, Meier, and Ong (2004) identified barriers to accessing mental health care experienced by senior ethnic subgroups, Chinese (over 65 years old) and Tamils (over 55 years old). The main barriers included unfamiliarity with mental disorders; lack of knowledge about the mental health care system; cultural and language barriers; shortage of mental health care provider, mainly psychiatrists; unavailability of psychosocial services and relying on unspecialized agencies; lack of interdisciplinary services that take into account ethnic background along and elderly and mental health care; and problems with the referral process.

On a larger scale, Long (2010) systematically reviewed 160 data sources, including peer-reviewed articles that addressed immigrants’ health issues. Despite excluding all papers published in a language other than English, his review confirms the notion that new immigrants face barriers when accessing health care services, and summarized these barriers into three main categories: geographical barriers, such as difficulty finding family doctors in
the immigrants’ neighborhood areas; sociocultural barriers, such as language problems and culturally inappropriate care; and economic barriers, such as financial issues and inability to pay the direct cost of some treatments (Long, 2010).

A systematic review of 11 studies examined racialized immigrants’ experiences in accessing primary health care service in Canada. Carrasco, Gillespie, and Goodluck (2009) concluded that the main barriers to access primary care as perceived by racialized immigrants were: language insufficiency and ineffective communication with care providers, perceptions of physicians being rushed and lacking empathy, lack of knowledge about the Canadian health care system, limited clinical health information from care providers, long wait times for appointments and referrals, receiving culturally incongruent care, and financial difficulties. Notably, a major financial issue for newly landed immigrants in the provinces of British Columbia, Quebec, and Ontario is the three-month wait to be enrolled in the public health plans of those provinces; during this period they need to purchase private insurance, but they do not have to do so in other provinces or territories of Canada (Fierlbeck, 2011).

The findings of qualitative studies that investigate the difficulties immigrants experience when receiving health care have also been reported. Dastjerdi (2012) interviewed five social workers and 33 Iranian health care professionals who have provided care for Iranian immigrants in Toronto. These professionals believed that the main barriers Iranian immigrants encounter in receiving care are language difficulties, knowledge insufficiencies, and financial issues (Dastjerdi, 2012). Similarly, the results of a survey of family physicians in Montreal indicated that the predominant obstacle experienced by physicians in attending to immigrant families was the language barrier (Papic, Malak, & Rosenberg, 2012). Papic et al.

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Carrasco, Gillespie, and Goodluck (2009) used “racialized immigrant” as a term that is more appropriate than “visible minority”. The authors relied on Galabuzi’s definition of racialization: “Racialization – Process by which racial categories are constructed as different and unequal in ways that leads to social, economic and political impacts” (Galabuzi, 2001, p10).
(2012) explained that few of these physicians employed interpreters or completed cultural competency training. Additionally, Ngwakongnwi et al. (2012) found that French-speaking immigrants in Calgary experienced communication and language difficulties when accessing health care services (Ngwakongnwi et al. 2012).

Language insufficiency, as recent research suggests, is one of the most common barriers that hinder new immigrants from receiving appropriate care. Although many new immigrants may be highly educated in their home country, they may be considered ‘low health literate’ because their limited English or French language skills make it difficult to understand, read, and search for health information (Zanchetta & Poureslami, 2006).

Discrimination is another difficulty some immigrants experience in their new society. A study that examined the effect of discrimination on immigrants’ health used data from the 2004 Statistics Canada General Social Survey, with a sample size of 24,000, to demonstrate that immigrants in Canada reported more discrimination than non-immigrants, and that discrimination has a negative effect on their health (Nakhaie & Wijesingha, 2015). A qualitative study explored Muslim women’s experiences when accessing maternity care in St. John’s, Newfoundland. The women encountered insensitivity and discrimination and received culturally inappropriate care when they accessed maternity care in clinics or hospital units. The two major concerns of this immigrant sub-group were discomfort with male care providers and care providers’ lack of knowledge about immigrant women’s cultural and religious practices (Reitmanova & Gustafson, 2007).

In a scoping review of the literature, including peer-reviewed articles, theses, and reports, Edge and Newbold (2013) examined new immigrants’ experiences of discrimination in health care facilities and the effect of discrimination on new immigrants in Canada. The

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4 Health literacy is the ability to read, understand, and act on health information (Medical Library Association, 2003).
researchers found that women from different ethnic groups perceived discriminatory treatment in health care facilities, ignorance of culturally inappropriate care, dismissal of immigrants’ personal health values, disrespectful behaviour from care providers (doctors and nurses), and reported being insulted and stereotyped.

It is evident from the above-mentioned studies that immigrants face obstacles when accessing health care in Canada. The main barriers they face include financial problems, language barriers, culturally incongruent care, lack of knowledge about health services, unawareness of availability of health services, difficulties in finding a family physician, and perceived discrimination.

### 3.4.2 Geographical Barriers to Accessing Health Care Services

Difficulties in accessing health care have also been studied with reference to the geographically residential location of new immigrants. A study conducted in Toronto observed the rate of hospitalization in districts where recent immigrants are concentrated as compared to other areas. Based on a multivariate regression analysis, the evidence suggests that there is some association between proportions of immigrants in Toronto neighborhoods and the hospitalization rate; as the proportion of recent immigrants increases, hospital admission rates increase (Glazier, Creatore, Cortinois, Agha, & Moineddin, 2004). Henceforth, the needs for tertiary health care in such areas increase.

Inability to find a family doctor in one’s residential area is another significant geographical barrier that immigrants may face. Asanin and Wilson (2008) determined that new immigrants living in Mississauga, Ontario, were unable to easily find a family doctor in their neighborhoods (Asanin & Wilson, 2008). Also, French-speaking immigrants encountered challenges when searching for a family doctor in Calgary, Alberta

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5 Geographical accessibility is defined as “the geographical location of health care services and a persons’ ability to obtain care at that location” (Asanin & Wilson, 2008, p. 1276).
difculies tend to force new immigrants toward other alternatives such as walk-in clinics.

The increased utilization of walk-in clinics by new immigrants was noticed in particular neighborhoods in Mississauga where new immigrants are concentrated; Bell, Wilson, Bissonnette, and Shah (2013) found that recent immigrants tend to use walk-in clinics more than family doctors with private offices. Although the authors took into account physician characteristics such as whether they were accepting new patients, they did not compare the use of health services by immigrants and non-immigrants. The shortage of family physicians and low acceptance rate for new patients in the city can affect both immigrants and non-immigrants.

The geographical location is a variable that could act as a barrier to recent immigrants’ access to health care facilities and was included in the results of a qualitative study of 20 immigrant families in Montreal neighborhoods. The results suggest that geographical location in terms of proximity to health facilities was one of the most important determinants of selecting and using health services, including primary health care facilities (Leduc & Proulx, 2004).

There is a paucity of information explaining the effect of spatial factors on immigrants’ access to health care, particularly in small or mid-sized cities. The aforementioned studies confirm that geographical barriers to health care exist in large metropolitan areas (Bell et al., 2013; Asanin & Wilson, 2008; Glazier et al., 2004). It is also well understood that geographical location can be a determinant of selecting and using health facilities by recent immigrants (Leduc & Proulx, 2004). While these spatial barriers have been found in large cities like Montreal (Leduc & Proulx, 2004), Mississauga (Bell et al., 2013; Asanin & Wilson, 2008) and Toronto (Glazier et al., 2004), they may or may not exist
in small or mid-sized cities. Additionally, the aforementioned studies did not examine how the spatial barriers might affect access to emergency health care.

3.4.3 Access to Emergency Health Care during the First Three Months after Arrival

Medical emergency cases warrant quick responses and unhindered care. Any obstacle that hinders the delivery of emergency care may have a very serious impact on patients’ health and lives. It may also be considered a violation of patients’ rights and dignity. All individuals should, therefore, be able to access emergency health services without barriers. In Canada, all residents can obtain emergency health services based on their provincial insurance coverage. However, in some provinces, new immigrants have to wait for an average of three months to be enrolled in the provincial health insurance plan. Approximately 75% of new immigrants in Canada land in the three largest provinces every year. Of these, Ontario receives 40%, Quebec, 21%, and British Columbia, 14% (Statistics Canada, 2011b). These three provinces impose a three-month wait period for new immigrants to be enrolled in the provincial health insurance, which can negatively impact their access to health care.

The number of studies that have raised the issue of new immigrants’ access to emergency care during the first three, uninsured months is still modest. In a qualitative study using a phenomenological approach, Goel, Bloch, and Culford (2013) examined the experiences of newly-landed immigrants in Toronto who were not yet covered by the Ontario health insurance plan. Despite its small sample size (n=7), this study provided important insights into new immigrants’ experiences with health care during the uninsured months. The result of this study reveals that those immigrants were unfamiliar with the provincial health insurance system; they experienced financial loss, delay in seeking health care, and the consequent risk of poor health outcomes. The authors concluded that these difficulties can
create a negative impression of Canada among recent immigrants (Goel, Bloch, & Caulford, 2013).

In order to access and receive health care services in Canada, health insurance is essential. Indeed, being medically uninsured in Canada may affect accessibility to health care services. Another study that helpfully addresses immigrants’ insurance status and its effect on health care access is the retrospective quantitative study that compared the perinatal outcomes for uninsured and insured immigrant women at two hospitals in Toronto (Wilson-Mitchell & Rummens, 2013). In this study, researchers reviewed data from 453 medical records; out of these, 175 were uninsured and 278 were insured patients. Numerous outcome variables were tested in the analysis, such as the number of prenatal visits, rate of caesarean sections, maternal complications, admissions, and length of stay in the hospital. Frequencies, non-parametric t-tests, and chi-square tests were calculated to compare and describe medical interventions for the insured and uninsured migrant women. The results showed that 90% of uninsured pregnant immigrant women receive “less-than-adequate” prenatal care and 6.5% did not receive any prenatal care (Wilson-Mitchell & Rummens, 2013). Indeed, the findings of this study indicate and confirm that the lack of insurance is an obstacle that hinders immigrant women and their babies from receiving appropriate maternity care.

To explore health problems resulting from poor access to the health care system for reasons related to insurance and migration status, Rousseau et al. (2008) conducted 20 semi-structured interviews with health care providers and staff working in community organizations in the city of Montreal, Quebec, another province that imposes a waiting period. In some cases, the waiting period caused a delay in obtaining needed health care and subsequently led to a number of serious health problems, such as the near-death of a child because of delayed appendectomy surgery. Study findings also indicate that patients with no insurance delay seeking care when needed, have poor follow-up for chronic health conditions
such as hypertension and diabetes, have difficulties in accessing treatment for HIV and tuberculosis, and are at risk of developing psychological health problems. Furthermore, while child and youth mortality data were unavailable, one of the interviewees identified four cases of unjust death, believed to be directly related to insurance and migration status (Rousseau et al., 2008).

Lack of insurance can be a serious hazard to uninsured individuals’ health in the event of medical emergencies. For example, Caulford and D'Andrade (2012) described an unfortunate story. An uninsured young woman from Grenada studying in Canada visited a primary doctor with a serious complaint of sickle cell crisis. The primary doctor referred her to an emergency care center because her health condition required tertiary care. She was hesitant to go because previously payment had been requested in the emergency room before receiving treatment. After being reassured and told by her doctor that her case was a medical emergency not requiring advance payment, she went to the emergency unit. To obtain care at the emergency room, this patient was asked to pay $350. The patient could not afford that amount of money and explained to the health care providers that she would become unconscious soon due to the sickle cell crisis; an emergency health care provider told her that if she became unconscious, they would accept her without advance payment. This patient had no choice but to wait. After she fell unconscious, she was accepted in the emergency unit. After three days of hospitalization, a bill for more than $5,000 was sent to her (Caulford & D'Andrade, 2012). In this scenario, the lack of health insurance caused a delay of necessary care as well as additional health risks, and that delay seems unethical. Certain Canadian health policies related to access to care for the uninsured population appear to be inconsistent with the Canadian Charter of Rights and Freedoms’ principles of equal rights (Rousseau et al., 2008). While there could be similar incidents happening in different emergency
departments that may not have been reported, Caulford and D'Andrade’s report highlighted how the lack of insurance could seriously reflect on newcomers’ health.

Aside from these few studies, information about new immigrants’ access to emergency health care during the three uninsured month period is relatively insufficient. Thus, a study exploring this issue will explain the potential obstacles that new arrivals may encounter in accessing health care during the three month period. This is significant, especially after it has been noticed that recent immigrants, who have been in Canada for five years or fewer, were found to be 250% more likely to report access barriers in urgent care than nonimmigrants (Sanmartin & Ross, 2006). The current study will identify the major barriers that new immigrants encounter when seeking emergency care. Additionally, this study will attempt to answer the question: How prepared are new immigrants to obtain any needed emergency health needs during the first three uninsured months after arrival in Canada?

Answering these questions is important because new immigrants’ inability to access emergency health services may have very serious impacts on the immigrant population; it may delay necessary care, and consequently put patients’ safety at risk. For example, if a new immigrant in British Columbia complains of a serious health issue during the first three months after arrival, the immigrant may avoid going to a hospital because he or she does not have a health insurance yet. This may lead to a delay in receiving care and puts immigrants’ lives at risk. Likewise, any obstacle that hinders immigrants from accessing health care could act as a contributing factor to the deterioration of their health.

3.5 Gaps in the Literature

The aforementioned studies demonstrate that new immigrants face difficulties, and some suffer, when attempting to seek health care in Canada, but they have left four main gaps in our understanding. The first gap relates to study location. Almost all of the studies that
address immigrants’ access to health care in Canada were carried out in the major Canadian metropolitan areas (Montreal, Toronto and Vancouver) (Ali & Gravel, 2004; Glazier et al., 2004; Leduc & Proulx, 2004; Sadavoy, Meier, & Ong, 2004; Des Meules et al., 2011; Bissonnette, Wilson, Bell, & Shah, 2012; Papic, Malak, & Rosenberg, 2012; Destajerdi, 2012; Dastjerdi, Olson, & Ogilvie, 2012), or large Canadian cities, such as Calgary (Ngwakongnwi et al., 2012), and Mississauga (Asanin & Wilson, 2008). Little is known about immigrants’ access to health care in general and emergency care in particular in small and mid-sized Canadian cities.

Geographical distance and transportation are barriers that hinder accessing health services in a large city such as the city of Toronto with a population of 2,615,060 (Statistic Canada, 2013b). However, these spatial barriers may or may not exist in smaller cities. Notably, the number of immigrants who choose to live in mid-sized cities has been increasing over the last two decades (CIC, 2013a). The city of Kelowna is an appropriate area in which to conduct research on barriers to accessing emergency health care because it is a mid-sized city that has attracted a number of new immigrants over the last decade and it is likely to attract more immigrants in the foreseeable future.

Second, much of the previous research has focused on specific ethnic or subcultural groups. For example, Lai and Chau (2007) focused only on Chinese immigrants; Donnelly (2006) studied Vietnamese women; Hyman (2000) included only Southeast Asian women; Sadavoy, Meier, and Ong (2004) included Chinese and Tamils seniors, and Destajerdi (2012), and Dastjerdi, Olson, and Ogilvie (2012) focused on Iranian immigrants. These studies are definitely important within the context of multiculturalism, especially in culturally diversified countries like Canada, because there are differences among different subcultural groups (Kobayashi, Prus, & Lin, 2008). However, there is a lack of information pertaining to other groups’ access to health care such as white immigrants, South Americans, and Arabs. Thus,
research like the present one in which participants’ ethnic background and country of origin are not restricted would partially offset this shortage. Within this context, the city of Kelowna is an appropriate area to conduct this study as the numbers of Asians, South Americans and Arabs in Kelowna are noticeably increasing (Statistics Canada, 2015c) (See Tables 2, 3, and 4 in Chapter 4).

A third gap was observed in the data sources used in the previous studies. Many of the previous studies relied on health care professionals to obtain data about immigrants’ accessibility problems rather than immigrants themselves. Papic, Malak and Rosenberg (2012) collected data from 598 family physicians in the city of Montreal, and Destajerdi (2012) collected data from 38 health care professionals using a narrative inquiry approach. Many other studies relied on analysis of existing data sets. Sanmartin and Ross (2006), for instance, applied univariate analyses and logistic regression on data obtained from the Health Services Access Survey and the Canadian Community Health Survey (CCHS) to examine difficulties in accessing routine health care and difficulties in accessing immediate care as two outcomes variables and their relation with immigrants’ demographic, socio-economic and health factors. Newbold (2005) used descriptive and survival analysis on data from Statistics Canada's longitudinal National Population Health Survey (NPHS) to explore immigrants’ health and access to health care. Setia et al. (2011) used a logistic random effect model to assess immigrants’ access to health care with socio-economic variables and to compare two measures of access to health care (reporting unmet health need and having a regular physician) among immigrants and non-immigrants. Wilson-Mitchell and Rummens (2013) applied frequencies, non-parametric t-tests, and chi-square tests on data obtained from medical charts to compare and describe medical interventions for insured and uninsured immigrant women. Some of the other studies were reviews of previously published research (see Edge & Newbold, 2013; Thomson et al., 2015; Carrasco, Gillespie, & Goodluck, 2009;
Long, 2010; De Maio, 2010). Although Long’s systematic review provides strong evidence that immigrants experience obstacles when accessing health care services, it excluded studies that were published in a language other than English. De Maio (2010), who also excluded non-English-language studies, focused on immigrants’ health outcomes but did not examine the association between access to health services and health outcomes. In addition, De Maio excluded non-empirical reports.

The above-mentioned studies focused on correlations among different variables related to immigrant health and produced valuable and significant results. They used data from different sources such as health care professionals, medical charts, LSIC, and NPHS, but paid little attention to new immigrants’ subjective experience or direct input. The few exceptions are Asanin and Wilson (2008) and Leduck and Proulx (2004). Asanin and Wilson (2008) collected data from immigrants themselves, and Leduck and Proulx (2004) used a qualitative approach, interviewing mothers and fathers. The present study relied on immigrants as the primary source of data, using a questionnaire and follow-up interviews to investigate immigrants’ own experience with accessibility to emergency health care services.

Finally, little is known about new immigrants’ experiences when seeking emergency health care services in Canada. The previous studies addressed immigrants’ access to a variety of health care settings/specialties, but did not examine access to emergency care specifically. For example, they assessed access to primary health care (Carrasco, Gillespie, & Goodluck, 2009), walk-in clinics (Asanin & Wilson, 2008), family physicians (Papic, Malak, & Rosenberg, 2012), mental health care (Reitmanova & Gustafson, 2009; Thomson, Chaze, George, & Guruge, 2015), and maternity care (Reitmanova & Gustafson, 2007).

Furthermore, although new immigrants are eligible for health care coverage under the Canada Health Act, a three-month wait period is imposed in the province of British
Columbia, during which newly arrived immigrants are not insured (Fierlbeck, 2011; Goel, et al., 2013). There is very limited data to illustrate how newly landed immigrants deal with health care needs during this period. Goel et al. (2013) examined this issue in Toronto, but his study does not provide information about how immigrants are prepared to meet their emergency health needs during the uninsured period. In addition to Goel et al., Asanin and Wilson (2008) claim that new immigrants in Mississauga experienced economic barriers to access health care during the three-month wait, but this study did not discuss how new arrivals managed to meet their emergency needs during that critical period.

3.6 Summary

New immigrants to Canada are generally healthier than the general population and their health begins to decline over time. Peer reviewed studies confirm that new immigrants experience social, economic, cultural, and geographical barriers in accessing health care services during their early stage of settlement in Canada. However, a gaps were found in the literature. The gaps that were found in the previous studies are related to study areas, target population, data sources, and access to emergency care coupled with accessing care during the first three months after arrival in Canada when new immigrants are medically uninsured. Most of the previous studies addressing immigrants’ access to health care had been conducted in large Canadian cities. Relatively little is known about this accessibility problem in mid-sized cities. Less is known about immigrants’ access to emergency health services. To address these gaps, this study deals with new immigrants’ experiences when seeking urgent care in the Emergency Department (ED) in Kelowna, a mid-sized city. The study also considered recruiting immigrants from different cultural backgrounds. Additionally, in this study, a mixed methods approach was used, by which qualitative and quantitative data are collected and analyzed. Both qualitative and quantitative data complement each other to
provide an in-depth understanding of the barriers that are encountered by recent immigrants when accessing emergency health services. In the following chapter, the research methods used in this study will be described.
Chapter 4  Methodology

4.1  Overview

The primary objective of this study is to examine new immigrants’ experiences in accessing emergency health care services in the city of Kelowna. The main research questions guiding this study are: (1) What are the major barriers that new immigrants face in accessing emergency health services during the first five years after arrival in Kelowna, a mid-sized Canadian city? (2) How prepared are new immigrants to obtain any needed emergency health care during the first three months in British Columbia when they are not covered by the provincial health insurance plan? (3) What are the coping strategies do new immigrants use to overcome the accessibility barriers to emergency health care services in Kelowna? (4) What recommendations can be made to improve new immigrants’ access to emergency health care services in Kelowna?

Data for this research were collected between April 2015 and August 2015 through a mixed-methods approach: a survey of 40 new immigrants, followed by semi-structured interviews with a sub-sample of eight survey participants. This chapter describes the research design including the study area, study population, sample design, and data collection procedures and tools.

4.2  Study Area

The city of Kelowna in the Okanagan region in the province of British Columbia was chosen to be the area of the study, for several reasons:

1) The city of Kelowna is a mid-sized city that has a fast-growing population with a potential to increase in cultural diversity in the future.

2) Kelowna is a candidate for attracting more immigrants.
3) Virtually no studies have addressed immigrants’ access to emergency health care services in small and mid-sized cities in Canada in general, and the interior of British Columbia in particular.

4) Kelowna has good emergency health care services, with an Emergency Department (ED) in a tertiary health care facility, Kelowna General Hospital (KGH).

4.2.1 Kelowna: Context and Background

Kelowna is the largest city in the Okanagan Valley (City of Kelowna, 2009), with a population of approximately 122,000 (City of Kelowna, 2014). It is located about 150 kilometers north of the United States border and 400 kilometers east of Vancouver. The average daytime temperature in Kelowna during July and August is 27.4 centigrade and ranges between minus eight to zero centigrade during winter. In addition, Kelowna has agricultural lands and farms, and it is bordering 110 kilometers length of Okanagan Lake (City of Kelowna, 2009). Kelowna has a variety of institutions and organizations that make it internationally recognized. The most prominent institutions are the two educational facilities: Okanagan College, which offers a wide range of college programs and education courses, and the University of British Columbia Okanagan Campus (UBCO), which offers undergraduate and postgraduate programs and has unique research facilities and highly qualified academic personnel (UBC, 2014). Kelowna also has an international airport serving nearly 1.5 million travelers annually (City of Kelowna, 2009; Kelowna International Airport, 2014).

Kelowna has become an increasingly important city in the interior of British Columbia. The presence of unique natural characteristics (climate, water, and lands), as well as the other essential services such as education, travel, and health services, make Kelowna attractive, especially to international students and retired seniors (Brown, 2013). However,
the city has some problems and challenges that need attention from city planners and decision makers.

One of the most important challenges in Kelowna is the very high cost of housing (Teixeira, 2009, 2010), which has been given priority on the City’s agenda, along with the goal of attracting more immigrants (Teixeira, 2009; City of Kelowna, 2011). These issues are not unrelated; studies have shown that low-income immigrants (Oh, 2010; Teixeira, 2009, 2010, 2011; Karl, 2013), as well as students (McEwan & Teixeira, 2012) and seniors (Brown, 2013), face difficulties obtaining suitable, affordable housing in Kelowna. However, relatively little is known about these groups’ access to health care and emergency health services in Kelowna. In reviewing the literature, the investigator of this research has not found any peer-reviewed studies that address new immigrants’ access to emergency health care services in the city.

### 4.2.2 Health Services in Kelowna

Numerous health care institutions are available in the city of Kelowna. Kelowna General Hospital is the largest hospital in the southern interior of BC; it provides comprehensive tertiary health care and has an Emergency Department (ED) that provides 24-hour service (Interior Health, 2015c). Some of the hospital departments were recently expanded. The Interior Heart and Surgical Center (IHSC) which provides advanced cardiac care and surgical procedures was opened in September 2015. It is the first cardiac critical care center outside of Victoria and the lower mainland (Interior Health, 2015a). Emergency medical response is provided in the city of Kelowna through BC Ambulance Service (BC Emergency Health Service, 2015). Additionally, the city has a variety of medical clinics. Walk-in clinics offer primary health care, including physical assessments, treatment of minor injuries and lacerations, vaccinations, and allergy shots (KCR, 2014, 2015). Further, the outreach Urban Health Center located in Kelowna is one of ten primary health care centers.
available within the interior region; it provides comprehensive and coordinated primary health care services such as a checkup with a doctor, a visit to a physiotherapist, and public health nursing services.

Additionally, home and community care facilities, which provide a variety of care and assistance services for their clients who have chronic, palliative or rehabilitative health care needs, are available in the city. Some subspecialty-based care services and agencies serving special needs are also available, such as the Asthma Care Center, BC mental health offices, as well as Kelowna’s four kidney disease clinics, and a transplant clinic that provides follow-up care for organ transplant recipients (Interior Health, 2013).

The services of some other health facilities, such as the Bridge Youth and Family Services Society which provides a range of health services, including addiction treatment and family counselling (The Bridge Youth and Family Services Society, 2014), are not covered by the provincial Medical Service Plan (MSP).

### 4.2.3 Immigrant Population in the City of Kelowna

In 2011, the immigrant population in Kelowna was approximately 15,980 (Statistics Canada, 2014b).

Table 1 shows the number of immigrants in Kelowna in different periods (before 1961 to 2011).

<table>
<thead>
<tr>
<th>Period of Immigration</th>
<th>Number of Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 1961</td>
<td>3655</td>
</tr>
<tr>
<td>1961 to 1970</td>
<td>2310</td>
</tr>
<tr>
<td>1971 to 1980</td>
<td>2080</td>
</tr>
<tr>
<td>1981 to 1990</td>
<td>1510</td>
</tr>
<tr>
<td>1991 to 2000</td>
<td>2835</td>
</tr>
<tr>
<td>2001 to 2011</td>
<td>3590</td>
</tr>
<tr>
<td>Total</td>
<td>15,980</td>
</tr>
</tbody>
</table>

(Source: Statistics Canada, 2014b)
In 2014, Kelowna’s total population exceeded 120,000 individuals (City of Kelowna, 2014); around 16% of them were immigrants. Historically, immigrants came to Kelowna from European, English-speaking countries; over time, more heterogeneity and diversity has emerged. From 2003 to 2007, for instance, Kelowna received immigrants from different countries in varying proportions, England 20%, India and the USA, nearly 10% each, the Philippines and Korea, around 5% each, and Germany and China, 4% each (Bahbahani, 2008). Table 2, Table 3, and Table 4 show the source countries of immigrants coming from the Americas, Europe, African, and Asian countries to the city of Kelowna in 2011.

**Table 2: Number of North, Central, and South American Immigrants in Kelowna, 2011**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>America</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>2,155</td>
<td>1,060</td>
<td>1,095</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1,155</td>
<td>510</td>
<td>645</td>
</tr>
<tr>
<td>Mexico</td>
<td>145</td>
<td>100</td>
<td>40</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>245</td>
<td>145</td>
<td>100</td>
</tr>
<tr>
<td>Peru</td>
<td>65</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Other places of in Americas</td>
<td>480</td>
<td>210</td>
<td>215</td>
</tr>
</tbody>
</table>

(Source: Statistics Canada, 2014b)

The tables above, in addition to Table 2 and Table 3 show the number of immigrants (male and female) in Kelowna in 2011 and their countries of origin. These data also illustrate how the city of Kelowna is becoming a more heterogeneous city.
Table 3: Number of European Immigrants in Kelowna, 2011

<table>
<thead>
<tr>
<th>Europe</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>3,350</td>
<td>1,640</td>
<td>1,715</td>
</tr>
<tr>
<td>Italy</td>
<td>335</td>
<td>165</td>
<td>170</td>
</tr>
<tr>
<td>Germany</td>
<td>1,705</td>
<td>790</td>
<td>920</td>
</tr>
<tr>
<td>Poland</td>
<td>530</td>
<td>265</td>
<td>270</td>
</tr>
<tr>
<td>Portugal</td>
<td>120</td>
<td>70</td>
<td>45</td>
</tr>
<tr>
<td>Netherlands</td>
<td>595</td>
<td>285</td>
<td>310</td>
</tr>
<tr>
<td>France</td>
<td>130</td>
<td>55</td>
<td>75</td>
</tr>
<tr>
<td>Romania</td>
<td>205</td>
<td>105</td>
<td>95</td>
</tr>
<tr>
<td>Russia</td>
<td>170</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>Ukraine</td>
<td>280</td>
<td>150</td>
<td>125</td>
</tr>
<tr>
<td>Croatia</td>
<td>275</td>
<td>120</td>
<td>150</td>
</tr>
<tr>
<td>Hungary</td>
<td>225</td>
<td>105</td>
<td>120</td>
</tr>
<tr>
<td>Bosnia</td>
<td>90</td>
<td>35</td>
<td>55</td>
</tr>
<tr>
<td>Serbia</td>
<td>155</td>
<td>90</td>
<td>60</td>
</tr>
<tr>
<td>Ireland</td>
<td>130</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>Other places in Europe</td>
<td>1100</td>
<td>545</td>
<td>560</td>
</tr>
</tbody>
</table>

(Source: Statistics Canada, 2014b)

Table 4: Number of African and Asian Immigrants in Kelowna, 2011

<table>
<thead>
<tr>
<th>Africa</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>20</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Algeria</td>
<td>40</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>South Africa</td>
<td>270</td>
<td>170</td>
<td>100</td>
</tr>
<tr>
<td>Other places in Africa</td>
<td>115</td>
<td>55</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asia</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>1,210</td>
<td>595</td>
<td>615</td>
</tr>
<tr>
<td>China</td>
<td>460</td>
<td>190</td>
<td>270</td>
</tr>
<tr>
<td>Philippines</td>
<td>565</td>
<td>220</td>
<td>340</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>145</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>110</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Pakistan</td>
<td>60</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Iran</td>
<td>130</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Korea, South</td>
<td>280</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>Taiwan</td>
<td>60</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Japan</td>
<td>140</td>
<td>15</td>
<td>125</td>
</tr>
<tr>
<td>Other places in Asia</td>
<td>380</td>
<td>160</td>
<td>140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oceania and other</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>405</td>
<td>190</td>
<td>215</td>
</tr>
</tbody>
</table>

(Source: Statistics Canada, 2014b)
Immigrants in Kelowna live in different areas of the city, but are somewhat concentrated in the central area. Figure 1 shows the distribution of immigrants as a percentage of the total population in 2006.

Figure 1: Immigrant as a Percentage of Total Population in the City of Kelowna (Source: Teixeira, 2009, p. 326)

The majority of immigrants in Kelowna are young; approximately 62% of them are 15 to 44 years old at the time of arrival (Teixeira, 2009, Statistics Canada, 2014b). Almost two-thirds of the immigrants in Kelowna have a postsecondary education with a median employment income of approximately $36,000 (BC Statistics, 2006). Table 5 summarizes immigrants’ income compared to the total population in Kelowna in 2006.
Table 5: Immigrants' Income in Kelowna 2006

<table>
<thead>
<tr>
<th></th>
<th>Immigrants</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population with income</td>
<td>14695</td>
<td>85620</td>
</tr>
<tr>
<td>Total 2005 income (median)</td>
<td>$22,748</td>
<td>$25,134</td>
</tr>
<tr>
<td>Total 2005 income (average)</td>
<td>$30,629</td>
<td>$33,647</td>
</tr>
<tr>
<td><strong>Employment Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked full year, full time</td>
<td>3595</td>
<td>29130</td>
</tr>
<tr>
<td>Full year, full time (median)</td>
<td>$35,995</td>
<td>$38,363</td>
</tr>
<tr>
<td>Full year, full time (average)</td>
<td>$43,756</td>
<td>$46,355</td>
</tr>
</tbody>
</table>

(Source: BC Statistics, 2006)

4.2.4 Immigrant Services in Kelowna

A few organizations provide support services to new immigrants in Kelowna, including:

1) Kelowna Community Resource Society (KCR), which provides settlement and integration services such as education and orientation services, employment assistance, life skills, translation services, and community connections (KCR, 2013).

2) Kelowna Friendship Society, which provides English language classes for new immigrants.

3) Intercultural Society of Central Okanagan, which offer settlement services such as English language classes (Intercultural Society of the Central Okanagan, 2015).

Other institutions include the Okanagan Chinese Canadian Association (OCCA), which promotes mutual understanding, respect, and acceptance among different cultural communities in the region, and Living Positive Resource Centre Okanagan that delivers advocacy and support services to needy people. Other organizations offer housing support services, such as housing co-operatives (e.g., subsidized housing programs), and the Society of Hope, which offers quality affordable housing opportunities (KCR, 2015). The Gospel
Mission, a Christian association, provides support for homeless people of the interior of British Columbia.

4.3 Research Design

The lack of studies dealing with new immigrants’ access to emergency health care in Kelowna made an exploratory case study more appropriate than an explanatory study. A mixed-methods design, which collects and analyzes quantitative and qualitative information within a single study (Teddlie & Tashakkori, 2009; Tariq & Woodman, 2013; Creswell, 2014) was used to explore the accessibility issue in some depth. Mixed-methods research “helps answer questions that cannot be answered by qualitative or quantitative approaches alone” (Creswell, 2006, p. 9). One of the common reasons for using the mixed method research is ‘complementarity’ which is defined as “using data obtained by one method to illustrate results from another” (Tariq & Woodman, 2013, p.3). The mixed methods approach was used in this study because the study aims to understand the accessibility problem from multiple perspectives and to answer multiple research questions.

The research questions guiding this study call for an understanding of real life experiences with emergency health care and providing insight about any barriers to accessing emergency health services. The best way to answer this is to survey a number of new immigrants to collect quantitative data that provides descriptive information about the magnitude of the problem, then interview a subsample of survey respondents to gather qualitative data to provide a more thorough understanding of the real life experience with accessing emergency health services. A common weakness of the questionnaire is that it cannot provide a comprehensive understanding of respondents’ real life experiences; for example, respondents may misinterpret questions, and responses to close-ended survey questions do not capture rich details regarding respondents’ experiences. The qualitative method of face-to-face interviews offsets such weaknesses.
Data for this study were collected between April and August 2015, in two stages. In the first stage, data were gathered from a volunteer sample of 40 new immigrants through questionnaires distributed to the target population. In the second stage, semi-structured, face-to-face interviews were conducted by the researcher with a subsample of eight new immigrants who participated in the survey. The aim was to gather qualitative data in order to enrich the quantitative data that were collected by the survey. The results from the questionnaires guided the development of interview questions. The aim was to gain a deeper understanding of new immigrants’ accessibility to emergency health care services and to compile a list of suggestions and recommendations for improving the new immigrants’ access to emergency health care in the future.

### 4.3.1 Target Population

The population for this study was new immigrants who were born outside Canada and arrived in Canada within the last five years (after January 2010), and were living in the city of Kelowna at the time the study was conducted. The study participants were a group of new immigrants (n= 40), males and females, 19 years old or older, who had moved to Canada as landed immigrants, and had accessed the ED in Kelowna at least once, either for their own health care or because they accompanied a family member (e.g., a child or adult relative) who required health care. Undocumented immigrants and refugees were excluded as these groups of people have special health needs that differ from the target population’s health needs. New immigrants who were not able to read and understand English were also excluded. All potential participants were screened for the above-mentioned eligibility criteria (see Appendix B for the screening for eligibility form).6

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6All potential participants were also screened to determine if they had participated in another concurrent study conducted by Shirley Chau and Carlos Teixeira “The health and wellbeing of immigrants in Kelowna.” One individual was found to have had participated in Chau and Teixeira’s study and was excluded.
### 4.3.2 Sampling

Recruitment of eligible new immigrants from the target population for this study was expected to be difficult. The researcher was unable to obtain a list of new immigrants living in Kelowna from Statistics Canada, Service BC, Kelowna Community Resource, or other governmental or non-governmental organizations. This challenge resulted in using a probability sampling technique unrealistic for this research. Participants in this study were recruited mainly through the snowball sampling technique. The snowball technique allows the researcher to include those potential participants who are hidden or not known (Burton, 2000; Atkinson & Flint 2001). The snowball technique involves establishing contact with a suitable candidate for participation in the study and then asking the participants if they can suggest anyone else who fits the participation criteria and may be willing to take part in the study (Burton, 2000).

A sample of 40 new immigrants participated in this study. As an exploratory study, the intent is not to generalize the results of the data, but to provide illustration and understanding about barriers that new immigrants experience in accessing emergency health care in Kelowna, and how prepared they are to obtain any needed emergency health care during the first three uninsured months after arrival in Canada. Baker & Edwards (2012) suggest a sample size between 12 and 60 participants for exploratory studies. Aiming for a sample of 40 respondents for this study “offers the advantage of penetrating beyond a very small number of people without imposing the hardship of endless data gathering, especially when researchers are faced with time constraints” (Baker & Edwards, 2012, p. 9). In addition, some scholars have argued that aiming for saturation of responses is impractical because achievement of this is difficult to prove (Mason, 2010). The sample of 40 new immigrants provided a range of responses, sufficient to answer the primary research questions of this exploratory study. Similar studies (Teixeira, 2009; Oh, 2010; Karl, 2013) have utilized the
responses of approximately 30 participants to achieve similar objectives. Within this context, a sample size of 40 participants was therefore deemed sufficient to provide an overview of immigrants’ experiences in accessing emergency health care in the city of Kelowna.

4.3.3 Data Collection Procedure

Participants were contacted through personal contacts, and through local community agencies, including Kelowna Community Resources (KRC), Kelowna Friendship Society, Okanagan College, Islamic Center of Kelowna, Okanagan Hispanic Church, and Sikh Temple. These organizations were provided with a recruitment poster that included an introduction to the study and the researcher’s contact information. The leaders of these organizations passed the recruitment poster to potential participants and directed those interested in the study to contact the researcher. Potential participants contacted the researcher and indicated that they were willing to participate in the study. Each potential participant was offered an initial contact letter with a brief description of the study and five screening questions (Appendix B). Interested, eligible individuals were contacted by the researcher in person or via e-mail or postal mail and provided with a package containing (a) an official invitation letter (Appendix C), (b) survey consent form (see Appendix D), (c) honorarium form, and (d) an envelope containing $20 as a token of appreciation. The official contact letter specified the project title, study objectives, time commitment and length of study, benefits of the study for the participants and the community, and participants’ confidentiality and right of withdrawal from the study (see Appendix C).

In total, 76 potential participants were screened for eligibility, of which 62 met the eligibility criteria. The questionnaire was delivered to the 62 eligible immigrants. Out of the 62, 18 did not respond (they did not return the questionnaire). The researcher made up to three attempts by phone call and email to reach those 18 potential participants; of them 11
promised to return the questionnaires but never did, and seven withdrew from the study for personal reasons such as travel and time constraints.

In total, 44 questionnaires were completed and returned, for a response rate of 71%. Of these 44 questionnaires, four were rejected either because the respondent failed to meet all of the eligibility criteria or too much data were missing or inconsistent. All eligible participants in this study were asked to read, sign and date the consent form, and keep a copy provided. They were asked to indicate at the end of the questionnaire whether they were willing to be contacted for a follow-up interview, and whether they were interested in receiving a summary of the study final report.

4.3.4 Questionnaire Design, Study Variables and Analysis

The use of a questionnaire has many advantages; it allows data to be collected inexpensively from a large number of dispersed participants; it is convenient in terms of privacy and confidentiality; and it minimizes potential bias introduced by an interviewer, or multiple interviewers, intentionally or unintentionally.

The questionnaires were delivered by hand, or emailed as an attached document, or mailed with a pre-stamped return envelope to the participants. The survey was preceded by a consent form (appendix D) explaining the objectives of the study and the rights of the participants. The consent form clearly indicated that participants had the choice to refuse to answer any questions. In addition, the form stated that participants could withdraw from the survey process at any time without explanation (See Appendix D). The participants were informed that the questionnaire would take 30 to 45 minutes to be completed. The returned questionnaires were kept in a locked filing cabinet in the supervisor’s office, to which access is limited.

Regarding the design of the questionnaire, approximately 65% of the questions were adopted, with slight modifications, from relevant and reliable sources — the Longitudinal
Survey of Immigrants to Canada (LSIC) (Statistics Canada, 2007), the Canadian Community Health Survey (CCHS) (Statistics Canada, 2013b), and a questionnaire previously used in a study conducted by Teixeira (2011). The questions were mainly taken from the sections of LSIC and CCHS that address health issues and access to health care, which allowed for comparative analysis with national data. The questions were selected from these sources for many reasons. First, the LSIC and CCHS questionnaires are reliable measures. Second, the questionnaire items have strong face and content validity. Third, the questions have the ability to collect data that allow descriptive analysis to be used and the resulting numbers and percentages provide insight about the magnitude of the accessibility problem.

The aim of the questionnaire was to collect data and produce descriptive statistics that, along with qualitative data, would guide the researcher in gaining an in-depth understanding of the barriers and difficulties that have been experienced by immigrants when trying to meet their emergency health needs during their early stage of settlement in the Kelowna. Thus, the survey was designed carefully to gather data that the researcher anticipated would answer the research questions.

The questionnaire consisted of eight groups of questions. The first group of questions prompted participants to provide information about their immigration histories. The second group of questions elicited information on new immigrants’ health histories. The third group covered respondents’ need to seek emergency care since their arrival in Kelowna. The fourth set of questions enquired about barriers faced when seeking emergency health care. This was followed by the fifth set of questions that focused on experiences during the first three-uninsured months after arrival in Canada. The sixth group of questions explored the coping strategies used to deal with the challenges encountered when accessing emergency health care. In the seventh section, respondents were asked to provide suggestions for achieving better access to health care. Finally, the eighth section covered the demographic information.
The survey questions were designed to extrapolate information aiming to answer the main research questions, and with consideration of appropriate formatting and wording, aiming to encourage completion of the questionnaire and avoid biased questions (Babbie, 2010). All questions were clear, concise, and logically sequenced, so that a question would not influence the answer of the subsequent questions. Vague terms, jargon, abbreviations, and leading questions were avoided. Face validity of the questions was considered, that is to say, the questions were checked to establish whether they appeared to measure the construct. Further, four experts in research methodology, health and immigrants’ issues independently evaluated the questionnaire; only a few changes were made, according to their recommendations.

All responses to the closed-ended questions in the questionnaire were entered in SPSS. Descriptive statistics were used to analyze these quantitative data. The results were compiled and organized into quantitative tables and graphs. Answers to the open-ended questions were analyzed according to common themes.

4.3.5 Participants’ Follow-Up Interviews

The follow-up interviews were pre-planned to be conducted with a subsample of seven to ten participants from those who completed the questionnaires. The two selection criteria for this subsample were that participants had experienced troublesome barriers in accessing emergency health services, and were willing to be interviewed.

At the end of the questionnaire, each participant was asked to indicate whether he or she was willing to be contacted for a follow-up interview and, if so, they signed a consent statement. Fifteen participants indicated that they were willing to participate in the interviews. From those, ten consenting participants were contacted by phone or email and invited to take part in the interviews. The ten participants were selected because their survey responses indicated that they could provide more details about their experience in the use of
the ED (e.g., during their first three months in Canada) that would enrich the survey data. Eight out of the ten responded and agreed to be interviewed.

The main goal of the follow-up interviews was explained to the participants. The interviews were in-depth, face-to-face, and they took place at a time and location convenient to each participant. Each interviewee was asked to sign a consent form (Appendix F) before the interview began and received $10 as a token of appreciation for his/her participation in the interview. The interviews were completed in July and August 2015 in the city of Kelowna. The interviews lasted for 30 minutes, on average, and were tape-recorded. Tape-recorded data provides detailed, comprehensive and accurate information that the researcher can recheck many times by replaying the tape when needed. The collected data were then transcribed verbatim, coded, organized by theme, and analyzed by the researcher.

The questions and topics of the interviews were developed after completing the first phase of the data collection in this research. The open-ended interviews questions were designed to provide in-depth understanding of numerous aspects of emergency health accessibility problem. The interviews focused on three main themes:

1) Perceptions regarding the barriers in accessing emergency health care and the coping strategies.

2) Experiences and perceptions of accessing emergency health care during the first three-uninsured months after arrival in British Columbia.

3) Recommendations to improve access to emergency health care services provided for new immigrants in the city of Kelowna in the future.

Questions for the interviews were predetermined based on the results of the data obtained from the questionnaire, and were asked in a systematic and consistent order for all interviewees (See Appendix G for the interview guide).
In conducting these interviews, the researcher was able to gain access to information that was not mentioned in the questionnaires. This information about new immigrants’ experiences with emergency health care expanded the understanding of the accessibility issue, especially during the first three months after arrival in Canada. Semi-structured interviews “allow the researcher to ask questions from the interview schedule in the order that best fit with the responses of the interviewee, also allow the interviewer some freedom to probe for elaboration on responses” (Bryman, 2004, p. 113).

The quantitative survey data were enriched by the qualitative interview data, providing a better understanding of the accessibility issues to emergency health care and clarifying the survey results. The data obtained from the follow-up interviews corroborated the survey data.

4.4 Limitations

A few limitations of this study need to be addressed. First, the self-selection bias inherent in the sample recruitment means the results are not representative in any way, but do illustrate the type of experiences newcomers have when they use emergency health services in Canada in a mid-sized city and how they perceive any difficulties they faced, along with their suggestions for change. Also, the sample basically excluded newcomers who did not speak or read and write in English; while potential participants were notified that they could use a relative or a friend to translate the questionnaire and their responses to it, only two participants did. Additionally, the possibility of a low response rate, which is a common disadvantage of the questionnaire, was expected to occur. Using the snowball sampling technique was helpful to overcome this problem. Furthermore, one of the main limitations of a self-administered questionnaire is that the respondents’ answers could not be clarified. However, this limitation was overcome by conducting the follow-up interviews, in which some participants had the ability to give information that is more detailed.
4.5 Strength

The main reason for using the exploratory type of research in this study is that very few studies addressing the access to emergency health care by recent immigrants have been conducted in a mid-sized Canadian city yet. Thus, this exploratory research was essential to gain an understanding of the barriers to accessing emergency health care in a mid-sized city. Therefore, the first strength of this project is derived from its originality. Once insight and understanding of the barriers encountered by immigrants when seeking emergency health care are obtained, future studies can formulate or develop hypotheses with more detailed investigations, including testing relationships among key variables and generalizing the results. The second strength of this research is that it can be used as a reference for future research examining immigrants’ access to health care in mid-sized cities in North America and other immigrants’ receiving countries. Another key element is that the results of this study provide a basis for making recommendations for achieving better access to emergency health care, and enabling the integration of vulnerable immigrant groups in the Canadian society. Finally, the study area has added strength to this project. The city of Kelowna was a suitable area for conducting this study because it has the two components of this interdisciplinary study. The first is the geographical component represented by immigrant population and geographical character of the city as it is a mid-sized city. The second is the health component represented by the presence of emergency health services in the city.

4.6 Summary

The purpose of this chapter was to review and discuss the methods of data collection used in this study. The discussion included an explanation of the study area and the rationale for choosing the study area, and the study population and the sampling techniques. This chapter also explained the design of the questionnaire that was administered to participants, and the semi-structured interview procedure with new immigrants’ subsample. Finally, the
chapter highlights the main strengths and limitations of the proposed research.

Data collection for this study began on April 2015 and concluded at the end of August 2015. In total, 40 new immigrants participated in this study. There are significant benefits to the design of the questionnaire distributed to new immigrants and the semi-structured interview process with a subsample of eight new immigrants from those who participated in the survey. The data collected from these two processes were analyzed to produce the research results and recommendations.
Chapter 5 New Immigrants’ Experiences with the Emergency Health Care Services

5.1 Overview

This chapter consists of four major sections to report findings from analysis of survey responses: 1) The socio-demographic profile of the study sample; 2) Respondents’ health status; 3) The use of emergency health care services in Kelowna by respondents; and 4) New immigrants’ experiences with the emergency health services. The results presented in this chapter address the first major research question about the major barriers that new immigrants face when accessing emergency health services during the first five years after arrival in Kelowna.

5.2 Socio-Demographic Profile of Survey Respondents

All of the participants were screened for eligibility before the questionnaires had been distributed. The screenings confirmed that all participants were born outside Canada and entered Canada within the last five years (after January 2010) as officially landed immigrants. In total, 40 participants above 19 years old participated in this study. They all have used the Emergency Department in Kelowna at least once, either for their own health care or when they accompanied a family member (a child or adult relative) who required emergency health care. The survey collected data on socio-demographic variables to describe the sample, including gender, age, marital status, education, English skills, occupation, and source of income.

5.2.1 Gender, Age, and Marital Status

Among 40 participants, 21 (52.5%) were females and 19 (47.5%) were males. Their ages ranged from 20 to 70 years, with a median age of 35. The majority (85%) were young; their ages ranged from 19 to 49 years (see Table 6). With regard to marital status, 30 participants (75%) indicated that they were married and 10 (25%) were single.
Table 6: Gender, Age, and Marital Status

<table>
<thead>
<tr>
<th>Gender</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>19</td>
<td>47.5</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>52.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age category</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>30-39</td>
<td>15</td>
<td>37.5</td>
</tr>
<tr>
<td>40-49</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>50-59</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>&gt;60</td>
<td>3</td>
<td>7.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>30</td>
<td>75.0</td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>25.0</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

5.2.2 Education, English skills, Source of Income, and Occupation

The sample of new immigrants was well-educated, with two-thirds of them having at least one university degree (see Table 7). This result is consistent with BC Statistics (2006) and Teixeira (2009) who claimed that immigrants in Kelowna are overall highly educated.

Table 7: New Immigrants’ Educational Levels

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Education</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Post-Secondary Diploma</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>University Degree</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Post-Graduate Degree</td>
<td>10</td>
<td>25.0</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

When participants were asked about their English-speaking skills, two stated that they had poor English skills, 12 indicated that they speak English fairly well, 11 stated that they speak English well, and 15 claimed they speak English very well (see Table 8).
Table 8: New Immigrants’ English Abilities

<table>
<thead>
<tr>
<th>English Abilities</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Fairly Well</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>Well</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>Very Well</td>
<td>15</td>
<td>37.5</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

Regarding income, half of the respondents indicated that their main source of income at the time of the survey was employment. Twelve (30%) participants were financially dependent on their families, parents, or spouse/partner. Four (10%) participants relied on investments as a source of income. Two participants were receiving income assistance, and another two participants were receiving pension.

Figure 2: New Immigrants Main Source of Income

Most (72.5%) of the respondents were earning less than $50,000 annually (Figure 3), with one-quarter in the low-income range of less than $20,000 yearly. The respondents’ incomes were slightly lower than that of the general population, with an average of
approximately $31,000, compared to $33,647 for the total population in 2005 (BC Statistics, 2006).

**Figure 3: New Immigrants’ Annual Income**

As employment and income are interconnected, respondents were asked to specify the kind of work they did before and after coming to Canada. Their answers indicated that slightly more than one-third (35%) of the respondents had jobs in Kelowna that were not congruent with their academic credentials. For example, one respondent was a pharmacist in Iran, but she was working as a pharmacy clerk in Kelowna. Another respondent had been a teacher in India, but the only job he found in Canada was custodial work. Nine of the respondents (22.5%) had not found a job in Kelowna, although seven of them had a university degree. These results are consistent with the findings of many other studies that find recent immigrants working in low-skilled jobs and encounter difficulties finding work commensurate with their education (for example, Lauer, Wilkinson, Yan, Sin, and Tsang, 2012).
5.2.3 Country of Origin

Reflecting the greater diversity of newcomers to Kelowna, the survey respondents came to Canada from a wide range of countries, as shown in Table 9. With regards to the participants’ ethnic backgrounds, there were ten South Asians (25%), nine Arabs (22.5%), four South Americans (10%), four Filipinos (10%), four White (10%), two Koreans (5%), and two Chinese (5%).

Table 9: New Immigrants' Country of Origin

<table>
<thead>
<tr>
<th>Country</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Algeria</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Chile</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>China</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Egypt</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>England</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Iran</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Iraq</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Japan</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Mexico</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Morocco</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Russia</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>South Korea</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
<td>5.0</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

5.2.4 Year of Arrival and Immigration Class

All the participants in this study arrived in Canada as landed immigrants after January 2010. A total of 10 immigrants (25%) arrived in 2010, six (15%) arrived in 2011. Eight (20%) arrived in 2012, 11 (27.5%) arrived in 2013, and five (12.5%) arrived in 2014. While their immigration classes varied, the majority of participants fell under the family class (45%)
and the federal skilled worker class (40%), combined. Table 10 presents the participants’ immigration classes upon arrival.

Table 10: The Participants’ Immigration Classes

<table>
<thead>
<tr>
<th>Immigration Class</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Class</td>
<td>18</td>
<td>45.0</td>
</tr>
<tr>
<td>Federal Skilled Worker</td>
<td>16</td>
<td>40.0</td>
</tr>
<tr>
<td>Provincial Nominee Program</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Business Class</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

5.2.5 Area of Residence in Kelowna

Residential location can be an indicator of socioeconomic status. It also gives an idea of the geographical distance between home and the hospital ED. When asked about their area of residence in Kelowna, the participants’ responses showed that at the time of the survey, 15 respondents were living in Rutland, seven were living in Glenmore, seven were residing downtown, six were residing in Mission, and three were living in South Pandosy (Figure 4). Those who resided in the downtown and Lower Mission areas live closer to the hospital and could more easily rely on public transportation than those living in Rutland, Glenmore, and Upper Mission. Although even the latter lived between nine and 16 kilometers from the hospital, and routes to the hospital are not crowded in Kelowna compared to those in big cities.
5.3 Respondents’ Health Status

Before proceeding to the use of emergency care services by new immigrants in the city of Kelowna, the questionnaire explored the respondents’ health in terms of prevalence of chronic illness and self-evaluation of their overall health.

The health status of the person who used the ED (participant or participant’s family member) was generally good; the majority (31 or 77.5%) reported having no previous history of disease. Of the nine respondents with a chronic illness, hypertension was indicated by four, and a history of heart disease was reported by three participants (see Table 11).
Table 11: Prevalence of Chronic Diseases among New Immigrants in Kelowna

<table>
<thead>
<tr>
<th>Disease</th>
<th>N=40</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No History</td>
<td>31</td>
<td>77.5%</td>
</tr>
<tr>
<td>History of hypertension</td>
<td>4</td>
<td>10.0%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3</td>
<td>7.5%</td>
</tr>
<tr>
<td>Neurological disorder</td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Cancer</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hematology disorder</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Liver/Gallbladder disease</td>
<td>1</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Note. *The percent of cases exceeded 100% because the nine respondents who have positive history were able to select more than one disease (a multiple response question) (Source: New Immigrants’ Questionnaire Survey, 2015)

The participants were asked to rate the overall health of the new immigrant who visited the ED in Kelowna (participant or participant’s family member). As outlined in Table 12, the majority (35 or 87.5%) reported a rate higher than fair. Only five estimated their health as fair or poor.

Table 12: New immigrants’ Self-Rated Health

<table>
<thead>
<tr>
<th>Health</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Fair</td>
<td>4</td>
<td>10.0%</td>
</tr>
<tr>
<td>Good</td>
<td>15</td>
<td>37.5%</td>
</tr>
<tr>
<td>Very good</td>
<td>11</td>
<td>27.5%</td>
</tr>
<tr>
<td>Excellent</td>
<td>9</td>
<td>22.5%</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

This result is in line with the results of other studies (Ali, McDermott & Gravel, 2004; McDonald, & Kennedy, 2004; Newbold, 2006) that have found that new immigrants are, in general, healthy and that the rate of chronic disease among new immigrants is low, and is, therefore, consistent with what is known in the literature as the healthy immigrant effect (Ali, McDermott & Gravel, 2004; Newbold, 2005; Newbold, 2009a; Fuller-Thomson, Noack & George, 2010; Des Meules et al., 2011, Ng, 2014).

The fact that new immigrants are, in general, young (Statistics Canada, 2008; Newbold, 2009a; Statistics Canada, 2014b) may partially explain why they are generally

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healthy. Another logical explanation is that the CIC policy, which required the applicants to pass a mandatory medical examination prior to being issued a landing visa (Beiser, 2005, CIC, 2013b), may have been excluding those who have serious or chronic medical illnesses.

5.4 The Use of Emergency Health Services

Conditions that require emergency care such as traumas, injuries, or internal medical conditions may occur anytime with or without the presence of alarming or predisposing factors. The need for emergency health care service, therefore, is unpredictable. To explore whether they needed and actually used the emergency health services, participants were asked how many times they and their family members had used the ED since they arrived in Kelowna. The responses demonstrated that half of the participants had visited the ED only once, 12 (30%) visited the ED twice, seven (17.5%) used the ED three times, and only one (2.5%) participant visited the ED four times.

The participants were further asked in what capacity they visited the ED. More than half (27 or 67.5%) of the participants used the ED as a patient, and 16 (40%) had gone to the ED when accompanying an immediate family member. Three (7.5%) participants visited the ED as a companion of a relative (extended family member). Those who used the ED more than once were accompanying a family member or a relative on their first, second, or third visit.

5.4.1 Nature of the Complaints for which Participants Used the ED

Before exploring any barriers the participants experienced in accessing emergency care, it was important to understand whether the new immigrants used the ED in Kelowna appropriately, that is, for truly urgent or emergent conditions, or inappropriately for non-urgent medical conditions.
According to the Canadian Association of Emergency Physicians (CAEP, 2015), there are five emergency categories (triage categories) used in the Canadian triage system: resuscitation, emergent, urgent, semi-urgent, and non-urgent, described as follows:

1) A resuscitation case is defined as a life- or limb-threatening condition that needs immediate intervention (e.g., cardiac arrest and severe respiratory distress).

2) An emergent case refers to a potential threat to life, limb, or function, requiring rapid intervention (e.g., coma, severe trauma, head injury, sudden severe chest pain, severe asthma, and drug overdose).

3) An urgent case is defined as a condition that may deteriorate to a serious problem (e.g., moderate trauma, mild to moderate asthma, and acute moderate pain).

4) A semi-urgent condition is a less critical condition that is related to age, distress, or has a potential for complications (e.g., headaches or chronic pain).

5) A non-urgent condition may be acute, but may be part of a chronic illness; intervention could be delayed, or patients could be referred to other hospital units or a non-emergency health care unit (e.g., sore throat, upper respiratory tract infection, vomiting with no diarrhea, and mild non-acute abdominal pain).

In the absence of clinical assessment records, it is difficult to judge the urgency level (triage category) for the cases in which the survey respondents sought emergency care. However, the researcher used the information provided by the respondents, i.e., their presenting complaint at the ED, previous medical history, and other relevant information such as age, pain level, and arrival mode, to create descriptive scenarios and match them to the triage categories, specifically three categories: emergent, urgent, and non-urgent.

Several studies (Worster, Sardo, Eva, & Fernandes, 2007; Fernandes et al., 2013) have assessed the reliability of triage scales by providing triage nurses with patient information by which the nurses judged the patients’ urgency levels (triage category).
Similarly, Alquraini, Awad, and Hijazi (2015) assessed the CTAS interrater reliability by introducing scenarios to triage nurses. Worster et al. (2007) established that the use of summary (paper-based scenarios) is an acceptable alternative for real case scenarios when judging the triage urgency level in assessing CTAS scoring reliability.

An example of a case that was judged to be emergent involves a male patient who has a history of hypertension, diabetes and heart disease. He visited the ED complaining of chest pain, and was accompanied by his daughter. His daughter participated in the study and she described the medical complaint thus: “. . . my father was dizzy and weak, after we arrived in the hospital, my father fell down, lost his consciousness” (Survey Respondent 23). Another example of a case that was judged to be an emergency was that of a male participant who arrived by ambulance with a complaint of severe headache and weakness of one side of the body. The respondent described his complaint as: "I had a severe hemiplegic migraine. . . . They [the ED care providers] were suspecting brain hemorrhage . . . and I’ve been transferred by the ambulance to ER. . . . That was the most serious visit” (Interviewee 8).

An example of a case that was judged to fall under the urgent category was described by the participant thus: “. . . my husband had chest pain, it was really bad. He has a family disease issue . . . heart disease” (Survey Respondent 8). Another example: “I was pregnant in the first trimester, eight to nine weeks, and I had bleeding with abdominal pain . . . it was bleeding and pain, and I really had to see a doctor. So, I decided to go to ER” (Interviewee 1). A third example: “My son had difficulties in breathing and this is something we had to take it seriously. We went to the walk-in clinic and they recommended that he has to go to the emergency ‘right now,’ and they faxed a report to the ER” (Interviewee 7).

An example of a case that was judged to be non-urgent: a 33-year-old healthy man visited the ED with a complaint of a runny nose, cold, and fever.
The researcher’s preliminary estimations of the level of urgency of ED visits were as follows: ten cases (25%) were judged to be non-urgent, 24 (60%) were estimated to be urgent, and five (12.5%) were considered under the emergent category. Only one case (2.5%) was not judged due to insufficient information (see Table 13).

### Table 13: Estimated Level of Urgency for the New Immigrants’ ED Visits

<table>
<thead>
<tr>
<th>Urgency level</th>
<th>N=40</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Urgent</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>Urgent</td>
<td>24</td>
<td>60.0</td>
</tr>
<tr>
<td>Emergent</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

As presented in the table above, the majority of the cases were estimated to be urgent or emergent, which indicates that the participants used the ED appropriately for true medical emergencies.

The inappropriate use of ED (using the ED for minor or non-urgent health problem) increases the demand on the ED and leads to inefficient consumption of the ED resource. Since the Canadian Institutes for Health Information (CIHI, 2015) reported that 43% of all visits to EDs in Canada in 2003-2004 were non-urgent, the participants’ pattern of usage is relatively lower than that of the general population. Almost 75% of participants’ conditions for which they sought ED care fell under the urgent (CTAS Level 3) or emergent (CTAS level 2) categories.

#### 5.4.2 Having a Family Physician

The majority of survey respondents (29 or 72.5%) reported having a family physician in Kelowna. Those who did not were either unsure of how to identify and contact a family doctor, or were unable to find a family doctor who was accepting new patients. A participant from Egypt stated:
Another problem I found here in Kelowna was that it is not easy to find a family doctor. This is a very critical issue for us as a family with three kids. I waited for one year to find a family doctor, but I couldn’t find any family doctor to accept us. We went to a walk-in clinic [and asked a walk-in clinic doctor to be our family doctor], but they told us to search online. We did search online to see who are the family doctors available . . . there was no opening. We asked some of our friends to recommend us to their family doctors but it didn’t work… everyone [family doctor] is busy. (Interviewee 7)

Previous studies by Asanin and Wilson (2008), and Ngwakongnwi et al. (2012) revealed that newcomers face difficulties in finding family doctors and not having a family doctor hinders newcomers’ accessibility to health care. However, Asanin (2008) and Wilson and Ngwakongnwi et al. (2012) studies were conducted in relatively large cities. The former was conducted in Mississauga and found that the unavailability of family doctors in the immigrants’ geographical locations was one of the major difficulties immigrants face in accessing health care services (Asanin & Wilsom, 2008). The latter was conducted in the city of Calgary and found that French-speaking immigrants encounter challenges when searching for a family doctor (Ngwakongnwi et al., 2012). Factors that could possibly be associated with this barrier include language insufficiency, discriminations, cities sizes, and geographical distances to health care facilities.

5.4.3 Association between not having a Family Physician and Using the ED

In a few (four) cases, the lack of family doctor led participants to rely on the ED, even when they knew their medical issue was not urgent. The majority (36 or 90%) visited the ED because they believed that their medical conditions were true medical emergencies. In other words, the participants were unlikely to visit the ED as an alternative to family doctors’ clinics. This conclusion is supported by two findings/indicators: a) three quarters of new
immigrants participated in the study have family doctors, b) most of the cases and complaints for which immigrants sought emergency care seemed urgent or emergent as explained previously.

### 5.4.4 Availability of Emergency Health Services in Kelowna

When asked to rate the availability of the emergency health services, as presented in Figure 5, the majority of the respondents (34 or 85%) rated the availability of service as good, very good, or excellent. Only six new immigrants (15%) rated the availability as poor or fair.

![Figure 5: Participants’ View of the Availability of Emergency Care Services in Kelowna](image)

This result seems logical as Kelowna General Hospital provides comprehensive health care services including 24 hours emergency care service (Interior Health, 2015c).

### 5.5 New Immigrants’ Experiences with Emergency Health Care in Kelowna

The survey respondents were asked some questions related to their experiences with the emergency health care services in the city of Kelowna. These questions inquired mainly about the barriers and difficulties participants faced when accessing and receiving emergency care and quality of care provided by the emergency health care providers. The participants
were also requested to rank the overall experience with the ED in Kelowna and the barriers to obtaining ambulance services.

5.5.1 Barriers in Accessing Emergency Care

Survey respondents were instructed to choose all difficulties they encountered from a list (multiple response questions), and were given an option to write-in unlisted barriers or difficulties they had faced in a narrative format. The majority of respondents (37 or 92.5%) claimed that they encountered difficulties in accessing emergency health services, and only three participants (7.5%) stated they did not face any difficulty.

The most frequently reported barrier encountered by respondents with respect to their access to emergency health care was long wait times, reported by 33 participants (82.5%). Language barrier was the second most common problem, reported by 16 participants (40%). The third most frequently reported barrier was confusion due to inadequate information about how long it would take to receive ED service from a physician and treatment questions or issues, reported by 10 participants (25%). Culturally incongruent care and transportation problems were each reported by six (15%) participants. Perceived discrimination and insurance problems were reported less frequently by 12.5% of the participants each. Table 14 presents the most common barriers experienced by the survey respondents when using the emergency health services in Kelowna.
Table 14: Barriers Encountered by New Immigrants in Accessing Emergency Health Care

<table>
<thead>
<tr>
<th>Barriers</th>
<th>N=40</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long wait time</td>
<td>33</td>
<td>82.5%</td>
</tr>
<tr>
<td>Language barriers</td>
<td>16</td>
<td>40.0%</td>
</tr>
<tr>
<td>Information problem</td>
<td>10</td>
<td>25.0%</td>
</tr>
<tr>
<td>Culturally inappropriate care</td>
<td>6</td>
<td>15.0%</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>6</td>
<td>15.0%</td>
</tr>
<tr>
<td>Lack of health insurance</td>
<td>5</td>
<td>12.5%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>5</td>
<td>12.5%</td>
</tr>
<tr>
<td>Cost too much money</td>
<td>5</td>
<td>12.5%</td>
</tr>
<tr>
<td>Hospital is far from where I live</td>
<td>4</td>
<td>10.0%</td>
</tr>
<tr>
<td>The service was not available</td>
<td>3</td>
<td>7.5%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td>No barriers</td>
<td>3</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

Note. *The percent of cases exceeded 100% because the respondents were able to select more than one barrier (a multiple response question) (Source: New Immigrants’ Questionnaire Survey, 2015)

5.5.1.1 Long Wait Time

Long wait times was reported not only as a the most common barrier, but also as the most bothersome difficulty that immigrants experienced during their visits to the ED. The length of wait times to be seen by an emergency physician varied, as reported by the participants. While two participants indicated that they were seen by the physician within half an hour, the wait times in the ED ranged from two to eight hours.

EDs in Canada implement CTAS guideline to achieve proper access to emergency care based on priorities and in a timely manner. According to the CTAS national guideline, there are five emergency triage levels. Each level has a specific time frame during which a patient should be seen. Triage level one is for resuscitation cases such as unconsciousness and major traumas. These cases should be seen by a physician immediately after arrival in ED. Triage level two is for emergent cases such as chest pain and head injury, these should be seen by a physician within 15 minutes of arrival in ED. Urgent cases such as pregnancy with vaginal bleeding and moderate trauma are categorized as triage level three and should be seen within 30 minutes. Triage level four is for semi-urgent cases such as minor trauma and
should be seen within one hour. Non-urgent such as sore throat can wait for 2 hours or more (CAEP, 2015).

While there were no resuscitation cases described by participants in this study, five cases (12.5%) were estimated to fall under the emergent category, and 24 (60%) cases were judged to be urgent. Qualitative data that were gathered from the questionnaires and the follow-up interviews suggested that the wait time in several cases exceeded the wait time recommended by the CTAS. Table 15 provides examples of some respondents’ descriptions of the presenting complaint at the ED, the estimated triage level assigned, and the time spent waiting in the ED to be seen by a physician.
<table>
<thead>
<tr>
<th>Respondent (R)</th>
<th>Presenting Complaint at the ED as reported by the participants</th>
<th>CTAS Level</th>
<th>Respondents’ narrative data about the wait time</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 8</td>
<td>“My husband had a chest pain- really bad.” “… he has [a history of] family disease … heart disease”</td>
<td>Level 2 Emergent</td>
<td>“When we arrived at the emergency, they [triage staff] checked my husband’s chest right away but since then we had to wait for a doctor more than seven hours…”</td>
</tr>
<tr>
<td>R 30</td>
<td>“I was very sick and my blood pressure was low. I waited for more than one hour then It was the doctor took me inside after my friend talked to him. I was after that [put] on respirator”</td>
<td>Level 2 Emergent</td>
<td>“I was very sick . . . and I was dizzy, and having severe pain. The triage nurse sent me to the waiting area and [I waited for] more than an hour. The doctor came and was not happy with… [the triage decision] and he transferred me to the critical care area.”</td>
</tr>
<tr>
<td>R1</td>
<td>“My son hurts by bumping into a table and his head was bleeding, sutured in the ED.”</td>
<td>Level 3 Urgent</td>
<td>“It took more than four hours for my son to have his turn.”</td>
</tr>
<tr>
<td>R16</td>
<td>“My daughter was ill, wheezy chest and high-grade fever not responding to medication (40C) and vomiting. She had a history of febrile convulsion”</td>
<td>Level 3 Urgent</td>
<td>“We had to wait for three hours to see the doctor with no treatment or investigations offered”</td>
</tr>
<tr>
<td>R 27</td>
<td>“I was pregnant at that time and I had bleeding and severe pain.”</td>
<td>Level 3 Urgent</td>
<td>“I had to wait two hours to see a doctor, they seemed too busy because of lack of staff.”</td>
</tr>
<tr>
<td>R 37</td>
<td>A 74-year-old man visited the ED because of active bleeding from the nose. He was accompanied by his daughter.</td>
<td>Level 3 Urgent</td>
<td>“My dad has a syndrome where he bleeds internally without any warning. When he feels sick, he has to be immediately admitted, and last time it took the ER about 4 hours just to get him in a room.”</td>
</tr>
<tr>
<td>R 9</td>
<td>A young lady visited the ED complaining of anxiety and emotional distress.</td>
<td>Non-Urgent</td>
<td>“When I arrived there [ED] . . . then I told them the problem. They told me to sit down and they will call me to see the doctor. It was 8 pm, I waited from 8 pm to 5 am.”</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)
Long wait time to receive care is a major long-standing problem in the Canadian health care system, including EDs. Undoubtedly, the ED long wait times is not only faced by new immigrants, but by native-born as well. Previous reports demonstrate that Canada ranks the lowest among 11 developed countries in terms of wait times for primary or secondary health care (waiting to be seen by a doctor, a nurse, and a specialist). Almost half of Canadian patients wait for more than four hours during emergency room visits. In contrast, less than 5% of ED patients in Germany, United Kingdom, and the Netherlands wait more than four hours (CIHI, 2012).

While this problem is a general one, interview data suggests that some new immigrants found the very long wait in the ED intolerable; it was the cause of significant displeasure, as one participant noted:

When I arrived in the ER, they [the triage nurses] asked me what the problem is, I told them I am having breathing issues and they told me to wait. That [waiting] was the most difficult part. I had many visits to ER and I had some other issues. . . . But to see a doctor, it took a couple of hours and then the doctor saw me, it took other hours to get the treatment. . . . I did not know what to do, I really was pissed off. . . . I have many other things to take care of. (Interviewee 6)

Many participants believed that the long wait time has become normal and acceptable to Canadians. However, they found the long wait very irritating; it made them feel frustrated, powerless, and helpless. They were not expecting the wait to be so long because of their positive perceptions of the Canadian health care system, and because some of them were accustomed to quicker responses in other countries. For instance, one participant said the “wait time did not meet my expectation. In Korea, it is faster . . . maybe the Canadians used to [long wait times in the ED], but I didn’t used to it at all” (Interviewee 2). Another participant said something similar:
I was frustrated because in Japan we don’t need to wait that long, we can see the
doctor very quickly. But I knew [that I would wait for a long time to see a doctor]
because I watched the news, and they are saying [in the TV news] that in emergency,
there is a long wait time. (Interviewee 1)

In most cases, no information about the anticipated wait time was given to the participants
when they were in the ED. Leaving emergency patients waiting without reassurances or
updates seems to have heightened their dissatisfaction. This was a shared experience among
many of those who reported long wait as a barrier accessing emergency care. Below are
selected quotes indicating their dismay:

I went to the emergency and stopped at the reception [the triage area]; they [the triage
nurse] checked my temperature and did the screening, and I had to wait for a long
time — two hours. I was in pain and they asked me how much pain I am having from
zero to ten, I said six to seven. . . . When I was waiting, they [HCPs] did not talk to
me, no information, no medication, nothing. (Interviewee 1)

The nurse said [there was] only one doctor [on duty], we have to wait. We waited for
five hours. Nobody to help or answer our questions. I tried to ask somebody like a
manager, but nobody was there. We were left helpless. (Survey Respondent 4)

The lengthy wait time can lead to negative consequences. Patients accumulate in the ED,
which causes delays for others. ED patients lose a significant amount of time, as described by
a participant, “In ED, I had to wait for three hours to see a doctor and then a couple of hours
to get the treatment, so it is almost half of the day” (Interviewee 3).

In the follow-up interviews, the participants were also asked how their experience differ
when they used emergency care in countries other than Canada, the majority (six out of the
eight participants with experience of emergency care in other countries mentioned that the
wait time was shorter in South Korea, Japan, Bangladesh, Iran, Egypt, and Lebanon. This was
not a reflection of the comparative quality of emergency care, however. Some participants noted that long wait times in the ED was a general problem, faced by many patients:

The problem we faced is that we had to wait for four hours to see the doctor . . . .

When I was waiting, I found a lot of other patients waiting too. There was a lady came before us and was waiting. She was crying of pain, she had renal colic, and it was strange that she had waited for more than five hours. (Interviewee 8)

Notably, long waits to receive care are a system-related problem beyond the control of new immigrants.

5.5.1.2 Language Barriers

Sixteen participants (40%) reported that they had faced language problems when they sought care in the ED in Kelowna. The problem of communication is not a system-related problem, and new immigrants vary in their English-speaking capabilities. Nevertheless, data from the interviews indicated that some new immigrants with good English skills still face language barriers when dealing with medical terminology; as one of the participants noted, “for me, I didn’t face any other problem, but sometimes for the language, sometimes for professional medical words, I feel like I need a person to translate for me” (Interviewee 4). The same concern was mentioned by another interviewee: “Even if your English is good, it is sometimes difficult to use medical terms, [I am] not familiar with all medical terms. I used my dictionary to find some words of medical terms” (Interviewee 2).

What made the language barrier a serious problem was the lack of professional interpretation service. In some cases, the HCPs used their own initiative to understand the patients’ complaints as one participant noted, “when the nurse figured that it is difficult to communicate with my dad in English, she started acting by hand, using sign language to communicate with him” (Interviewee 4). Most of those who needed interpretation assistance in the ED relied on a family member or relative (more details see chapter 7, coping
strategies). A participant from Japan, for instance, who visited the ED as a patient accompanied by her husband, stated that: “My husband is Canadian and he understands Japanese. I explained to him what happened and the pain [I was complaining from] so he could translate [to the nurse]” (Interviewee 1).

This finding is consistent with previous studies that show that newcomers in Canada generally face difficulties accessing health care due to language insufficiencies (Wu, Penning, & Schimmele, 2005; Sanmartin & Ross, 2006; Zanchetta & Poureslami, 2006; Asanin & Wilson, 2008; Newbold, 2009a; Long, 2010; Dastjerdi, 2012). These studies, however, did not explore which new immigrant subgroups or categories face language barriers. The data from the current study suggested an association with the country of origin. A participant from Algeria, for instance, reported language problems as the most serious barrier she faced in the ED. In Algeria, the two most common language spoken are Arabic and French, so English was the participant’s third language. Participants from England and Nigeria, on the other hand, had no language problem because English is the native language in England and a commonly used language in Nigeria.

Another variable that seemed to be associated with reporting a language problem was the participant’s level of education. To examine the relationship between these two nominal variables, the independent variable was classified into two categories (below university degree and university degree or above). Data were entered in SPSS and analyzed using a chi-square test for independence (see Table 16 and 17). The analysis revealed a statistically significant association between the level of education (independent variable) and reporting language barriers (dependent variable), $\chi^2(1, N = 40) = 5.171, p = .023$. 


Table 16: Level of Education by Language Barriers

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Reported language barriers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University Degree and Above</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Expected Count</td>
<td>5.2</td>
<td>7.8</td>
</tr>
<tr>
<td>Count</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Expected Count</td>
<td>10.8</td>
<td>16.2</td>
</tr>
<tr>
<td>Below university degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>Expected Count</td>
<td>10.8</td>
<td>16.2</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Expected Count</td>
<td>16.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Note. *0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.20.

Table 17: Chi-Square Test Statistics

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>6.857a</td>
<td>1</td>
<td>0.009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction*</td>
<td>5.171</td>
<td>1</td>
<td>0.023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>6.889</td>
<td>1</td>
<td>0.009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td>0.015</td>
<td>0.012</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>6.685</td>
<td>1</td>
<td>0.010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td></td>
<td></td>
<td></td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

Note. *Computed only for a 2x2 table

Participants who had a university or graduate degree were less likely to report language barriers in the ED than those with an educational level below a bachelor degree. While this result is statistically significant, the sample is small and may not be representative, so the result may need validation. In other words, the association should be tested by replication with a larger sample, and other possible explanatory variables should be considered.

5.5.1.3 Inadequate Information

Newcomers’ unfamiliarity with the Canadian emergency care system may create an accessibility barrier. Many information-related problems were reported by the survey respondents: lack of knowledge about the emergency care system and about ambulance services and costs, as well as unavailability of information in the ED when requested.
Not providing information or reassurance to patients in the ED were two of the major information-related problems. For example, one participant said: “when [I] asked about the time (how long the wait will be), they did not answer, they don’t know... I waited for more than three hours to see a doctor... I needed information, I don’t know a lot” (Survey Respondent 12).

Another participant stated:

While we were waiting for the doctor, I wanted to make my husband comfortable sitting on the chair because he [was in] pain. I looked around to find a nurse, but no one was there for us and for the other patients. It was our first time to be there (in the ED), and I did not know where to buy some food... They [the nurses] were so busy to do their stuff. (Survey Respondent 8)

While the survey data analysis presented the information-related problems as the third most common difficulty, data from the semi-structured interviews not only corroborated the survey result but also revealed that the information-related problems were of a greater magnitude than originally found in the survey. Qualitative data from the interviews confirmed the lack of knowledge about the emergency care system (where to go and what to do in case of emergency). For instance, one of the interview participants said: “In my situation, I did not have any information about the emergency services, where to go, what to do, how to handle emergency situations, what kind of facilities will be provided and [what] I should expect” (Interviewee 6).

Frustration was an understandable reaction when respondents felt that medical help was needed right away and they were apparently ignored. A participant in one of the interviews expressed concerns when she was in her first year in Canada and had a medical problem that needed emergency care: “I was very upset because I did not know what is happening and what to do? I just needed someone to tell me... they [the ED care providers]
didn’t talk to me” (Interviewee 1). Half of the interviews participants (four out of eight) participants stressed their feelings of uncertainty in the ED: “When we went to the ED, I found a line and I stand in the line, but I was not sure whether this is the right line. . . . No one you can ask . . .” (Interviewee 2). Another interviewee stated, “The lab work took time. I did not know what is the time for the lab work to come back, I was very unhappy” (Interviewee 6).

While it is internationally known that health care in Canada is free as it is publicly funded, British Columbia is the only province in Canada that imposes a monthly fee for the provincial health insurance plan. Some participants were unaware of this; they were under the impression that it is free like in other provinces.

I was under the assumption that it would be free health care. I mean that it . . . ‘caught wind’ from the media, but then I came here [BC, Kelowna] and realized that it is not free, it is $66 [monthly] for singles and more than that for families.

(Interviewee 3)

Another participant had the same impression:

Before coming to Canada, I wasn’t familiar with the health care system and the insurance policy. . . . I knew that in Toronto you don’t have to pay monthly fees. . . . I knew about the policy insurance policy in Toronto, but I didn’t know the policy in BC. I didn’t know that I have to pay monthly fees, and I think it increases every year, it was $66 and now it is $72. I think this is a problem if your income isn’t high.

(Interviewee 4)

The various aspects of the multifaceted knowledge deficit about the Canadian health care system is an important finding of this study. It is consistent with the findings of previous studies that found recent immigrants in Canada do not know where to go for care (Wu, Penning, & Schimmele, 2005), are unfamiliar with the Western biomedicine model
(O’Mahony & Donnelly, 2007), and not knowledgeable about the Canadian health care system; they face difficulties in seeking, finding, and accessing health-related information (Zanchetta, M., & Poureslami, 2006).

5.5.1.4 Socio-Cultural Barriers

Receiving culturally incongruent care in the ED was reported by six (15%) survey respondents. Interviewees referred to cultural/communication differences between medical staff and patients, and to differences in views of health (holistic vs. biomedical):

Having care providers from different cultures will be good, they will have some kind of cultural backgrounds and language skills that will help. If doctors and nurses themselves are coming from different ethnic places, there will be no barriers in communications, this could be done by having more diverse staff . . . hire doctors and nurses from different places . . . that would accommodate different cultures. (Interviewee 8)

The doctor’s way of treating and dealing with me was definitely inappropriate. They (doctors) need to have a certain level of sensitivity to people [patients], to listen, to understand, to sympathize. But it seems that her [the doctor] questions were guiding to a diagnosis, to meet a textbook definition. That is exactly what I have felt. I think they need to make sure that the holistic health are all checked. I mean, spiritual health, emotional pain…these kinds of things are not taken care of. (Interviewee 3)

Perceived discrimination as an obstacle to receiving emergency care was reported by five (12.5%) survey respondents. Previous studies dealing with immigrants’ access to health care in Canada found that new immigrants encounter discrimination to their religious and cultural practices. However, these studies did not focus on emergency care situations, but routine and specialty care such as maternity care (Reitmanova & Gustafson, 2007), walk-in clinics (Asanin & Wilson, 2008), mental health care (Reitmanova & Gustafson, 2009;
Thomson, Chaze, George, & Guruge, 2015), and family physicians (Papic, Malak, & Rosenberg, 2012). Perceived discrimination and receiving culturally incongruent care did not seem to be a major barrier to accessing emergency care for the new immigrants who participated in this study, possibly because patients in EDs pay less attention to discrimination when care is urgently needed.

5.5.1.5 Geographical Barriers

Geographical barriers in accessing emergency health care were assessed in two forms, the first was the distance between residence and the hospital, and the second was transportation. Six survey respondents reported having a transportation problem when they needed emergency health care. Only four respondents said the hospital was far from where they lived.

This data suggests that geographical barriers in accessing emergency health care are not as severe a problem in Kelowna as in large cities such as Mississauga where geographical barriers were found to be one of the major problems that hinder immigrants’ access to health care (Asanin & Wilson, 2008). Geographical barriers may not be an issue because Kelowna is a medium sized city with a relatively low population. However, there are two small cities (West Kelowna and Winfield) located around Kelowna that do not have EDs. The residents and immigrants of these two cities rely on the ED at KGH when they need emergency care. Participants who live in these two cities were not included in this study. If they were included, the geographical barriers in accessing emergency care could possibly have been found to be of greater frequencies.

5.5.1.6 Financial Barriers

Financial barriers, such as paying money for care not covered by insurance (e.g. urgent dental care, and prescribed medication) were reported by five survey respondents. Another financial barrier was the lack of an insurance plan, reported only by five (12.5%)
respondents; this was a serious obstacle during the first three months after arrival in Canada. A possible explanation for why more survey respondents did not report the insurance issue as a barrier is that not all new immigrants needed or actually used ED care during the first three months in Canada. More details about the medical insurance issues will be discussed in the next chapter.

5.5.2 Quality of Emergency Health Care

To explore further newcomers’ experiences with emergency care services, the survey participants were asked to rate the care they received in the ED by the emergency doctor and the emergency nurse on a five-point rating scale. As outlined in Figure 6: Quality of Care Provided by ED Physician, most of the respondents rated the care provided by the ED doctor as good (11 or 27.5%), very good (15 or 37.5%), or excellent (4 or 10%). On the other hand, a quarter of the participants rated the ED doctor care as fair or poor. Those who rated the emergency physicians’ care as poor were further asked to specify why. Their answers indicated that some physicians’ approaches were not as good as they were expecting. One survey respondent described the physician’s bedside manner as detached and rushed:

We waited for seven to eight hours to see the doctor and when the doctor showed up, he was in a rush. He didn’t listen to us. I can tell he spent less than three minutes with us. We really didn’t like this. It was very disrespectful. (Survey Respondent 18)
In the follow-up interviews, two participants explained their dissatisfaction with the ED physician’s bedside manner. A participant who visited the ED complaining of anxiety and emotional distress at night stated,

I waited for nine hours to see the doctor . . . the hardest part was when I saw the doctor. The doctor said, “You know, your problem does not relate to me; you have an emotional problem and I am a physical doctor, and I cannot help you with that”. . . . He just talked to me rudely, he told me that this is not part of his specialty . . . I got irritated because of his kind of talking. (Interviewee 5)

Another participant who was not pleased with the emergency doctor’s care described doctor’s performance as “inappropriate” and lacked empathy (Interviewee 3).

On average, the poor quality of ED physician’s care was a serious concern to several participants; they felt the physicians’ bedside manner was uncaring.
The quality of care provided by the ED nurse was rated slightly lower than the quality of care provided by the ED doctor. Figure 7 shows the rate given by the respondents for the quality of ED nursing care.

![Bar chart showing the percentage of respondents rating nursing care as poor, fair, good, very good, and excellent.]

**Figure 7: Quality of Care Provided by ED Nurse**

As shown in Figure 7, eight (20%) of the survey participants reported poor nursing care, and seven (17.5%) reported fair nursing care. According to the respondents, the reason for this perception of nursing care was mainly the lack of professional behaviour among some nurses in the ED. They described the emergency nursing staff behaviour as rude, disrespectful, unhelpful, uncooperative, and arrogant. One survey respondent said, “the nurses were very rude . . . and [failed to] provide information . . . it is really hard to know what is going on sometimes” (Survey Respondent 37). Another survey participant noted, “[the ED nurses] don’t care. The way they look [it seems] they get upset when we ask them any question” (Survey Respondent 4). Another participant stated, “The nurses were not kind at all, the nurses did not give me enough information” (Survey Respondent 29). Two other
survey participants expressed their feelings of frustration because they believed that some nurses were arrogant and disrespectful:

I do not know about the policy, but I don’t like it when [the nursing care providers] take their positions higher than the patients . . . [the nurses] must know [that] to help a patient is not a volunteer [favour]. We pay the cost and we have the right [to receive professional health care]. (Survey Participant 8)

Another participant, who reported experiencing multiple barriers and difficulties in the ED, described the triage nurse’s assessment as dangerously wrong, as the participant believed that the nurse underestimated her case and made her wait, putting her in further risk of complications.

I was feeling dizzy, can’t work [can’t carry out her daily activities]. . . . In the ER, the [triage] nurse asked me to wait [while] I was very sick. I waited for one hour, then the doctor came and took me to the critical care area; he wasn’t happy with the nurse [the triage nurse’s decision] . . . she asked me to wait while I was very sick. (Survey Respondent 30)

The same participant described the nurse behaviour as disrespectful and degrading:

The nurse was very rude, disrespectful, and arrogant. She thinks she is superior . . . taking advantage of being a nurse . . . I couldn’t believe what she did to me. She never listened to what I was saying. (Survey Respondent 30)

The data from the follow-up interviews supported the questionnaire finding that suggested that several participants faced challenges with the HCP’s professionalism. In the follow-up interviews, several participants voiced their dissatisfaction with the HCP’s approach and way of communication. One participant, who was displeased with the ED nurses’ behaviour, stated,
One time [one of my visits to the ED] . . . the same time that I was waiting long, they [nurses] were talking to each other and laughing. I think they do not care that I am waiting, hungry, sleepy . . . maybe they were laughing at me. (Interviewee 5)

Another interviewee stated that the nurse talked with her in an unmannerly fashion:

[T]he way she [the nurse] talked to me was not nice. I felt she was not respecting me . . . there was a baby with us and the baby was scared and crying. The nurse yelled at me and said “Do something with the boy” . . . I was expecting her to speak respectfully and provide explanations and support rather than giving instructions.

(Interviewee 2)

Notably, not all of those who reported difficulties with the care providers’ approach perceived this approach/attitude as discriminatory. Only five (12.5%) reported perceived discrimination in the ED (see Table 14). Further research is required to clarify whether nonimmigrants have similar or different perceptions and experiences with emergency care providers’ behaviour.

5.5.3 Overall Experience with Emergency Care Service

When participants were asked about their overall experiences with the ED services in Kelowna, almost half (45%) of the participants rated them as either “somewhat worse than expected” or “much worse than expected” (see Figure 8). According to the survey data, the reasons for this rating included the long wait, unavailability of information or unavailability of personnel who could provide information, perceived uncaring behaviour from medical staff, and concerns over the adequacy of clinical care.
In many cases, there was a combination of two or more difficulties reported. For example, a participant, who accompanied her father to the ED, reported a clinical care issue and long wait:

My dad has a syndrome where he bleeds internally without any warning. When he is sick he has to be immediately admitted. Last time [last visit to the ED], it took the ER about four hours just to get him in a room. (Survey Respondent 37)

Another participant noted, “One time I was in the emergency, I felt that they [the health care providers] do not care enough, they were not taking me [my complaint] seriously” (Survey Respondent 9).

Data from three the follow-up interviewees suggested that participants found the HCPs ignorant or inconsiderate of some aspects of care. An interviewee, who was pregnant and visited the ED with a complaint of abdominal pain and vaginal bleeding, stated, “They [the triage nurses] checked my blood pressure and temperature, they did not ask about the bleeding and pain . . . they did not check” (Interviewee 1). Interviewee 3 expressed a similar
concern: “as I first arrived, I was met by a doctor who asked a whole bunch of questions without conducting any test, no blood pressure, no blood test, nothing ever . . . nothing, just questions and an assumption was made” (Interviewee 3). Interviewee 6 noted, “They [the care providers] could probably have spent a little more minutes to discuss or to give you the mental peace [some reassurance]” (Interviewee 6).

Interestingly, four interviewees perceived the hospital ED as short-staffed and believed the shortage could be the reason for the poor quality of care. One participant stated, “They [the care providers] don’t have enough time to talk with you, I assume this is probably because of the workload. They seemed short of staff” (Interviewee 6). A second interview participant shared a similar opinion:

Most of them [the health care providers] are good people. They try to help, but I think they [the ED team] don’t have enough nurses and they don’t have time, but some of them sometimes are rude and maybe because of the night shift and the bad mood. I always try to be understanding and justify their behaviour. (Interviewee 5)

Certainly those who came to Canada with the impression that the Canadian health care system is perfect were disappointed; and this had a negative impact on their perception of the image or reputation of Canada. One participant explained the feeling of her friend who was a new immigrant and faced difficulties with the emergency care:

My friend wanted to come to Canada. When she came, she was happy that she is in Canada, but she was disappointed with the quality of care in the ED. She said, “I wish I could have been in Korea.” . . . This is something related to your health which is an important aspect of peoples’ life (Interviewee 2).

In conclusion, the quality of health care provided in the ED was found to be poorer than expected on several levels: the long wait time, unavailability of information or
unavailability of personnel who could provide information when needed, perceived uncaring and disrespectful behaviour from HCP, and clinical care safety concerns.

5.5.4 Experiences with Ambulance Services

Of the twelve survey respondents (30%) who used the ambulance service, only four mentioned that they faced some difficulties. Two respondents reported a long wait time for the ambulance to arrive, and another two reported financial barriers. While the survey data’s descriptive analysis showed that new immigrants did not face serious barriers with the ambulance service, data from the interviews illustrated that, newly arrived immigrants had been given no knowledge of or guidance on the ambulance services. Unawareness of the ambulance services and the cost of the ambulance services was described by three interviewees. An adult participant, who had shortness of breath at night and needed to go the ED, called 811 (BC health information phone line) to gain some information. He stated,

I called that 811 number and asked for the ambulance, they provided me with some information that if it [my medical condition] is not super emergency, they are going to charge me around $500. So I decided to call my friend instead. (Interviewee 6)

Another participant talked about her experience when she accompanied her father, who was having chest pain and dizziness, to the ED:

My dad had to drive to the hospital, only my dad has a driving license. My mom and I don’t have a driving license . . . . We did not call the ambulance because I heard from my Canadian friends that the ambulance is expensive and it would cost us around $200. (Interviewee 4)

Qualitative data gathered in the follow-up interviews demonstrated that new immigrants in Kelowna experienced two main obstacles to accessing the ambulance services: a lack of knowledge and the high cost. As a consequence, some new immigrants avoided requesting an
ambulance when needed, mainly due to unfamiliarity with and misunderstandings of the ambulance service and financial barriers associated with accessing this service.

5.6 Summary

This chapter began by describing the study sample, their overall health and their use of emergency health care services in the city of Kelowna. The chapter further provided an answer to the first research question: What are the major barriers that new immigrants face when accessing emergency health services during the first five years after their arrival in Kelowna? This question was investigated by analyzing the quantitative and qualitative data gathered in the survey and interviews.

The survey data showed that 92.5% of the new immigrants who participated in this study reported experiencing barriers to accessing emergency care services in the city of Kelowna. After analyzing and merging quantitative data from the survey with qualitative data from the interviews, a better understanding of the barriers and their severities was gained. The main barriers new immigrants experienced were arranged in a descending order (from the most frequently reported to the less frequently reported). The barriers are listed as follows: Long wait times, perceived inadequacy of care, language barriers, information problems, culturally incongruent care and perceived discrimination, geographical barriers, and financial burden.

In general, the barriers experienced by the participants when accessing emergency health care can be classified under two main categories. The first is system-related barriers, which can be defined as the barriers that new immigrants experience and arise from the system i.e. they are out of immigrants’ control. These include long wait times, poor quality of care, culturally inappropriate care, exposure to discrimination, and unavailability of services. The second is individual-related barriers, which refers to barriers that arise from the immigrant person, not the system (barriers due to personal situations). These include
language barriers, transportation problems, and lack of knowledge about available health care resources.
Chapter 6  Experiences with the Emergency Care Services during the First Three Uninsured Months

6.1 Overview

In Canada, residents obtain emergency health care when needed based on their provincial insurance coverage. However, new immigrants in some provinces have to wait for an average of three months to be enrolled in a health insurance plan. Particularly, the province of British Columbia imposes a three-month wait period for new immigrants to register in provincial health insurance, formally known as the Medical Service Plan (MSP). The three-month uninsured period was given attention in this research because of the small number of studies that have focused on new immigrants’ access to emergency care during the first three-uninsured months.

The occurrence of emergency medical conditions is unpredictable. In cases of medical emergencies, new immigrants may be considered a vulnerable group as they may have a knowledge deficit about the provincial health insurance policy. They may also have inadequate psychosocial support to deal with any need for urgent health care. Additionally, many new immigrants come to Canada with a spouse and children. Logically, the likelihood of the need for emergency health services increases when the family size increases. Under these complex circumstances, it is essential to understand how prepared new immigrants are to deal with medical emergencies during the first three uninsured months after arrival in British Columbia (second research question).

6.2 New Immigrants’ Awareness of the Uninsured Period

To examine the newly landed immigrants’ awareness of the three-month wait for the provincial insurance plan, participants were asked to indicate whether they, on arrival, were aware that they would have to wait for three months to be enrolled in the Provincial MSP. Fourteen participants (35%) indicated that they had no knowledge of the three-month wait,
and 26 participants (65%) stated that they were aware of the three-month period. Of those 26 participants who were aware of the three-month wait, the majority received information from relatives, friends, coworkers, and community members, and some used governmental websites. Table 18 shows the main sources new immigrants used to gain knowledge about the health insurance policy in British Columbia including the three-month wait period.

**Table 18: Source of Information Used to Learn about the Three-Month Wait Policy**

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>N=26</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives or friends</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td>Government source, e.g., CIC</td>
<td>8</td>
<td>30.7</td>
</tr>
<tr>
<td>Employer/coworker</td>
<td>5</td>
<td>19.0</td>
</tr>
<tr>
<td>Community members</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>Airport official</td>
<td>1</td>
<td>3.8</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

The table above illustrates that new immigrants largely rely on relatives and friends as well as community members to learn about the health insurance policies. This shows that there was limited guidance from the immigration and health sectors and community settlement agencies.

Data from the follow-up interviews confirmed that new immigrants relied mainly on their families and relatives, but some used the governmental website to gather information related to insurance policies, including the three-month wait. One interview participant noted,

When I came here first [to British Columbia], I knew about the three-month policy . . . my wife told me. My wife was in a Ph.D. program at the UBC, and UBC told her.

They [UBC] told her that during your first three months you have to cover yourself . . .

. I bought a private insurance. (Interviewee 8)

Another participant who used a governmental website to gain knowledge about the insurance policy stated,
Before I came to Canada, I was aware that I have to wait for three months to get the MSP, I checked Service BC website before leaving Japan . . . Some new people may not know [about the three-month wait to get the MSP]. If they have to go to ER, [they may face] financial problems. (Interviewee 1)

6.3 Preparation for the First Three Uninsured Months

The survey participants were asked how they prepared for medical emergencies that might occur during the first three months in Canada; 18 (45%) did not prepare, and 22 (55%) did prepare. The main preparatory actions taken by those 22 (55%) respondents were gathering information about the provisional health insurance policy in British Columbia and purchasing a private insurance plan to cover any health care during this period.

6.4 Enrollment in Private Insurance

The survey participants were asked whether they actually purchased private health insurance: to cover the cost of health care, if needed, during the first three months while waiting for provincial MSP coverage. The responses were equally divided, 20 (50%) participants purchased private insurance and 20 did not.

Of those twenty participants who did not purchase private insurance, eight (40%) respondents claimed that they did not know that they had to have private insurance, six (30%) stated that private insurance was too expensive, and three (15%) participants chose not to enroll in private insurance at their own risk (Table 19).

Unawareness of the three-month wait policy and the cost of private insurance were the most common reasons why new immigrants did not buy private insurance to cover for any health care during their first three months in British Columbia. The lack of insurance may impede access to necessary health care when needed, leaving the uninsured new immigrants with unmet health needs (the next few pages provide details about the extent to which the lack of health insurance coverage caused accessibility problems).
Table 19: Reasons for Not Purchasing Private Insurance during the First Three-Uninsured Months

<table>
<thead>
<tr>
<th>Reason</th>
<th>N=20</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private insurance costs too much money</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>I did not know that I should do so</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>I took the risk</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Insurance company refused</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>I had an international health insurance</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Others (not specified)</td>
<td>1</td>
<td>5.0</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

6.5 The Need for Health Care during the First Three Months

The survey respondents were asked whether they had any medical conditions which may have required treatment during their first three months in Canada, and whether or not they actually used health care services during that period.

Figure 9: Need for and Use of Health Services during the First Three-Months in Kelowna

As presented in Figure 9, the survey data showed that 16 respondents had medical conditions that may have required treatment during their first three months in Canada. Out of those 16, six actually used the health service, and ten did not. Those ten participants, who had medical conditions but did not seek medical attention, were asked a multiple choice question in which they could provide more than one answer to why they did not seek medical attention. The results are indicated in Table 20.
Table 20: Reasons for Not Receiving Medical Care During the Uninsured Period

<table>
<thead>
<tr>
<th>Reason</th>
<th>N=10</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No insurance plan</td>
<td>9</td>
<td>90.0%</td>
</tr>
<tr>
<td>Financial constraints</td>
<td>5</td>
<td>50.0%</td>
</tr>
<tr>
<td>Problem was not serious</td>
<td>3</td>
<td>30.0%</td>
</tr>
<tr>
<td>Long wait time in the ED</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Did not know where to go for care</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td>Others (not specified)</td>
<td>1</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Note. *The percent of cases exceeded 100% because multiple responses were allowed.
(Source: New Immigrants’ Questionnaire Survey, 2015)

For the most part, the respondents did not seek medical attention because they had no insurance coverage or had other financial constraints. A few respondents believed that their cases were minor medical conditions that did not need medical care.

Qualitative data from the open-ended survey questions elaborated on the reasons for not seeking care. For example, a woman who twisted her ankle went to the ED, but, when asked to pay, she left the ED without treatment because she thought the cost was very expensive: “They [the ED registration staff] asked for $1500 in advance for the twisted ankle!” (Survey Respondent 28).

6.6 Experiences with Health Care Services during the Uninsured Period

The data from the follow-up interviews corroborated the survey finding that the three uninsured months generated barriers to accessing emergency health services. Interviewees were encouraged to talk about their experiences with health care services during their first three months in Canada. They described two main barriers: knowledge deficits about the provincial insurance policy and the Canadian emergency health care system, and financial barriers to accessing health care services. As a result of these barriers, some new immigrants postponed or avoided seeking health care.

6.6.1 Financial Problems

According to the survey data, half of the new immigrants participating in the survey were not medically insured during their first three months in Canada. They did not purchase
private insurance to cover any health care. Many of them believed that private insurance was too expensive. One interview participant stated, “It [the three-month wait] is not fair, it is just not fair. . . . The first three months, you will be extra careful because you gonna pay for the private insurance” (Interviewee 3). Another participant noted,

My family did not get private insurance [to cover the three-month wait] because they thought it was expensive for them. They tried to avoid any danger [that could cause injury] and stayed at home. Fortunately, nothing happened but [the three-month wait period] was stressful. (Interviewee 5)

Some of those who were uninsured faced financial problems in accessing emergency care. Two interviewees recounted the experiences of other new immigrants who had medical conditions for which they sought medical care and had no choice but to pay for the care they received.

I had a friend who was pregnant. During her first three months in Canada, she applied for the MSP. But when she was waiting for the MSP, she had a baby. She spent $6000 only for the baby [the hospital delivery]. I think this is not proper. (Interviewee 2)

Luckily, I did not need to go to the ED during my first three months in Kelowna, but I had a friend who was new in Canada and she was not insured that time, she actually fell down and broke her hand. We took her to the hospital and she was in pain. . . . She was not insured that time and she had to pay $1200 upfront in the ED. (Interviewee 6)

Financial challenges were found to be a major barrier for new immigrants to accessing necessary care during their first three months in British Columbia. This contradicts the main objective of the CHA, which is to facilitate providing reasonable access to health care services without obstacles, financial obstacles in particular (Health Canada, 2010).
6.6.2 Lack of Knowledge about Emergency Care Services

In addition to their unfamiliarity with the provincial insurance policy (56% of the participants were unaware of the provincial insurance policy, including the three-month period), data from the interviews demonstrated that newly landed immigrants were lacking information about how to deal with emergency situations and how to access emergency health care. When conversing about their experiences during their first three months in Canada, several participants disclosed that they were unfamiliar with the emergency care system in Canada. One young new immigrant who needed emergency care in his first month in Kelowna stated, “In my situation, I did not have any information about the emergency services, where to go, what to do, how to handle emergency situations, what kind of facilities will be provided and I should expect” (Interviewee 6).

The knowledge deficit about provincial insurance could be due to the differences among Canadian provinces. For example, British Columbia imposes the three-month wait period, while Alberta does not. Some new immigrants participating in this study were under the impression that they would be enrolled in the provincial insurance coverage immediately after arrival in Canada, regardless of where they would land.

Another factor that could possibly explain the knowledge deficiency is the lack of clear information provided to immigrants by governmental sources. While a lot of information is available from governmental sources, it is scattered across different websites such as that of the CIC and the Ministry of Health. Some of this information was unclear. For example, the CIC website states,

All provinces and territories will provide free emergency medical services, even if you do not have a governmental health card. Restrictions may apply depending on your immigration status. If you have an emergency, go to the nearest hospital. If you
go to a walk-in clinic in a province or territory where you are not a resident, you may be charged a fee. (CIC, 2015b, para.1)

This information, which was published on a main branch of the federal government’s website and meant to be for new immigrants, may leave newcomers with an impression that the emergency care in Canada is always free. Many of the new immigrants in British Columbia, however, used medical emergency services during their first three months in Canada and were charged fees for the medical emergency services (examples will be provided later in this chapter).

6.6.3 Delay in Receiving Specialty Health Hare

The three-month wait for the provincial insurance plan creates significant delays in receiving health care. Even if the new immigrant has private insurance, it does not cover specialty care. An interviewee whose family was privately insured during their first three months in Kelowna stated,

One of my kids had to have a referral to eye specialist. But we could not go because this specialty was not covered by the private insurance, so we had to wait until the three months are over. Then we had to wait for four months to get an appointment, so altogether it took us seven months to see a specialist because of the insurance policy—the three-month wait and the referral policy. (Interviewee 7)

The same participant gave another example of when his wife needed specialty care but was not able to access it. The participant declared,

My wife wanted to see a doctor [specialist] but we had to wait until the three months finished to be able to see a specialist. Because private insurance doesn’t cover for specialists . . . Her case wasn’t very serious but it was something we still need to see a doctor for. (Interviewee 7)

Delays in receiving specialty care could reflect a larger systemic problem that may have a
negative impact on new immigrants’ health, such as the deterioration of the condition for which specialty care is needed.

6.6.4 Avoiding Required Medical Care

The follow-up interview participants were asked if they or their family members needed emergency medical care services during their first three months in Canada but did not use it. The responses were in line with the survey data. Interviewees described some of the cases in which emergency health care services were required, but were not used mainly due to the financial barriers associated with the three-month uninsured period.

I was having problems and pain . . . because I have a lack of iron [iron deficiency anemia], but I didn’t go to the hospital or to a doctor because I knew I would have to pay . . . so I used traditional medicine . . . used my own remedy at home. (Interviewee 4)

I have a friend who was a new immigrant, she got a severe burn on her leg. It was so bad. She could not even walk because of the burn . . . [the burn] was with hot tea . . . She didn’t go to the hospital because she didn’t have health coverage at that time . . . she was lucky because her parents are both physicians. They were here [in Kelowna] and they bought cream and medicine . . . and they took care of her for two weeks. (Interviewee 4)

Another interviewee who had a non-urgent medical problem during her first three months in Kelowna stated “I hesitated to go [to the ED] because I have to pay . . . it costs you $1500 or $2000 to get treatment in ER. It is really expensive” (Interviewee 2).

6.6.5 Unacceptability of International Insurance

A few participants had bought international health insurance plan before coming to
Canada, however, international insurance plans are not accepted in Canada. Two interviewees raised this issue. One of them declared,

International health insurance doesn’t cover us here in Canada because of political and economic definitions. . . . If there could be a way to iron this out, to let international health coverage be applicable here [in British Columbia/Canada], it would solve the problem. (Interviewee 3)

New immigrants may use the health service if they pay. While it is not clear whether they can ask for reimbursement from the international insurance companies, the fact that international insurance is not being accepted may result in financial and mental burdens that could lead to the avoidance of seeking care and worsening of the medical condition.

6.6.6 Impact of the Three Uninsured Months on New Immigrants’ Perceptions of Canada

Two interviewees commented on how the uninsured period affected immigrants’ feelings and perceptions of Canada. One participant stated,

The three-month policy should be changed . . . no, I mean should be cancelled for helping new people. I have a friend with two kids in Alberta, and two weeks after she landed in Alberta, she had to go to the emergency for her little son. When she asked the ER staff, they told her that she is covered [by the provincial insurance plan] since the first day she arrived in Alberta. She felt welcomed . . . I think it is a wonderful feeling when you know that you are [medically] covered the first day you land, feeling like the [country] is caring for you and your family. I did not have such a feeling in BC. (Interviewee 4)

For this participant, a feeling of welcome would have been experienced if she had been eligible for the provincial insurance plan from the first day she landed in British Columbia.

Another interviewee (Interviewee 3) affirmed that the three-month wait for provincial health
insurance, and the accessibility barriers associated with these three months, changed his perception about the image and reputation of Canada. These results are consistent with those of Asanin and Wilson (2008) who found that for new immigrants, the three-month wait period was associated with difficulties accessing health services and, therefore, had a negative impact on new immigrants’ feelings and perceptions of Canada.

6.7 Summary

This chapter sought to provide an answer to the second research question: How prepared are new immigrants to obtain any needed emergency health care during the first three uninsured months after arrival in British Columbia?

The survey data revealed that almost half of the new immigrants participated in this study were not well prepared to obtain emergency health care in case it would have been required during their first three months in Canada. They neither gathered information about the provincial insurance policy before arrival in Canada nor bought private health insurance to cover for their first three-uninsured months. The main reasons they did not purchase private insurance were unawareness of and unfamiliarity with provincial insurance regulation that imposes the three-month wait and that the private insurance was too expensive.

Qualitative data from interviews confirmed the survey results. These interviews showed that the three-month wait policy itself is a system-related barrier that hinders new arrivals’ access to health care. On their arrival to British Columbia, many immigrants were unaware of the provincial insurance regulations including the three months wait. This unawareness left many new immigrants without private insurance during this period. Many of those had medical conditions that required health care, but faced serious financial barriers to access health care during this period.

The main challenges new immigrants reported related to their first three months in Canada, when they were medically uninsured, include lack of knowledge about the
emergency health care system, unfamiliarity with the three-month wait policy, financial
difficulties, and the non-acceptability of international insurance. These challenges had two
significant consequences. The first was avoidance of seeking required health care. The
second was delays in receiving emergency and specialty care. Interview data also revealed
that the three months wait policy had negative repercussions on new immigrants’ feelings and
on the image of Canada.
Chapter 7 Coping Strategies and Recommendations

7.1 Overview

This chapter explores the coping strategies new immigrants used to deal with the barriers and difficulties they encountered when accessing emergency health services and their suggestions for change. Data related to the coping strategies and recommendations from both the survey and the interviews were analyzed and, thereby, answered the third and fourth research questions: What coping strategies do new immigrants use to overcome the accessibility barriers to emergency health care services in Kelowna? And what recommendations can be made to improve new immigrants’ access to emergency health care services in Kelowna?

7.2 Coping Strategies

The difficulties of accessing health care have the potential to cause new immigrants dissatisfaction, frustration, and stress; they also have the potential to leave new immigrants with unmet health needs, or put their health at risk. When exposed to difficulties and challenges, people usually resort to coping mechanisms to alleviate these difficulties. Coping strategies new immigrants use to deal with or overcome emergency care accessibility barriers were assessed under three main categories: immigrants’ immediate reactions to the barrier faced in the ED, help and support-seeking strategies, and specific self-created strategies (personal initiatives or personal endeavors).

7.2.1 Immediate Action/ Reaction/Response

To explore how new immigrants deal with the difficulties they encountered in the ED, such as the long wait, lack of knowledge, and poor or inadequate quality of service, participants were asked what actions they took to overcome these difficulties. Of the 37 participants who faced one or more difficulties, more than half (23 or 62.2 %) did not
immediately react to the difficulties encountered. In other words, they were suffering in silence or they used silence or non-action as a response to these difficulties. One-third (13 or 35.2%) of these 37 participants relied mainly on obtaining some immediate help such as interpretation and transportation from relatives and friends (see Table 21).

Table 21: Immediate Actions Taken to Deal with the Difficulties Faced in the ED

<table>
<thead>
<tr>
<th>Action</th>
<th>N=37</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No action was taken</td>
<td>23</td>
<td>62.2</td>
</tr>
<tr>
<td>Sought support from a relative or a friend</td>
<td>13</td>
<td>35.1</td>
</tr>
<tr>
<td>Sought support from an employer/coworker</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Complained to a concerned authority</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Source: New Immigrants’ Questionnaire Survey, 2015)

Five interview participants did not take action (remained silent) in response to their dissatisfactions with their ED experiences. The interview data not only ratified the survey results but also added more findings on why dissatisfied new immigrants did not act. Data from interviews indicated that the main reasons why new immigrants did not take immediate actions to deal with the difficulties experienced in ED were: incapable of advocating for their rights to emergency health care, perceived that nothing would be changed or improve, and fear that negative consequences could result if they raised their concerns.

Reports of not being able to advocate for their rights was evident in three of the interview participants. A participant who had waited in the ED from 8 pm to 5 am wanted to know more about when she would receive medical attention, wanted something to eat and a blanket, was asked whether she requested anything from the ED staff. She answered, “No, I did not, I was shy, and I felt that I should not take ER peoples’ time” (Interviewee 5). Another interviewee did not take any action because he believed that most patients were suffering, not only him. When asked if he tried to take action to deal with the long wait time, he stated,

I did not try . . . I was waiting, a lot of other people were waiting [too]. There was an
old lady waiting before us and she was crying of pain, she had severe renal colic . . . it was very strange that she had been waiting for 5 hours. (Interviewee 8).

Interviewees were reticent about expressing any complaint under the circumstance, as another interviewee, who reported disrespectful nurse behaviour, pointed out:

No . . . I know a lot of people face problems [in the ED] . . . you don’t want to argue with them [care providers], especially when you are in a ‘vulnerable’ situation. They are an authority and you do not want to make problems (Interviewee 2).

Another participant who expressed frustration because of a long wait time in the ED and perceived poor quality of care from health care providers noted that,

The reason why I did not do anything to deal with these difficulties is that people told me that is what you get when you go there [to the ED]. I was upset with their reaction, [but] even if you complain, nothing will change. You just have to deal with it [accept it].

(Interviewee 1).

It is evident from the aforementioned quotes that new immigrants suffered in silence or used non-action as a coping technique similar to learned helplessness, feeling unable to advocate for their rights to medical care, nothing would be accomplished by complaining, and fearful that negative consequences could result if they raised their concerns.

As mentioned previously, the issue of poor quality of emergency care services was raised by many of the participants (45% of the survey participants rated their experience with the ED services as worse than expected) (see Figure 8). The reported poor quality of services was on several levels, including long wait times, unavailability of information or personnel who could provide information, perceived careless behavior from HCPs, and inadequacy of quality of care in terms of clinical safety.
Interior Health, the regional health authority that oversees the management of health care in Kelowna, has a policy aimed at resolving any patient’s complaint regarding the quality of care and improving health care services in Kelowna and other Interior Health authority regions. According to Interior Health, patients who face problems with the care they received are encouraged to speak with their care provider or with a supervisor or manager and try to resolve the problem at the time and place where the care was received. If the complaint is not resolved, patients are encouraged to submit their concern to Interior Health’s Patient Care Quality Office (PCQO). PCQO will work with the patient to identify a reasonable resolution to the problem, and will provide the patient with a result of the complaint and explanation of any action that would be taken (Interior Health, 2015b). Similar processes are handled by the College of Registered Nurses of British Columbia (CRNBC) (CRNBC, 2015) and College of Physicians and Surgeon of British Columbia (CPSBC) (CPSBC, 2015).

When the survey participants were asked to indicate whether they were aware of each of these remedies, the majority (71%) were not aware that they could submit a complaint to PCQO, 34 (85%) were not aware that they could submit a concern about the care received by the emergency physician to the CPSBC, and 36 participants (90%) were not aware that they could submit a complaint or concern about the care received by the emergency nurse to the CRNBC.

The fact that new immigrants did not raise their concerns or make a formal complaint about the quality of care received in the ED, including the quality of care received from the health care providers could be explained by the finding of this study that new immigrants do not have a comprehensive knowledge of the Canadian health system and were not familiar the complaints policy that is in place. They simply accepted the unsatisfactory situations in
the ED. However, new immigrants tend to call for a family member or a friend to help in alleviating issues that are not system-related such as language barriers and transportation.

### 7.2.2 Help-Seeking Strategies

Some new immigrants approach individuals or groups to obtain assistance with the problems they encounter in accessing health services. Participants were asked to indicate whether they needed and requested any kind of help or support to alleviate the problems they experienced in accessing emergency health services, and, if they did, to specify from whom they received help. The responses indicated that 12 (30%) did not need help either because they did not face any problem or because they felt the problem was not big enough to ask for help. Around three-quarters (28) of the participants indicated that they needed and requested help to deal with the problem experienced. Of the 28 participants who requested help, the majority (25 or 89.3%) used family and friends as the main source of help. Less frequently, they relied on different cultural, religious, and community organizations for help and support. Table 22 illustrates the main source of help new immigrants used to deal with the difficulties in accessing emergency care services in Kelowna.

With regard to the type of help received from the above-mentioned individuals, groups, or organizations, information was selected the most often, by 25 out of 28 (89.3%) participants. This is consistent with the fact that they lacked information about emergency health services. As well, this indicates that new immigrants become extremely resourceful in terms of gaining information. Language or interpretation assistance, as well as advice and counselling, were the second most frequent types of assistance needed and received. Table 23 demonstrates the type of help received by new immigrants with the problems they faced in accessing emergency care services.
Table 22: Main Sources of Help Used to Deal with Emergency Care Access Barriers

<table>
<thead>
<tr>
<th>Source</th>
<th>N= 28</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative or friend</td>
<td>25</td>
<td>89.3%</td>
</tr>
<tr>
<td>Ethnic cultural group</td>
<td>5</td>
<td>17.9%</td>
</tr>
<tr>
<td>Religious group</td>
<td>5</td>
<td>17.9%</td>
</tr>
<tr>
<td>Community organization</td>
<td>4</td>
<td>14.2%</td>
</tr>
<tr>
<td>Employer/Coworker</td>
<td>4</td>
<td>14.2%</td>
</tr>
<tr>
<td>College/University</td>
<td>3</td>
<td>10.7%</td>
</tr>
<tr>
<td>Health worker</td>
<td>3</td>
<td>10.7%</td>
</tr>
<tr>
<td>Immigrants serving agency</td>
<td>2</td>
<td>7.1%</td>
</tr>
<tr>
<td>Government</td>
<td>2</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

*Note.* The percent of cases exceeded 100% because the respondents were able to select more than one barrier (a multiple response question) (Source: New Immigrants’ Questionnaire Survey, 2015).

Table 23: Type of Help Received to Deal with Emergency Care Access Barriers

<table>
<thead>
<tr>
<th>Type of Help</th>
<th>N=28</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>25</td>
<td>89.3%</td>
</tr>
<tr>
<td>Language/Interpretation</td>
<td>15</td>
<td>53.6%</td>
</tr>
<tr>
<td>Advice/Counselling</td>
<td>15</td>
<td>53.6%</td>
</tr>
<tr>
<td>Transportation</td>
<td>12</td>
<td>42.9%</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>10</td>
<td>35.7%</td>
</tr>
<tr>
<td>Child Care</td>
<td>7</td>
<td>25.0%</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>2</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td><strong>307.1%</strong></td>
</tr>
</tbody>
</table>

*Note.* The percent of cases exceeded 100% because the respondents were able to select more than one source (Source: New Immigrants’ Questionnaire Survey, 2015).

Interestingly, data from both the survey and the interviews revealed that no request for help was made with regard to the long wait time in the emergency department or the quality of care issue. This is possibly because the long wait time and quality of care issues are system-related problems, and the social support or help seeking strategy will probably not help resolve or alleviate such a problem. However, from the type of help requested by new immigrants, a conclusion can be drawn that new immigrants seek assistance when the problem they face is not system-related, such as needing information, child care, and transportation.
7.2.3 Personal Endeavor Coping Strategies

Other participants used their own mechanisms to deal with the barriers and difficulties they faced in accessing emergency services. When asked about how he dealt with the barrier he faced in the ED, a participant who was very dissatisfied with the quality of ED physician care stated, “I used spiritual and religious practices, I was writing poetry and praying to relieve the stress” (Interviewee 3).

Another common coping strategy identified among those who were not insured during their first three months in Canada, was using an alternative to emergency medical care. Four stories of using alternative medicine were noted during the interviews. One participant who needed emergency care but did not use it due to lack of insurance during her first three months in Canada used her own traditional medicine as an alternative to the emergency medical care:

One day, I was having problems and pain because . . . I have a lack of iron [iron deficiency anemia], but I didn’t go to the hospital or to a doctor because I knew I would have to pay . . . so, I used a traditional medicine . . . used my own remedy at home.

(Interviewee 4)

While this strategy may be helpful, in serious emergency situations this strategy may not always be beneficial. It may lead to deterioration of the medical condition resulting in serious complications, and therefore, putting the patient’s life at risk.

To sum up, data from the survey and interviews revealed three coping strategies new immigrants use to deal with the accessibility barriers. In terms of immediate reactions to the difficulties they faced in the ED, they were found to be non-complainers and used silence/no action. This strategy was found to be common in dealing with the system-related barriers that are out of participants’ control such as long waits and inadequacy of care. With regard to
more general and long-term difficulties, new immigrants were found to be support-seekers and used help-seeking strategies. This strategy was found to be common in dealing with barriers that are not system-related such as language and transportation. Personal endeavors (self-created actions taken at the individual level) were another coping mechanism used by a few participants, usually by uninsured immigrants during their first three months in Kelowna. Examples of this strategy include delaying use of health services and using alternative medicine.

7.3 Recommendations

The previous two chapters illustrated the multiple barriers and difficulties new immigrants face with accessing emergency health care in Kelowna. Long wait times to receive care, language barriers, poor quality of care, unprofessionalism from health care providers, and lack of knowledge about the emergency care system are the most common barriers newcomers face with accessing emergency health care. Furthermore, the three-month wait period required before being covered by the provincial health plan was found to be a major accessibility barrier immigrants faced after arriving in British Columbia. As a result, some changes are required to improve overall accessibility to emergency health care for newcomers to British Columbia. The research participants made various proposals that could help prevent, or, at least, mitigate accessibility barriers for new immigrants in the future. The participants’ recommendations and suggestions were taken into consideration when addressing the fourth research question of this study: What recommendations can be made to improve new immigrants’ access to emergency health care services in Kelowna? Cooperation from decision makers in the field of migration and health care are necessary to address these recommendations.

Based on their experiences and the barriers they faced in accessing emergency health care, the 40 survey participants were requested to write their recommendations for improving
new immigrants’ access to emergency health services. As well, all of the interview participants were asked what they would suggest in order to improve emergency health care for new immigrants to Kelowna in the future. Several areas for improvement were identified in subthemes according to the participants’ responses. Listed below are the areas that need improvement, along with the suggestions and recommendations made by participants for each area.

7.3.1 Long Wait Time

Long wait time to receive care in ED is a huge problem that was reported by the majority of the new immigrants. A total of 24 (60%) survey participants and six out of eight interview participants recommended that the wait times to see a physician in the ED should be shortened. Some of those participants believed that decision makers should identify the leading causes of long wait times and try to find a solution for these causes. A recent immigrant who came from India stated,

We don’t wait for seven to eight hours in India, emergency [health care] in India is faster. They [the policy makers] have to find the problem and solve it. We hate going to the emergency [the ED] because of the waiting time. (Survey Respondent 32)

Moreover, the failure to provide ED patients with an estimated timeframe for which they would be seen by a physician was a concern raised by multiple participants. This failure leaves patients frustrated and confused, and feeling powerless. Many of the survey participants suggested that care providers should offer an estimated time frame during which ED patients would be seen by the ED physician.

7.3.2 Communication and Language Barriers

It is important for the care provider and new immigrants to understand each other when discussing health-related issues. The issue of language barrier was reported by 40% of the survey participants. One-quarter of the survey participants, and three out of eight
interview participants, suggested incorporating interpretation services in the ED. While the majority gave a general short statement suggesting having an interpretation service in the ED, some others gave a longer and more specific statement offering a possible solution. Interviewee 4, for instance, gave a general short statement stating, “For new immigrants, I think it is going to be helpful if they can get interpretation service in ER.” Another interviewee was more specific and stated, “For those who do not speak English, it would be good if they can have a translation service, maybe not on-site, if that is not applicable, but by phone or telecommunication” (Interviewee 8).

Other participants believed that having care providers who speak more than one language could help improve the communication. A survey participant who speaks Arabic and French fluently but has limited English skills stated, “Screening staff (triage nurses) should include bilingual [English and French] nurses” (Survey Respondent 2). Another participant noted, “Having multicultural nurses will be great. They will have some kind of cultural backgrounds and language skills that will help new immigrants” (Interviewee 1).

Interpretation services, either on-site or by telecommunication, as well as augmenting care providers’ language skills, would improve the communication between new immigrants and care providers in the ED, therefore, alleviate the language barrier.

7.3.3 Quality of Emergency Health Care

The study findings revealed that there were multifaceted problems related to the quality of emergency health care provided for new immigrants in the city of Kelowna. Below are some of these problems and participants’ recommendations for improvement.

7.3.3.1 Resources and Staffing

There was a common perception among many of the study participants that the ED in Kelowna was short of staff and resources. Many participants suggested providing back-up for care providers and increasing the ED resources. One survey participant stated, “I thank all of
the caring medical people for their help and sympathy, but I think they need more resources and staff… to be able to give faster and good care, and less waiting time” (Survey Respondent 9).

This statement was echoed by another interviewee who said: “I think they [administrator/ decision makers] should increase the budget for the ER, I mean increase staffing . . . nurses, doctors, and beds . . . this would reduce the wait time” (Interviewee 5).

One study participant was an emergency physician. When asked about his recommendations, he suggested appointing/ creating subspecialties within the ED that could provide care for special emergency patient groups, mainly children and pregnant women. According to this participant, having subspecialties in the ED would shorten the waiting time and prevent the risk of distribution of infection in the ED waiting area:

[S]ubspecialties within the ED would be [helpful], I think it is a must. We should start by having pediatric ER and then obstetric ER. Both [children and pregnant women] are high-risk populations and they can get infection while they are waiting in the ED wait area. This [having subspecialties in ED] would also shorten the wait time . . . the wait time is a huge problem. (Interviewee 8)

Consideration for increasing the available resources and the number of staff may be helpful in reducing the overall wait time, and improve the quality of care provided in the ED. This outcome would be beneficial for all emergency patients including immigrants and nonimmigrants.

7.3.3.2 Health Care Providers

The health care providers’ approach was a barrier to receiving a quality health care in the ED. Many of the survey participants stressed the importance of the care providers’ bedside manners and made suggestions for improvement. The main suggestion was to provide care providers with training and education related to professionalism including better
communication and respect. One participant wanted authorities to “teach and tell the doctors to spend more time with us and listen to us and respect us. Of course not all of them, but those who are disrespectful . . . Some of them were very respectful and helpful” (Survey Respondent 19). In the follow-up interviews, several participants (five out of eight) voiced their dissatisfaction with the health care providers’ approach. The main recommendation made in this regard focused on training for care providers to improve their professional behaviour and communication skills: “Doctors and nurses need to be careful and respectful when they talk with patients. I think there should be some psychological and ethical training” (Interviewee 5).

7.3.3.3 Culturally Congruent Care

Receiving culturally incongruent care in the ED was another difficulty experienced by some participants (see Table 14). Some of the participants’ responses implied that they believed that the majority of the care providers at the ED in Kelowna had white ancestry. Several participants recommended integrating/incorporating doctors and nurses from other racial and cultural backgrounds to the ED care team. An interviewee mentioned, “Multicultural nurses will be great. They will have some kind of cultural backgrounds and language skills that will help new immigrants” (Interviewee 1). Another interviewee stressed the same point:

[Having] care providers from different cultures will be good, they will have some kind of cultural background and language skills that will help . . . if doctors and nurses themselves are coming from different ethnic places . . . there will be no such barriers in communications, this could be done by having more diverse staff . . . hire doctors
and nurses from different places, that would accommodate different cultures.

(Interviewee 8)

Overall, the participants’ responses suggest that racial and cultural diversity of care providers would be useful in providing culturally appropriate care and may also be helpful to alleviate the language barriers.

7.3.3.4 Lacking Information in the ED Clinical Areas

Ordinary people, especially newcomers, are usually not familiar with the ED routines, policies, and procedures. Nor are they familiar with medical terms, medications, diseases, and complications. They tend to ask for information only when needed. Unavailability of information when needed in the ED was a commonly noted problem: information about the anticipated wait time, information about medication, information about clinical care and information related to health education. One of the participants’ recommendations in this regard was simply to provide information in the ED when needed. One of the survey participants claimed that he was given a medication in the ED without being provided with any explanation related to this medication. Under the recommendation section in the survey, this participant wrote, “There should be enough explanation before giving any medication” (Survey Respondent 12). Another survey participant stated, “The nurse should be more patient and should give information to the patient and the patient’s family [when required]. Also, maybe stop by every now and then when the patient is waiting to see if they need something” (Survey Respondent 37).

7.3.3.5 Feedback from Emergency Patients

Receiving feedback from emergency patients about their experience with the ED services may be useful in terms of improving the quality of care. This was a suggestion made by one interviewee:
If [the emergency care team/leaders/manages] can have questionnaires or evaluation forms that patients can fill in about their experience in ED and how satisfied they are. . . and where patients can write their complaint, then they can look at the questionnaire and make their service better. (Interviewee 2)

Despite the fact that this recommendation was made by only one participant, it was significant enough to be taken into account. A client feedback questionnaire is an efficient way to find how satisfied ED clients are, to identify the major problems with the ED service, and to find methods to improve the ED service.

7.3.4 Three-Month Wait for Provincial Insurance

The three-month wait for receiving the provincial insurance plan creates barriers for new immigrants' ability to access, not only emergency care but also routine and specialty care. The main challenges new immigrants reported related to their first three months in Canada, when they were medically uninsured, were: lack of knowledge about the emergency health care system, unfamiliarity with the three-month wait policy, financial difficulties, and delay in receiving emergency or specialty care when needed. The respondents suggested three main recommendations for improving new immigrants’ access to emergency care during the three-month uninsured period: cancellation of the three-month-wait, educating new immigrants about the emergency care system, and consideration for alternative insurance plans.

The study participants perceived the three-month wait policy as unfair, either because it discriminates against them compared to immigrants in other provinces, or because it creates a financial burden. Around 50% of the participants recommended cancellation of the three-month wait policy. Many others recommended shortening the three-month wait period. Some quotes that illustrated this finding include: “It is not fair to wait for three months in BC."
Immigrants in other province do not wait” (Survey Respondent 32). “It [three-month wait policy] is not fair . . . The first three months in the country [Canada], you have to be extra careful . . . you are going to suffer from financial problems…” (Interviewee 3).

Most people come here as federal [federally-sponsored] skilled workers. . . . It takes time for them to find a job, it goes up to two years to find a job. I think they should make some discount [the price of insurance and the MSP monthly fees] for them. (Interviewee 4)

I am not sure how the three-month wait problem can be solved, I am not sure whether this applies in BC only or it is all over Canada. If you can be covered from day one by MSP, it would be great for you as a newcomer. (Interviewee 7)

With regards to the knowledge deficit and unfamiliarity with the emergency care policies, a common perception raised by several participants was that new immigrants should be educated and informed about the Canadian health care system before arriving in Canada, or at the point of entry into Canada. Around a quarter of the survey respondents recommended educating new immigrants about the emergency health care system in Canada, including the three-month wait policy. Respondent 40, for example, stated, “Immigrants are not aware of all the information; if there is any way the emergency health information can be provided for new immigrants [that] would be highly recommended” (Survey respondent 40). Participants’ suggestions included providing new immigrants with clear information regarding the three-month wait and the importance of purchasing a private insurance plan to cover any emergency care costs if needed during that period.

New immigrants should be told about the emergency care policy at the point [time] they arrive. They have to be told that they have to buy an insurance to cover the period until they get the MSP, and they have to be told how much it will cost, and
what will be covered and what will not be covered, they need to be told everything.

(Interviewee 6)

In addition to the information related to the three-month wait, the same participant suggested providing new arrivals with information about the emergency care system and how to deal with any medical emergency:

I would say for the newcomers when they get information about how to settle in Canada and how to get a job they should have . . . I mean CIC office should provide information about how to deal with emergency situations. Because when you come, you do not have any idea about emergency issues, like where to go and what is the system and if you do not have insurance what the consequences will be. . . . These sorts of information should be provided, I think, on arrival, at the airport, maybe.

(Interviewee 6)

Another suggestion made by some respondents was allowing for or accepting alternative insurance plans, such as international insurance to cover the cost of any medical emergency care during the first three uninsured months after arriving in Canada:

International health insurance doesn’t cover here in Canada because of political and economic definitions, if there could be a way to iron this [out], to let international health coverage be applicable here, it would solve the problem. My recommendation again . . . to get rid of the three-month waiting and to create a system in place to allow different international health coverage to cover new immigrants in Canada.

(Interviewee 3)

While the private insurance is limited to emergency care, one interviewee suggested considering third party insurance: “because private insurance doesn’t cover non-emergency care, and dental care . . . maybe making third party insurance will help” (Interviewee 4).
In summary, the participants’ main recommendations specifically for three uninsured months were: abolition of the three-months wait period, thereby alleviating the financial burden; providing very new immigrants with the necessary information related to the three-month policy and the emergency care system in British Columbia, thereby overcoming the knowledge de-efficiency; and considering alternative international insurance.

7.4 Summary

The purpose of this chapter was to explore the coping strategies new immigrants use to deal with the barriers they encountered when accessing emergency health services and their suggestions for change.

Data from the survey and interviews revealed three responses new immigrants use to cope with or deal with the emergency care accessibility barriers, these include: silence or non-action, help-seeking, and personal endeavors. In terms of immediate reactions to the barriers faced in the ED, new immigrants used silence or non-action. This mechanism was commonly used with the system-related barriers such as long wait, inadequacy of care, and care providers’ negative approach. Help-seeking strategy was found to be commonly used by new immigrants to deal with problems that are not system-related, such as language barriers, transportation problems, and knowledge deficit. Personal endeavor coping strategy was another coping mechanism new immigrants used. This strategy was found to be commonly used by new immigrants who were medically uninsured during their first three months in Canada. Postponing health care and using alternative care to emergency medicine are examples of this personal endeavors.

The study participants were asked to provide their personal suggestions and recommendations for improving new immigrants’ access to emergency health care. Their comments and suggestions can be summarized into a number of key recommendations:
1) Reducing the wait time in the ED and providing the ED patients with an estimated wait time to be seen by a physician.

2) Incorporating interpretation services into the ED.

3) Improving the quality of care in the ED, which can be achieved by:
   a. increasing the available resources and the number of staff in the ED,
   b. enhancing effective communication and improving ED care providers’ professionalism by providing them with training and workshops,
   c. providing new immigrants with culturally congruent care by encouraging a multicultural environment at the ED and hiring care providers from multicultural backgrounds,
   d. providing new immigrant patients with the necessary explanation and information related to their health, or their care plan when needed in the ED clinical area, and
   e. continuously receiving feedback from emergency care receivers in order to identify any problems and find a method to resolve them.

4) Providing new immigrants with clear and accurate information about the emergency care system in British Columbia.

5) Providing new immigrants with clear and accurate information about the three months wait for the provincial insurance before they arrive in British Columbia, or at the point they arrive.

6) Cancelling the three-month wait policy or, at least, shortening the three-month wait period.

7) Reevaluating the possibility of accepting international insurance.

This was the summary of the recommendations made by the new immigrants based on their own experiences with the emergency health care services in the city of Kelowna. Taking
into account these recommendations, this study yields final recommendations to the immigration and health sectors at local, provincial, and Federal levels (see Chapter 8).
Chapter 8 Conclusion

8.1 Overview

British Columbia receives 35,000 newcomers yearly, representing 14 percent of the total number of immigrants to Canada (CIC, 2013a); a growing number of these newcomers move to Kelowna. During their early stage of settlement, they should face no barriers to access health care, especially in case of emergency. Accessing health care when needed is a fundamental human right that is guaranteed by the CHA. Barriers to accessing necessary health care may delay the new immigrants’ integration in the city. More importantly, accessibility barriers may put new immigrant patients’ safety at risk. Addressing barriers to accessing emergency health care and eliminating them are necessary to reduce inequality, promote equitability, faster integration, and prevent health complications. For these reasons, the barriers that hinder new immigrants from accessing emergency health care must be of direct concern to health care providers, health care policy makers, immigration and government officials, academic researchers, and community organizations members.

Little research has been conducted on new immigrants’ experiences with emergency health care services, particularly in small and mid-sized cities like Kelowna. The primary objective of this study was to examine the new immigrants’ experiences with emergency care services in Kelowna, a mid-sized city in the interior of British Columbia. This exploratory research used the responses of 40 new immigrants to a questionnaire survey in order to identify the major barriers to accessing emergency health care and the coping strategies used to alleviate these barriers. The study participants also provided recommendations for improving the new immigrants accessing to emergency health care in Kelowna in the future. In addition to the questionnaire responses, a sub-sample of eight participants was interviewed. The eight interviewees shared their stories and their real life experiences with
emergency care and discussed the accessibility barriers and difficulties they faced during their first three months in Canada when they were waiting for the provincial insurance. This chapter highlights the main findings of this study and yields policy recommendations for policy reevaluation and change.

8.2 Research Findings

The key findings of this study falls under four main spheres: new immigrants’ health and the use of emergency care service by new immigrants in Kelowna, barriers faced by new immigrants when accessing emergency health care, the three-month wait for the provincial insurance plan, and the coping strategies used by new immigrants to deal with the accessibility barriers.

With regards to new immigrants’ health and the use of emergency services, the study found that the study participants are overall healthy. The majority (87.5%) of the participants rated their health as good, very good, or excellent; and the prevalence of chronic illness among them was very low (77.5% reported having no previous history of disease). These two findings are consistent with what is known in the literature as the healthy immigrant effect (Ali, McDermott & Gravel, 2004; Newbold, 2006, Fuller-Thomson, Noack & George, 2010).

Some new immigrants faced difficulty finding a family physician in Kelowna to accept them as patients in their practice. Around a quarter of the study sample did not have a family doctor in Kelowna. However, there was no association between not having a family physician and the use of the ED. In other words, the majority of new immigrants did not use the ED in Kelowna as an alternative to a family physician. After evaluating the new immigrants presenting complaints at the ED, the researcher determined that approximately 75% of the total immigrants’ visits to the ED were for true urgent or emergency cases that required a timely response. This suggests that, overall, new immigrants in Kelowna use the ED appropriately, that is, they do not use the ED for minor medical conditions that could be
taken care of in a routine or non-urgent care center. This result does not diverge from Quan et al. (2008) who revealed that patients from visible minorities and racial groups were more likely to contact general practitioners than white patients, and the use of hospital care services by the visible minorities is significantly less than white patients.

With regards to the major barriers to accessing emergency care, the quantitative data showed that the majority (92.5%) of participants in this study experienced barriers when accessing emergency care services in the city of Kelowna. After analyzing and merging quantitative data from the questionnaires with qualitative data from the follow-up interviews, the results revealed the main difficulties/barriers to access emergency care included: long wait times in the ED, poor quality and inadequacy of emergency care services, language barriers, and information problems including knowledge deficiency. Other issues experienced less frequently included culturally insensitive care and perceived discrimination, geographical barriers, and financial barriers.

Long wait times in the ED was the most common difficulty experienced by new immigrants. In most of the cases, the long wait was made more trying because no information about the estimated wait time was provided. Leaving ED patients waiting without providing any information about the estimated time to be seen has a negative impact on the patients, causing feelings of frustration and helplessness. This problem is experienced by both immigrants and nonimmigrants, however, several participants viewed the long wait as unacceptable and intolerable. Many believed that long waits in EDs have become routine, normalized, and accepted by Canadians, but it should not be so.

Additionally, the study results indicate that there is no problem with the availability of emergency health care services in Kelowna, as perceived by 85% of the new immigrants. However, one of the significant difficulties new immigrants experienced with the emergency care services was related to the quality of care provided in the ED. Almost half (45%) of the
participants reported their overall experiences with the ED services as worse than expected. The reasons for this poor rating included the unavailability of information in the ED or unavailability of personnel who could provide information when needed, perceived uncaring behaviour from HCPs, ignorance of some aspects of care, delay in receiving care, and clinical care safety concerns. In most cases, there was a combination of two or more quality of care issues experienced.

A key finding of this study was the new immigrants’ perception and experience with the health care providers, ED physicians and ED nurses in particular. While most participants perceived the ED physician care as good, very good, or excellent, a quarter of the participants rated the ED physician care as fair or poor. The new immigrants’ main concern was the ED physician’s approach and bedside manner; several participants perceived the ED physician’s manner as detached, inhuman, and rushed. This finding is very similar to that of Asanin and Wilson (2008) with new immigrants in the city of Mississauga.

The quality of care provided by the ED nurses was rated even lower than the quality of care provided by the ED doctor. More than one-third (37.5%) of the new immigrants participating in this study reported fair or poor ED nursing care, mostly due to a perceived lack of professional behaviour among some nurses in the ED. Several participants described the emergency nursing staff as disrespectful, unhelpful, uncooperative, degrading, and arrogant. This finding is in line with that of Edge and Newbold (2013) who showed that disrespectful behaviour from health care providers (doctors and nurses) was a common problem experienced by immigrant women when using health services.

This study demonstrated that language insufficiency is a common barrier to accessing emergency care. Language barriers were reported by 40% of the study participants (see Table 14). In some cases, language barriers were due to difficulties understanding medical terms, and absence of professional interpretation service in the ED. Many previously conducted
studies (Wu, Penning, & Schimmele, 2005; Sanmartin & Ross, 2006; Zanchetta & Poureslami, 2006; Asanin & Wilson, 2008; Newbold, 2009a; Long, 2010; Dastjerdi, 2012) have indicated language difficulty is a common barrier faced by immigrants in a variety of health care settings. However, these studies did not provide much information about the magnitude of the language problem and did not provide information about which immigrant subgroups are actually facing language difficulties. The current study found that there is a statistically significant association between the new immigrants’ educational level and reporting language barriers in the ED. New immigrants who have a university degree or above were less likely to report experiencing language barriers in the ED than those with diplomas and secondary education.

Lack of knowledge and relevant information about emergency care system poses a major barrier to accessing emergency care. Information-related problems were reported by 25% of the survey respondents. Data from interviews, however, indicated that information problems were of higher magnitude than originally found in the survey. Information problems included: newcomers’ unfamiliarity with the emergency health care system in Canada, lack of knowledge about where to go and what to do in case of emergency; newcomers’ lack of information about ambulance services and costs; and the unavailability of information in the ED when required. This finding is consistent with Cortinois et al. (2012) who reported that new arrivals lack information or the source of information. The result is also consistent with that of Samaritan and Ross (2006) who indicated that recent immigrants do not know where to go when urgent medical care is needed.

Other barriers experienced by new immigrants in Kelowna, but with less frequency were: sociocultural barriers, financial difficulties, and geographical barriers. Receiving culturally incongruent care in the ED was reported by only six (15%) participants, and perceived discrimination in the ED was relatively of low frequency, it was reported by only
With regards to financial barriers, around 12% of the participants reported they had experienced financial barriers, such as paying for uninsured services (e.g. dental care, and prescribed medication). The geographical barriers were represented by the distance between their residence and the hospital in Kelowna and transportation problems. Overall, geographical barriers in accessing emergency health care in Kelowna do not seem to be of a high magnitude compared to bigger cities, possibly because Kelowna is a medium-sized city with a relatively small population.

Regarding ambulance services, the study found that the majority of new immigrants in Kelowna (70%) did not need to use the ambulance service. Of those who needed ambulance services, a small proportion experienced obstacles to accessing them; two participants had avoided requesting an ambulance when needed, mainly due to unfamiliarity with and misunderstandings about the ambulance service and the cost.

In addition to the above-mentioned emergency care accessibility barriers, a key finding of this study was related to the three-month wait policy. Similar to Ontario and Quebec, the Province of British Columbia imposes a three-month wait for newcomers to be enrolled in the provincial insurance plan. This was found to be a serious obstacle that hinders newly arrived immigrants from accessing necessary health care during their first three months in British Columbia. The research demonstrated that some new immigrants in Kelowna actually faced barriers to accessing health care during their first three months after landing. The main challenges new immigrants reported that were specific to their first three uninsured months included: lack of knowledge about the emergency health care system, unfamiliarity with the three-month wait policy, financial difficulties, and delay in receiving emergency or specialty care when needed.

Another key finding of this research is that half of the participants had not been prepared to deal with their medical emergencies and obtain emergency health care during
their first three months after landing. This conclusion was based on two indicators. Firstly, 45% of the participants did not know about the provincial insurance policy before arriving in Canada. Secondly, half of the participants were medically uninsured. They never bought private insurance to cover the cost of medical care during their first three months while waiting for provincial insurance. Regarding the main reasons why those 20 participants did not purchase private insurance, eight claimed they did not know that they had to have private insurance, six (30%) said private insurance was too expensive, and three (15%) participants choose not to enroll in private health insurance plan at their own risk.

During the time when half of the study participants were uninsured, some had medical conditions that required health care, but delayed seeking treatment because of the high cost. In a few critical situations when treatment could not be delayed, new immigrants used the ED service and had to pay a large amount of money ($1500 to $2000) which was a financial burden. On the one hand, delaying needed treatment put new immigrants’ health at risk. On the other hand, seeking treatment and paying $1500 to $2000 for a single visit to the ED was a serious burden. Either way, this contradicts the objectives of the CHA which is to provide reasonable access to care without financial barriers (Health Canada, 2010).

Based on these findings, it is possible to conclude that the three-month wait policy created significant barriers in accessing emergency health care for some of the participants, several of whom either suffered as a result, or delayed treatment for non-emergency medical issues. The study also revealed that the three-month wait policy may have a negative repercussion on the image and reputation of Canada.

As for the 20 (50%) participants who were prepared to deal with medical emergencies during their first three months, their preparatory actions were made before arriving in Canada or within the first few days in the country. The first was gathering information about the provincial insurance policy. The second was purchasing private insurance to temporarily
cover any emergency health care if needed during this period. When participants wanted questions about health care answered, most of them relied on their relatives and friends to learn about the provincial insurance policy and the Canadian emergency health care system.

When the participants had problems with accessing emergency health care, they coped by relying on three types of coping strategies: silence or non-action, help-seeking, and personal initiatives. When they experienced immediate problems, such as a long wait time, quality care issue, or discrimination, new immigrants tended to stay silent or did not act. None of the participants complained about the difficulties he/she faced in the ED to the staff or administrators or filed a formal complaint to a concerned authority such as Interior Health or professional bodies. The main reason for not taking immediate action to deal with obstacles or difficulties experienced in accessing emergency health care was feeling incapable of advocating for their rights mainly due to a lack of knowledge about where to raise a concern or make a complaint; a perception/belief that nothing will be changed or the service will not get better; and fear that filing a complaint or raising a concern would have a negative impact on them. The majority (77.5%) of the participants were not aware that they can submit a complaint to PCQO; 34 (85%) were not aware that they can submit a concern about the care received by the emergency physician to the CPSBC; and 36 (90%) were not aware that they can submit a complaint or concern about the care received by the emergency nurse to the CRNBC.

When faced with non-system-related barriers such as language problems, transportation, and lack of knowledge, the study sample of new immigrants tended to use a help-seeking strategy. Around three-quarters (28 or 70%) of the participants indicated that they requested help to deal with a problem experienced in the ED. Of the 28 participants who requested help, the majority (25 or 89.3%) used family and friends as the main source of help. Less frequently, some new immigrants used different cultural, religious, and community
organizations for help and support. The type of help sought was usually information; other types of help sought included language and interpretation assistance, advice and counselling, and transportation.

Some participants used their own mechanisms to deal with the barrier or difficulty they faced. This personal endeavor coping strategy was commonly used by those who were medically uninsured during the first three uninsured months. An example of the personal endeavor coping strategy was to rely on traditional or alternative therapies. While this strategy may be helpful, in serious emergency situations it may lead to a deterioration of the medical condition and serious complications, and therefore, put the patient’s life at risk.

Finally, a cautionary note: the findings of this study cannot be generalized to reflect the experiences of all newcomers since the study sample is small and may not be representative. The sample was limited to new immigrants who had been in Kelowna for five years or less. Over time, those immigrants will possibly become more aware of and familiar with the Canadian emergency health care system including how to navigate this system. They may, therefore, have less accessibility barriers. Moreover, international students, refugees, and undocumented immigrants were not included in the study, and these groups likely face particular issues regarding access to emergency health care that did not arise in this study. Furthermore, sampling bias may have occurred since almost half of the respondents were recruited through personal contacts. The researcher established contact with potential participants who then referred the researcher to participants from their own acquaintances (snowball technique). Therefore, the study sample may have some differences from the general new immigrant population of Kelowna. But as an exploratory study, the results illustrate in some detail the sorts of issues and difficulties a diverse group of newcomer families and individuals living in Kelowna, British Columbia, faced when seeking emergency medical services. The study was designed to focus on problematic experiences with the
emergency care system and explore newcomers’ difficulties, so their positive experiences may not be well determined; nevertheless, the issues reflected in the data are useful as the basis for the following suggestions for improvements to the health system and enhanced sensitivity to certain aspects of the integration challenges that newcomers must navigate health services in Canada.

8.3 Recommendations

Based on the research findings and the participants’ suggestions and recommendations, a number of recommendations can be made for the health and immigration sectors at the local, provincial, and federal levels. The ED at KGF, Interior Health Authority, Ministry of Health of British Columbia, and CIC Canada may need to work interdependently and collaboratively to achieve the goals of these recommendations.

First, this study strongly demonstrates the need for evaluating the wait time in the ED to determine if it is matching the time recommended by CTAS. Despite the fact that long waits are a long-standing and complex problem in Canada and the reasons for the long wait are beyond the control of the EDs, Interior Health and ED at KGH may need to initiate new strategies to make sure that ED patients are being seen in a timely manner. Additionally, the study showed a strong demand for providing patients with an estimated wait time in the ED.

Second, the study demonstrates the need for providing new immigrants with accurate, precise, and concise information related to the Canadian emergency care system, including the provincial insurance policy, before their arrival or at the point of arrival. This could be achieved by encouraging new immigrants to review the website of the Ministry of Health of the province they will land in and by providing information at the point of entry. For example, a 15-minute orientation about the emergency care system could be provided at the airport while immigrants are waiting for the paper and passport work, or new immigrants could be given a two-page document in various languages about what to do in case of a
medical emergency. Also, immigrants’ integration agencies, such as Kelowna Community Resources, could be more diligent about providing new immigrants with information and support related to the emergency health care system.

Third, the research results suggest that the ED at KGH and Interior Health Authority should consider providing interpretation service to reduce the language barriers between care providers and receivers. While recruiting interpreters for many different languages may be unrealistic, a telecommunication interpretation service may be feasible and useful.

Fourth, the research findings suggest the need for more diversity among ED health care providers; this reduces language barriers and culturally inappropriate care for new immigrants. This could be achieved by hiring internationally-educated physicians and nurses. Furthermore, this study revealed that a relatively high proportion of the new immigrants faced significant problems with the care providers’ bedside manner. Thus, there is a need for the Interior Health Authority to consider improving the communication skills of nurses and doctors. Establishing professional behaviour workshops and training programs would achieve this goal. Moreover, the study recommends that professional regulatory bodies reinforce their code of conduct and professionalism. A method for soliciting ED patient feedback could identify care-related problems and help to solve them.

Fifth, the three-month wait for the provincial insurance plan seems to contradict the principles of the CHA. It creates a significant barrier for new immigrants to access health care. At the provincial level, the result of this study demonstrated the need for the Province of British Columbia to reconsider and reevaluate the risks and benefits of the three-month wait policy. Abandoning (cancelling) or, at least, shortening the three-month wait would alleviate the emergency care accessibility barriers for new immigrants to British Columbia during their first three months and would have a positive impact on new immigrants’ sense of positive feelings.
8.4 Areas for further Research

While little research emphasizes on new immigrants’ experiences with emergency care service, the results of this exploratory study has identified the major barriers and difficulties experienced by new immigrants when accessing emergency health services in a mid-sized city in British Columbia. Taking into account the study results and limitations, this study identifies several avenues for further research:

- A comparative study of new immigrants’ experiences with emergency care services in small versus large cities. Do the accessibility barriers vary? If so, how?
- A study to explore non-immigrants’ experiences with emergency health care services in Kelowna and other Canadian cities with a focus on how the Canadian-born population perceives the quality of care, health care providers’ approach, and the wait time in the EDs.
- Exploratory research examining experiences of long-term immigrants with emergency care services in mid-sized Canadian cities.
- Research exploring the experiences of refugees and international students with emergency care services. To date, few studies have examined the emergency care accessibility barriers of these sub-groups of newcomers to Canada.
- Larger-scale descriptive and explanatory studies that examine the associations between new immigrants’ sociodemographic factors and the nature and type of barriers experienced. The variables suggested include age, gender, educational level, income level, country of origin, and previous experiences with emergency care services in other countries.
- Further research into the feasibility of incorporating internationally-educated health care providers into emergency care centers in British Columbia, and
research into the benefits and risks of such a program, as well as public input towards this program.

- Finally, while lengthy ED wait times are a complex problem in Canada and have many reasons behind it, this study strongly demonstrates the need for further research with a primary aim of finding the other hidden reasons behind the long wait times in the EDs. Once all the reasons are discovered, further studies can assess all the reasons together and identify the best possible strategies for reducing wait times to a minimum, for example, a study using optimization methods of operational research to assess the dynamics of the ED patients’ flow system and evaluate possible solutions. The solution might be to modify the existing system or create a new program in Canadian EDs with an aim of reducing the wait time. Once a new program is developed, experimental research to evaluate this program would also be strongly recommended.

The above-mentioned areas of further research would fill gaps in the literature and identify health care accessibility barriers in various Canadian communities and cities, along with possible solutions.

Providing insight and understanding of the barriers encountered by immigrants when seeking emergency health care was the goal of this exploratory study. Future studies with a larger sample size can formulate hypotheses and conduct more detailed investigations, including testing relationships among key variables and providing generalizable results. This study can be used as a reference for future research examining immigrants’ access to health care in mid-sized cities in North America and other immigrant-receiving countries.

8.5 Conclusion

The study findings fill an important gap in the literature and provide an in-depth understanding of recent immigrants’ experiences with emergency health services outside the
major cities, making a significant contribution to knowledge in the field of population
geography and health care services. In addition to serving as a foundation for further
descriptive and explanatory research in immigrants’ health and access to care in mid-sized
Canadian cities, the outcomes and recommendations of this research provide health service
providers with a guide to evaluating and enhancing emergency health care service and policy.
The results of this study also yield policy and practice recommendations aimed at improving
new immigrants’ access to emergency health care in the future.
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Appendices

Appendix A: Location of the City of Kelowna within British Columbia

(City of Kelowna, 2013, p.2.4)
Appendix B: Initial Contact Letter and Screening for Eligibility

Irving K. Barber School of Arts and Sciences
3333 University Way
Kelowna, BC, Canada, V1V 1V7

March 12, 2015

Research Project:
Barriers Faced by New Immigrants when Seeking Emergency Health Services in Kelowna

Initial Contact Letter and Screening for Eligibility

To Whom It May Concern:

My name is Emad Awad. I am currently enrolled in the Master’s program at the University of British Columbia - Okanagan. As part of my degree requirements, I am conducting a research involving new immigrants’ access to emergency health care services in the city of Kelowna.

According to Statistics Canada, immigrants currently represent 16% of the population of the city of Kelowna. The city has a plan to attract more immigrants in the future. One of the essential needs of new immigrants is proper access to health care. The research, I am involved with, aims to examine the barriers new immigrants experience in accessing emergency health services in the city of Kelowna.

Your participation in this study will offer an important perspective. The results from this research can potentially create future policy changes, benefiting immigrants in Kelowna.

Screening Question:
To determine your eligibility to participate in the study, please answer the following questions.

1. Were you born outside Canada?
   - YES
   - NO

2. Did you arrive in Canada after January 1st, 2010?
   - YES
   - NO

3. Are you currently living in the city of Kelowna?
   - YES
   - NO

4. Since you came to Kelowna, have you used the hospital Emergency department or accompanied a family member to the hospital Emergency department?
   - YES
   - NO
If your answer to any of the previous questions was “NO”, you will not be eligible to participate in this study, please do not continue.

If your answer to all of the previous questions was “YES”, please go to the next question.

5. Did you previously participate in a study conducted by Dr. Shirley Chau and Dr. Carlos Teixeira entitled “The health and well-being of immigrants in Kelowna”?

YES  NO

If your answer to question 5 is “YES”, you will not be eligible to participate in this study, please do not continue.

If your answer to question 5 is “NO”, you are invited to take part in a survey and share with me your experiences in accessing emergency health services in the city of Kelowna.

Please provide me with your contact information below, and an official invitation letter with more detail about the study will be sent to you.

Name: 

Address: 

Phone Number: 

Email: 
Appendix C: Contact Letter to New Immigrants

Irving K. Barber School of Arts and Sciences
3333 University Way
Kelowna, BC, Canada, V1V 1V7

March 12, 2015

Research Project:
Barriers Faced By New Immigrants when Seeking Emergency Health Services in Kelowna

Contact Letter to New Immigrants

To Whom It May Concern:

My name is Emad Awad. I am currently enrolled in the Master’s program at the University of British Columbia - Okanagan. As part of my degree requirements, I am conducting a research involving new immigrants’ access to emergency health care services in the city of Kelowna. According to Statistics Canada, immigrants currently represent 16% of the population of the city of Kelowna. The city has a plan to attract more immigrants in the future. One of the essential needs for new immigrants is proper access to health care. The research, I am involved with, aims to examine the barriers new immigrants experience in accessing emergency health services in the city of Kelowna. The results of this study will be used to educate policy makers and health care providers and provide them with recommendations for achieving proper access to health care services for new immigrants in Kelowna.

Your participation in this study will offer an important perspective. The results from this research can potentially create future policy changes, benefiting immigrants in Kelowna. You are invited to take part in this important study and share with me your experiences in accessing emergency health services in Kelowna. The study consists of two parts, a survey and interviews. You will be asked to participate in a survey. After completing the survey, you may be called for a follow-up interview. The survey will take approximately 30 to 45 minutes to be completed. The interview will also take approximately 30 to 45 minutes to be completed. Please be assured that all the information you provide is highly confidential. The data will be recorded, analyzed, and reported in ways that guarantee anonymity and confidentiality. Your participation is voluntary and you have the right to withdraw from the study at any point with no consequences.

You will receive $20 as a token of appreciation for your participation in the survey. You will receive another $10 as a token of appreciation if you are selected for and participated in the follow-up interview. I will be contacting you within the next five days to determine your interest and valued participation in this worthwhile project.

Sincerely,
Emad Awad, MA candidate
University of British Columbia- Okanagan
Appendix D: Questionnaire Survey Consent Form

Irving K. Barber School of Arts and Sciences
3333 University Way
Kelowna, BC, Canada, V1V 1V7

Research Project:
Barriers Faced by New Immigrants when Seeking Emergency Health Services in Kelowna

Questionnaire Survey Consent Form – New Immigrant

Principal Investigator:
Carlos Teixeira, Professor
UBC Okanagan
Email: carlos.teixeira@ubc.ca
Phone: (250) 807-9313

Co-Investigator:
Emad Awad, Graduate Student
UBC Okanagan
Email: emad.awad@alumni.ubc.ca
Phone: (250) XXX-XXXX

The objective of this study is to examine the new immigrants’ experiences in accessing emergency health care services in the city of Kelowna. There is very little data published on the topic of the new immigrants’ experiences with emergency health care services in mid-sized cities like Kelowna. This study will explore the barriers new immigrants encounter when accessing emergency health care services in Kelowna, and the coping strategies they used to overcome these barriers. The study will also examine the new immigrants’ experiences with the first three months after arrival in Canada when the new immigrants are medically uninsured. The results of this study will be used to educate policy makers and health care providers and provide them with recommendations for achieving proper access to emergency health care services for new immigrants.

Emad Awad (UBC-Okanagan) is conducting research for the purposes mentioned above. You are asked to complete a survey that will last approximately 30 to 45 minutes. You can refuse to answer any questions and you can withdraw from the survey at any time without explanation.

All responses to questions will assist the researcher’s understanding of the barriers that new immigrants face in accessing emergency health care services in the city of Kelowna. You may ask, now or in the future, any question that you have about this study. Any question that you may have about the study will be answered to your satisfaction.

This study will be reported in a graduate thesis and will be available on the internet. The study results may also be published in a journal article and book. Please be assured that no information will ever be released or printed...
that would disclose your personal identity and that your responses will be kept completely confidential. Your participation in the survey is voluntary and your decision to participate or not to participate will have no effect on yourself or your access to emergency health services in Kelowna. You may withdraw your participation from this study at any time. You will receive $20 as a token of appreciation for your participation.

If you participate in this study, there are no risks greater than what you would experience in your daily life. The study has many benefits. By participating in this study, you will have an opportunity to express your feelings and experiences with accessing emergency health care in Kelowna. Also, your participation may contribute to recommendations for proper access to emergency health services for new immigrants in Canada. The result of this study will be used to support initiatives aimed at improving immigrants’ access to emergency health care in Canada.

If you have any questions about this research project, you may contact Emad Awad at any time. Telephone number: 250-XXX-XXXX, e-mail: emad.awad@alumni.ubc.ca

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. It is also possible to contact the Research Participant Complaint Line by email (RSIL@ors.ubc.ca).

Your signature below indicates that you have received a copy of this consent form for your own records.

My signature indicates that I consent to participate in this study.

____________________________ ______________________________
Signature of Participant    Print Name

____________________________
Date

*If you wish to receive an executive summary of the completed research, please complete the following contact information and a copy will be sent to you by mail or email.

Address: _____________________________________________________
Email: _______________________________________________________
Appendix E: Questionnaire Outline

New immigrants Access to Emergency Health Care in the city of Kelowna

Questionnaire Assessing Immigrants’ Access to Emergency Health Care Services in the City of Kelowna

Questionnaire Outline

A- Immigration history
B- Health history
C- Needs to seek emergency care since arrival in Kelowna
D- Barriers in accessing emergency health care
E- Accessing emergency care during the first three months after arrival in Kelowna
F- Coping strategies to overcome the barriers in accessing emergency care services
G- Recommendations for accessing appropriate emergency health care services
H- Demographic information
Thank you for taking the time to fill out this questionnaire concerning the experiences that new immigrants have in accessing emergency health care services in the city of Kelowna. Your participation in this questionnaire is voluntary and your decision to participate or not to participate will have no effect on yourself or your access to emergency health services in Kelowna. This questionnaire consists of eight sections.

**SECTION A: Immigration History**

1- What is your country of birth?

2- What is your date of birth?

3- What is your country of citizenship?

4- What was the date you arrived in Canada? (e.g., June 2010)

5- How old were you when you arrived in Canada?

6- What was your immigration class upon arrival in Canada?
   - Family Class
   - Business Class
   - Federal Skilled Worker
   - Provincial Nominee (PNP)
   - Live-in Caregivers
   - Refugee
   - Other, please specify

7- Who came with you to Canada? (Please mark all that apply)
   - I came alone
8- When you first arrived in Canada, what was the first province you landed in?


9- What year did you move to Kelowna?


10- What is the **main reason(s)** for choosing to live in the city of Kelowna?


11- In which area of Kelowna do you live?

- Rutland
- Glenmore
- Central/Downtown
- South Pandosy
- Mission
- Other, please
  
  specify__________________________
SECTION B: Health History

The following questions are about the health history of the person who used the Emergency department in Kelowna (that can be you or a family member you accompanied to the Emergency department)

12- After you came to Kelowna, have you been in the hospital Emergency department for any reason?
   o Yes
   o No

13- In what capacity have you been in the Emergency department? (Mark all that apply).
   o As a patient
   o Accompanying a family member (wife, son, daughter, father, mother)
   o Accompanying a relative (brother, sister, cousin)
   o Others, please specify__________________________

14- In general, how would you rate the overall health of the person who used the Emergency department in Kelowna (that can be you or a family member you accompanied to the Emergency department)?

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
</table>

15- What of the following disease/health issues do you/your family member have/has? (Please mark all that apply).
   o No disease or health problem (Go to question 17).
   o Hypertension (High blood pressure)
   o Diabetes (High blood sugar)
   o Heart disease
   o Cancer
   o Neurological disorder
   o Anxiety disorder
   o Depression
   o Other, please specify________________________________________
16- When did the problem(s) start?
   o Before coming to Canada
   o After coming to Canada
   o Some health problems started before coming to Canada and others started after coming to Canada, please specify__________________________

SECTION C: Needs to Seek Emergency Health Care since Arrival in Kelowna

17- Since you arrived in Kelowna, how many times have you/your family member visited the Emergency department?
   o None
   o One time
   o Two times
   o Three times
   o Four times
   o More than four times

18- How many of these visits to the Emergency department were within the first three months you/your family member were in Canada?
   o None
   o One time
   o Two times
   o Three times
   o Four times
   o More than four times

19- Thinking about the most recent visit to the Emergency department, please give a brief description of the complaint for which you/your family member sought emergency care (e.g., I was complaining of severe headache and for two days …., I had an accident and broke my foot….)

20- Do you have a regular family doctor in Kelowna?
   o Yes (Go to question 23)
21- Why do you not have a regular family doctor?
   - I do not know how to find a family doctor in the area
   - Family doctors in the area are not taking new patients
   - I have not tried to contact a family doctor
   - Other, please specify

22- When you/your family member visited the Emergency department, do you think you/your family member’s medical condition was not a medical emergency, but you went to the Emergency department because you did not have a family doctor?
   - Yes
   - No

Section D: Barriers in Accessing Emergency Health Care

Now some questions about your experience or your family member’s experience with emergency health care.

23- In general, what barriers or difficulties have you/your family member had getting emergency health care in the Emergency department in Kelowna? (Please mark all that apply)
   - No problems
   - Language problems
   - Care was not appropriate to my/my family member’s culture
   - Cost too much money
   - Long wait time to receive care
   - Lack of health insurance
   - Exposed to discrimination
   - Hospital is far away from our home
   - Transportation problems
   - The services needed were not available
   - I did not know where to go to get care
   - Other, please specify

24- Which of these difficulties would you say was the most serious? (Please mark one).
   - Language problems
o Care was not appropriate to my/my family member’s culture
o Cost too much money
o Long waiting time to receive care
o Lack of health insurance
o Exposed to discrimination
o Hospital was far away from our home
o Transportation problems
o The services needed were not available
o I did not know where to go to get care
o Other, please
   specify________________________________________

25- Thinking about the problem you identified as the **most serious**, please provide more details about this problem. (Example, what happened? Why you think this was a serious problem?).

   

26- Thinking about the problem you identified as the **most serious**, what action did you take to overcome this problem? (Mark all that apply).
   
o No action taken
o I asked a friend or relative for help/support
o I relied on immigrants’ societies such as (Kelowna Community Resource) for help/support
o I complained to concerned authorities
o Other, please
   specify________________________________________
   ________________________________________________
27- What barriers or difficulties have you had with ambulance services in Kelowna? (Mark all that apply).
   - I/my family member have not needed ambulance health services
   - No problems with getting ambulance services
   - Language problems with phoning the ambulance 911 service
   - Language problems with ambulance attendants
   - I do not know how to get emergency ambulance services
   - The care I received in the ambulance was not appropriate to my culture
   - The ambulance costs too much money
   - Long wait time for the ambulance to arrive
   - Exposed to discrimination
   - Other, please specify

28- Overall, how would you rate the availability of overall emergency health care services in Kelowna?
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

29- Would you say that your whole experience in accessing the Emergency department services in Kelowna for you or your family member has been …?
   - Much better than expected
   - Somewhat better than expected
   - About what you expected
   - Somewhat worse than expected
   - Much worse than expected

30- Overall, how would you rate the quality of care provided to you or your family member by the doctor in the Emergency department?
31- If your answer to question 30 was “Poor”, please explain why by giving some more details.

32- Overall, how would you rate the quality of care provided to you or your family member by the nurse in the Emergency department?

<table>
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<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
</table>

33- If your answer to question 32 was “Poor”, please explain why by giving some more details.

SECTION E: Accessing Emergency Health Care during the First Three Months after Arrival in Canada.

The following questions are about accessing emergency health care only during “the first three months” after arrival in Canada.

34- On arrival in Canada, were you aware that individuals who immigrate to British Columbia have to wait for three months after arrival in Canada to get enrolled in the Provincial Medical Service Plan (MSP)?
   o Yes
   o No

35 - On arrival in Canada, were you provided with the necessary information about the health insurance policies, including the three months wait to get enrolled in the Provincial Medical Service Plan (MSP)?
   o Yes (Go to the next question)
   o No (Go to question 37)

36- Who provided you with this information?
   o Friends
Community members
- Integration society
- Government (e.g., CIC website)
- Airport officials
- Other, please
  specify______________________________

37- Did you purchase private health insurance to cover for the **first three-uninsured months** after arrival to Canada?
- Yes ( Go to question 39)
- No ( Go to the next question)

38- If your answer to the previous question is "No," please explain why did not you purchase private health insurance? (e.g., I took the risk; I did not know that I needed to do so, it cost too much money etc.)
- I did not know that I needed to do so
- I took the risk
- Private health insurance costs too much money
- I tried, but the insurance company refused to enroll me
- I do not trust health insurance companies
- Others, please
  specify____________________________________

39- In general, what action did you/ your family member take as a preparation for any medical emergency that could happen during the **first three months** after arrival in Canada?
(Mark all that apply)
- No preparation
- Gathered information about health insurance policy from online sources
- Gathered information about health insurance policy from family/friend
- Relied on community organizations to provide me with the support I needed
- Bought private health insurance immediately after arrival in Canada to cover for the **first three-months**.
- Other, please
  specify____________________________________
40- During your **first three months** in Canada, have you/your family member been in an Emergency department?
   - Yes (Go to the next question)
   - No (Go to question 42)

41- Please give a brief description of the complaint for which you/your family member sought emergency care (e.g., I was complaining of severe headache and cough for two days ……, I had an accident and broke my foot, I fainted at home…..)

42- During **the first three months** after arrival Canada, have you/your family member had any medical problems for which you/your family member did not receive medical attention?
   - Yes (Go to the next question)
   - No  (Go to question 44)

43- Why did you/your family member **not** receive medical attention for this/these problem(s)? (Mark all that apply).
   - Problem(s) not serious enough
   - Financial constraints/costs not covered by insurance
   - No insurance plan
   - Long wait to receive attention
   - Didn't know where to go/how to access health care
   - Other, please
     
     specify__________________________________________________________
SECTION F: Coping Strategies

44- Some new immigrants approach people and organizations to get help with the problems they experience in accessing health services. From whom did you or your family member get help with the problem you experienced in accessing emergency health services? (Mark all that apply).

- No help needed
- Relative or household member
- Friend
- Employer/co-worker
- Ethnic/cultural group or association
- Religious group (e.g., church, mosque, synagogue, temple)
- Immigrant or refugee serving agency
- School, Community College, University (e.g., ESL/FSL teacher or staff)
- Community center or organization
- Health worker (e.g., doctor, nurse)
- Government agency
- Other, please specify

45- What kind of help did they give you? (Mark all that apply).

- Did not request any help
- Language help (e.g., translation, interpretation)
- Advice/counselling
- Information
- Transportation
- Financial help
- Legal help
- Child care
- Other, please specify

46- Are you aware that if you have a complaint about the care you received in the Emergency department, you can submit your complaint to the Interior Health’s Patient Care Quality Office located in Kelowna?

- Yes
- No
47- Are you aware that if you have a complaint about the care you received by the emergency doctor, you can submit your complaint to the College of Physicians and Surgeons of BC?
   o Yes
   o No

48- Are you aware that if you have a complaint about the care you received from the registered emergency nurse, you can submit your complaint to the College of Registered Nurses of BC?
   o Yes
   o No

SECTION G: Recommendations for Improving Immigrants’ Access to Emergency Health Care in Kelowna

Now, few questions about what changes need to be made to improve the access to health care for new immigrants in Kelowna.
49- What would you recommend to improve the access to the Emergency department services for new immigrants in Kelowna?

50- What would you recommend to improve the access to the Emergency department services for immigrants during the first three months after arrival in BC, Canada?

51- In general, what aspects of emergency health services policies should be changed?
SECTION H: Demographic Information

Finally, I would like to ask a few questions about yourself, and I would like to assure you again that all of the information will be kept strictly confidential.

52- You identify your sex as:
   o Male
   o Female

53- What is your ethnic origin?
   o White
   o South Asian (e.g., Pakistani, Indian, etc.)
   o Chinese
   o Black
   o Filipino
   o Arab
   o Latin American
   o Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian)
   o West Asian (e.g., Iranian, Afghan, etc.)
   o Korean
   o Japanese
   o Other, please specify_______________________________

54- Which of the following represents your marital status?
   o Married
   o Common law
   o Separated
   o Divorced
   o Widowed
   o Single/never married
   o Other, please specify_______________________________
55- What is your highest level of educational attainment? (Please choose one)
  o Primary education
  o Secondary education
  o Post-secondary certificate/diploma
  o University degree
  o Post-graduate degree
  o Other, please
    specify________________________________________

56- How well can you speak English? Would you say...
  o Poorly
  o Fairly well
  o Well
  o Very well

57- What kind of work did you do before coming to Canada? (e.g., doctor, nurse, teacher)

58- What is your current job/occupation in Canada?

59- What is your main source(s) of income? (Please mark all that apply)
  o Employment
  o Income assistance
  o Retirement Pension
  o Government Pension (CPP, OAS, GIS)
  o Other government sources (such as Employment Insurance or Disability Benefits)
  o Investments/Other Assets
  o Other, please
    specify________________________________________
60- What is your total household income for the past year?
   o Less than $10,000
   o $10,001 - $20,000
   o $20,001 - $30,000
   o $30,001 - $40,000
   o $40,001 - $50,000
   o $50,001 - $75,000
   o More than $100,000
   o Don’t know

61- Finally, please feel free to add any other comments or opinions about immigrants' access to emergency health care services in Kelowna.

Thank you very much for your time and contribution! Please enter your name and address if you would like to receive a copy of the research report.

After completing this questionnaire, please mail it in the enclosed envelope, or email it to: emad.awad@alumni.ubc.ca
As part of this research, some individuals may be invited to participate in a follow-up, face to face interview. The interview will last approximately 30 to 45 minutes. You may be contacted to participate in this interview. During the interview, you will be asked to provide the researcher with some more information about your experience in accessing emergency health services in Kelowna. Your participation in this interview is voluntary and your decision to participate or not to participate will have no effect on yourself or your access to emergency health services in Kelowna. You can refuse to answer any question, and you can withdraw from the interview at any time without explanation. No information will ever be released that would disclose your personal identity at any point. You will receive $10 as a token of appreciation for your participation in the interview.

Would you be willing to participate in the follow-up interview?

- Yes
- No

If you are willing to be contacted for the follow-up interview, please indicate below which way you would like to be contacted and provide your contact information.

- I preferred to be contacted by email, my email address is:

  

- I preferred to be contacted by phone, my phone number is:

  

My signature indicates that I consent to be contacted to be invited to participate in the follow-up interview.

____________________________                    ___________________________
Signature of Participant                                      Print Name
Appendix F: Consent Form- Semi-Structured Interview

Irving K. Barber School of Arts and Sciences
3333 University Way
Kelowna, BC, Canada, V1V 1V7

March 12, 2015

Research Project:

Barriers Faced by New Immigrants when Seeking Emergency Health Services in Kelowna

Semi-Structured Interview Consent Form

Principal Investigator:
Carlos Teixeira, Professor
UBC Okanagan
Email: carlos.teixeira@ubc.ca
Phone: (250) 807-9313

Co-Investigator:
Emad Awad, Graduate Student
UBC Okanagan
Email: emad.awad@alumni.ubc.ca
Phone: (250) XXX-XXXX

The objective of this study is to examine the new immigrants’ experiences in accessing emergency health care services in the city of Kelowna. There is very little data published on the topic of the new immigrants’ experiences with emergency health care services in mid-sized cities like Kelowna. This study will explore the barriers new immigrants encounter when accessing emergency health care services in Kelowna, and the coping strategy they used to overcome these barriers. The study will also focus on the health insurance issues during the first three months after immigrants’ arrival in Canada, and possible implementation of future emergency health care policies for immigrants. The results of this study will be used to provide policy makers and health care providers with recommendations for achieving proper and safe access to emergency health care services for new immigrants.

Emad Awad (UBC-Okanagan) is conducting research for the purposes mentioned above. You are asked to participate in a semi-structured interview that will last from 30 to 45 minutes. Your participation is voluntary and you can refuse to answer any questions and can withdraw from the interview at any time without explanation. The interview will be audio-recorded and you can ask that the audio recorder be turned off for a period of time while making a point that you do not want recorded. It is understood that the tape recording of the interview is for note taking use only by Emad Awad and his project supervisor (Dr. Carlos Teixeira). There will be no further use of the tapes in any
fashion. No one except Emad Awad and his supervisor, Dr. Carlos Teixeira will ever listen to the tapes.

Any questions that you have about the interview will be answered to your satisfaction. All responses to questions will assist the researcher’s understanding of the new immigrants’ experience in accessing emergency health care in the city of Kelowna.

The research findings are intended to provide recommendations that could be used to benefit new immigrants and their access to emergency health care. You may ask, now or in the future, any questions that you have about this study.

This study will be reported in a graduate thesis and will be available on the internet. The study results may also be published in a journal article and book. Please be assured that no information will ever be released or printed that would disclose your personal identity and that your responses will be kept completely confidential. Your participation in this interview is voluntary and that your decision to participate or not to participate will have no effect on yourself or your access to emergency health services in Kelowna. There are no risks to participate in the interview greater than what you would experience in your daily life. You may withdraw your participation from this interview at any time.

For your participation in the interview, you will receive $10 as a token of appreciation. If you have any questions about the interview and this research project, you may contact Emad Awad at any time. Telephone number: XXX-XXXX, e-mail: emad.awad@alumni.ubc.ca

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. It is also possible to contact the Research Participant Complaint Line by email (RSIL@ors.ubc.ca).

Your signature below indicates that you have received a copy of this consent form for your own records.

My signature indicates that I consent to participate in this study.

____________________________           ______________________________
Signature of Participant          Print Name

____________________________
Date

*If you wish to receive an executive summary of the completed research, please complete the following contact information and a copy will be sent to you by mail or email.

Address: _____________________________________________________
Email: _______________________________________________________

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Appendix G: Semi-Structured Interview Guide

Follow-up Interview Themes:

1) Perceptions regarding the barriers in accessing emergency health care and the coping Strategies.
2) Experiences and perceptions of accessing emergency health care during the first three uninsured months after arrival in British Columbia.
3) Recommendations to improve access to emergency health care services provided for new immigrants in the city of Kelowna in the future.

a) Perceptions regarding the barriers in accessing emergency health care and the coping Strategies.

1) Thinking about your [or your family member] most recent visit to the Emergency Department (ED), please tell me more about the reason for seeking emergency health care? What was the complaint?
2) Before arriving at the ED, tell me about what was it like getting to the ED. What difficulties, if any, did you experience getting to the ED?
3) After you [and your family member] arrived in the ED, what happened? What type of problems/difficulties, if any, did you [or your family member] experience? Which problem/difficulty was the most bothersome/serious? What was it like for you? What it was like for your family members?
4) What, if anything, did you [or your family member] do to deal with this problem? How helpful was this? What happened as a result?
5) What types of services were provided that met your expectations? What services didn’t meet your expectations? Please describe.
6) Some people who responded to the survey mentioned that they faced issues with the health care providers. Was this your experience? If so, please tell me what did you experience? How did you feel about this? What, if anything, did you [or your family member] do to respond to this? What happened as a result? How helpful was this?
b) Experiences and perceptions of accessing emergency health care during the first three uninsured months after arrival in British Columbia.

1) Before you arrived in Canada, what did you know about the Canadian health care system, and emergency services in particular?

2) During your first three months in Canada, did you have any medical problem for which you or any of your family members did not seek care or advice from a health care provider (e.g., doctor or nurse) or service? What was the problem? Why did you/your family member not seek health care for this problem? What did you/your family member do about the medical problem?

3) ONLY IF visited ED in 1st 3 months: Thinking about your visit to the ED during the first three months in Canada, please describe what type of problems/difficulties, if any, did you experience? What was it like for you? What was it like for your family member(s)? What, if anything, could have made the experience better?

4) Overall, what did you think about the quality of care provided to you/your family member by the health care providers (doctor, nurse, etc.) in ED? Probes (if needed): Tell me about the attitude of the care provider(s) towards you [or your family member? How did the attitude of the care provider make you feel?

5) Have you received emergency care in other countries before coming to Canada? Which country? How did the care you received in that country differ, if at all, from the care you received in the hospital ED in Kelowna?

c) Recommendations to improve access to emergency health care services provided for new immigrants in the city of Kelowna in the future.

1) We are particularly interested in how emergency services can be improved for newcomers to Kelowna. Based on your experiences, how do you think the emergency service could be improved? [Probe if needed: What could have been different?]

2) ONLY FOR THOSE WHO WENT TO ED in the first 3 MONTHS: What suggestions do you have for improving the emergency care services for new immigrants during the first three months after arrival in Kelowna? How your experience in accessing/getting health care could be improved for other people like yourself?

3) Any further suggestions/recommendations?

Is there anything else you would like to tell me about your experiences in accessing emergency services that I have not asked about?

Thank you very much for sharing your experiences with me.
Appendix H: Research Ethics – Certificate of Approval

The University of British Columbia Okanagan
Research Services
Behavioural Research Ethics Board
3333 University Way
Kelowna, BC V1V 1V7 Phone: 250-807-6802
Fax: 250-807-8438

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR:
Jose (Carlos) Teixeira

INSTITUTION / DEPARTMENT:
UBC/UBCO, Okanagan

UBC BREB NUMBER:
H15-00452

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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<tr>
<th>Institution</th>
<th>Site</th>
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<tbody>
<tr>
<td>UBC</td>
<td>Okanagan</td>
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</table>

CO-INVESTIGATOR(S):
Emad Awad

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Barriers Faced By New Immigrants when Seeking Emergency Health Services in the City Of Kelowna- A Mid-Sized Canadian City

CERTIFICATE EXPIRY DATE: April 9, 2016

DOCUMENTS INCLUDED IN THIS APPROVAL:

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<td>Interview Themes</td>
<td>1</td>
<td>March 12, 2015</td>
</tr>
</tbody>
</table>

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

This study has been approved either by the full Behavioural REB of the UBC Okanagan or by an authorized delegated reviewer.