From: llaing@ualberta.ca [llaing@ualberta.ca]
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To: alex71851@yahoo.com
Cc: Shenge, Nyitor A
Subject: FW: Acceptance of health improvement barriers among Alberta immigrants: The role of social and demographic factors

-----Original Message-----
From: cspeditr@ualberta.ca [mailto:cspeditr@ualberta.ca]
Sent: Wed 06/25/2014 1:42 PM
To: Lory Laing
Subject: RE: Reviewers comments

Dear Dr. Laing

This is to inform you that your paper "Health improvement barriers among Alberta immigrants: The role of social and demographic factors" has been accepted for publication in *Canadian Studies in Population*. You will receive information about the publication volume and other details shortly. I have already e-mailed you the reviewers' comments.

With best regards

Kamrul Islam
Assistant to the Editor
Canadian Studies in Population
Department of Sociology
5-25 Tory Building
University of Alberta
Edmonton, Alberta
Canada T6G 2H4
CanadianStudiesinPopulation@ualberta.ca

Health Improvement Barriers among Alberta Immigrants: The Role of Social and Demographic Factors

N.A. Shenge[1] and L. M. Laing[2]

[1] Department of Psychology, University of Ibadan, Nigeria
[2] Department of Public Health Sciences, School of Public Health, University of Alberta

Correspondence: Nyitor Alexander Shenge, PhD

Department of Psychology
Faculty of the Social Sciences
University of Ibadan
Ibadan, Nigeria
E-mail: na.shenge@ui.mail.edu.ng
Alternate: alex71851@yahoo.com
Phone: (234) 802-616-0134

Abstract

The role of social and demographic variables in influencing barriers to health improvement among Alberta immigrants and the Alberta general population was assessed in this study. Data were sourced from the Canadian Community Health Survey (CCHS) Cycle 1 of 2001. Using logistic regression analysis, it was found that job status played significant role in influencing barriers to improving immigrants' health. Among the general Alberta population, however, immigrant status, sex and marital status played significant roles in influencing barriers to improving the health of Albertans. Reasons for immigrants not receiving care were also identified as a follow-up on the health barriers. It was suggested that, as a way of better understanding and improving the health of Albertans of all categories, those social and demographic variables that pose as barriers to health improvement should be further researched, controlled and/or eliminated. The various reasons why immigrants do not receive care should also be further investigated and addressed.

Key words: Alberta immigrants, health improvement barriers, social and demographic factors

Introduction

Health care utilization, otherwise referred to as health service utilization (HSU), is the degree to which a community accesses available health services. It is also the measure of the population's use of the health care services available to them. HSU is broadly defined to include medical services (e.g. physician and specialist consultations, hospital use), mental health services, preventive health services and complementary/alternative medical services (CAM).

Health care utilization can be appropriate or inappropriate, of high or low quality, expensive or inexpensive. The study of trends in health care utilization provides important information on these phenomena and may spotlight areas that may warrant future in-depth studies because of potential disparities in access to, or quality of, care. Trends in utilization may also be used as the basis for projecting future health care needs, to forecast future health care expenditures, or as the basis for projecting increased personnel training or supply initiatives (1).

HSU as typically used in relation to access to care, and access, along with other variables, determine self-perception of health. It also points to the presence or absence of health improvement barriers among population groups. This study investigates barriers to health improvement among Alberta immigrants and, although it does not directly touch on health care utilization, it concentrates on the barriers to adequately utilizing health. Health care utilization, access and barriers are therefore closely related. Accessibility of health care and removal of barriers to health improvement are subjects of considerable importance in health research. Access is normally possible when barriers are removed. Access issues typically identified in immigrant health include the different realities of immigrant sub-populations (e.g. women, low-income individuals and victims of torture); the lack of knowledge/responsiveness among health care providers in meeting the needs of those other than the mainstream population; and communication and literacy issues (2).

Immigration Trends in Canada

Canada is historically a country of immigrants. Due to its decreasing birth rate and an aging population, the country depends on immigrants from other countries to keep her economy running smoothly. The country accepts proportionately more immigrants and refugees than any other country (3). Without sufficient immigration to compensate for below-replacement fertility, the Canadian population would start to decline in about 30 years (3).

Each year brings a new group of people who have chosen Canada as their home and who have been accepted as new residents by the federal government. Immigrants are defined as all persons who were not Canadian citizens by birth. In other words, an immigrant is a person who comes to settle in Canada as a permanent resident. Immigrants comprise a large and dynamic segment of Canada's population. They do not merely support the country's economy; they also help in sustaining a culture of diversity for which the country is traditionally known globally. In 1996, the total number of immigrants in Canada was 4,971,070, comprising 17.4% of the population (one in six people). This includes long- and short-term residents, different immigration classes and many different countries of origin. A total of 216,039 new immigrants arrived in Canada in 1997, a 4% decrease from 1996 levels. In 2004, 235,824 new immigrants arrived the country. One in five children in Canada is either an immigrant or the child of immigrant parents.

In 2001, Canada's 5.4 million immigrants made up 18.4% or one fifth of the population, the highest percentage in 70 years. Canada now receives more than 200,000 immigrants each year, and they account for close to 60% of population growth (3). The top five countries of origin among immigrants in 1999, 2000 and 2001 were the People's Republic of China, India, Pakistan, Philippines, and the Republic of Korea. Before 1996, majority of immigrants to Canada was from Europe. While immigrants from Europe still comprised the largest regional sub-group of immigrants in 1996, for the first time they accounted for less than half (47%) of the total immigrant population. Immigration demographics and trends have changed considerably over the last two decades, with the majority of new immigrants to Canada coming from non-European countries. Many more immigrants now come from Asia and Africa than ever before (2).

Between 1901 and 2001, thirteen million people had migrated to Canada. Of this number, 2.2 million (17%) had arrived in the 10 years immediately preceding 2002. The regions of origin and distribution of immigrants arriving Canada in 1997 were Europe and the U.K. (18%), Asia and

Pacific (54%), U.S., Caribbean, South and Central America (10%). Others were Africa and the Middle East (18%). In terms of immigrant category Economic class i.e. skilled workers and business accounted for 58%, Family members 28%, Refugees 11% and Other (caregivers, retirees, etc.) 3% (2).

The resulting increase in ethnic, cultural and linguistic diversity in Canada has been accompanied by a great and growing need for access to health care services. One of the national principles of Canada's Health Act is accessibility, which means that financial or other barriers to the provision of publicly funded health services are discouraged, so that health services are available to all Canadians when they need them (4). The principle of accessibility in the Canada Health Act stipulates that Canadians should have "reasonable access" to insured hospital and doctor services. However, the Act does not provide a clear definition as to what constitutes reasonable access. Although originally the primary concern was to eliminate financial barriers, lately the concern over access to health care has been associated primarily with the problem of waiting times. There is no doubt that a major problem of the current health care system is one of timely access. However, other potential problems with access may include hours of operation, transportation, location and cost.

The Phenomenon of Healthy Immigrant Effect in Canada

All immigrants to Canada are required to undergo medical examination (5). Based on this examination, applicants might be refused entry into Canada if they have a health condition that is likely to be a danger to public health or safety, or that could be very demanding on health or social services (3,6,7,8,9). Due to the health screening they go through, immigrants are usually healthier than the Canadian-born population. Research (3) has also reported a degree of self-selection among potential immigrants in the originating countries, with applicants likely to be individuals with the stamina and motivation to undertake the rigours that immigration entails.

It has been found that as time passes, the seeming advantage that immigrants have in the form of a healthy immigrant effect tends to diminish, as their health status converges with that of the host population. Some medical problems may arise as immigrants age, as well as when they are integrated and adopt behaviours that have negative health impacts (3,8). The health of immigrants at different times since immigration has been compared with that of the Canadian-born population, in terms of chronic conditions in general, heart disease, diabetes, high blood pressure, and cancer (3). Health behavior outcomes were also explored, as was their role in explaining observed health outcomes. Results showed that both male and female immigrants had lower odds of reporting chronic conditions in general, but odds increased with time spent in Canada.

Other health problems may be due to the stress of immigration itself, which involves finding suitable employment and establishing a new social support network. Health deterioration has been known to apply largely with immigrants with non-European origin, especially those who had arrived since the mid-1980s (6). European immigrants, by contrast, were similar to the Canadian-born with regard to health transitions. However, a concomitant increase in the frequency with which recent non-European immigrants consulted physicians suggests that the loss of health was real, and not merely an artifact of cultural or subjective differences in the perception of health status. It appears that the health advantage that new immigrants generally

have over long-term immigrants and the Canadian-born host population has dissuaded some health researchers from extensively investigating the health barriers that immigrants face or are likely to face.

The likelihood of deterioration in health has partly been related to socio-economic status, specifically, low education and low household income. Findings from the literature on immigrants' economic integration in Canada have shown that those with non-European origins are more likely than those with European origins to have low-paid jobs that require little education. Because immigrants with European origins share a similar culture with the Canadian-born, they may encounter fewer social, economic and lifestyle barriers than do those from non-European countries.

Accessibility of health care services as well as health improvement barriers faced by immigrants are two important areas that require further research. This need is borne out of the fact that understanding the complex context of immigrants' lives is critical to developing culturally appropriate and accessible health care practices and programs. Research on the impacts of health care reform also highlights some key policy gaps, including a lack of benchmarks to capture the potential differential impact of health reform on different immigrant groups. Related to this is the concern that aspects of health reform need closer examination from a gender and diversity perspective, particularly health promotion and prevention education (2).

Understanding access to health services and the barriers that citizens and residents face are very important in Canada's health system. Among other objectives it ensures that every Canadian has timely access to medically necessary health services regardless of his or her ability to pay for those services. Also, it ensures that no Canadian or Canadian resident suffers undue financial hardship as a result of having to pay health care bills. Inherent in these two objectives, particularly the first, is the requirement that the medically necessary services provided are of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada's health care system. Also of importance in the definition of access is the issue of fairness. The value of fairness underlies the patient-oriented principles of a universal, comprehensive, portable and accessible system that many Canadians strongly support. Fairness also means equity of access to the system, for instance, wealthy people should not be able to buy their way to the front of a health system's waiting lists (4).

Accessibility of health and barrier issues are increasingly becoming subjects of health research, with the focus being on ethnocultural minorities more often than on immigrant group (Health Canada, 1999). In immigration health literature, access issues identified include the different realities of immigrant sub-populations (e.g., women, low-income individuals and victims of torture); the lack of knowledge/responsiveness among health care providers in meeting the needs of those other than the mainstream population; and communication literacy issues (2). Previous immigrant research (10,11) on barriers to health care access has identified certain problematic areas. These include limited language proficiency, lack of resources, uninsured status, immigration status, the lack of awareness of how to navigate the health care system and lack of health care worker understanding of traditional remedies. Others are difficulty with transportation to and from appointments; inaccessible medical offices and equipment; lack of

knowledge by professionals about disabilities; delays in the referral process and scheduling of needed services; and limited coverage of equipment and therapy, with costs incurred adding up.

Among the consequences of these access problems are decline in the primary physical condition of the participant and an increase in secondary complications of that condition; reduced self-esteem, depression and stress; loss of income and missed time from work; and interference with social life and ability to live independently (13). Limited proficiency leads to faulty or wrong interpretation of patient symptoms by health care providers. As well, conditions such as unemployment, depression, surviving torture and being on social assistance also aggravate access or barrier problems. Race and racism also have an impact on delivery of services related to immigration, settlement and health (12). Similarly, professional beliefs/values, traditional medical practices and psychosocial determinants also affect delivery of health services (13).

Immigrant and host population groups do not necessarily encounter similar health improvement barriers; neither do groups encounter health improvement barriers in the same degree. For instance, access to services may be especially limited for immigrant women whose family and job responsibilities make the use of existing resources difficult. Immigrants without work may also encounter health improvement barriers differently. It has been found that first-generation Chinese women immigrants have difficulty accessing health facilities, learn little from health professionals about their illnesses and have few resources to help them understand their condition (14). There are issues of fundamental mismatch and tension between the beliefs, expectations and behaviours of Western-trained health care professionals and those of immigrant, refugee and women of different backgrounds. Cultural insensitivity, mental health problems and community empowerment has also been found to be relevant in the discussion of health improvement barriers (15).

Owing largely to cultural differences, health providers and immigrant patients differ in their expressed or implied health priorities. For instance, a study of 296 young immigrant families and 40 health care practitioners found marked differences in priorities between immigrant families and practitioners. Families gave more importance to children's health, isolation, day care and education, whereas practitioners suggest that the mother's health and the couple's relationship pose greater concerns (16).

Among Canadian immigrants who neither speak English nor French, serious communication problems lead them to receive deficient treatment, extended hospital stays, unnecessary testing, premature discharge and problematic follow-up (17). A national study of literacy shows that 28% of adults born outside Canada have extreme difficulty reading English or French. Illiteracy was more of a problem for women – (32% of women are illiterate compared to 24% of men (18). It has been observed that apart from having direct effect on health, language barriers also have a central impact on the entire range of social functions, specifically: education, economics, housing, employment, politics and law. Limited language skills also manifest themselves in other areas, such as perceived discrimination in employment opportunities or housing, thereby directly affecting the economic stability of immigrant families (11). Immigrants with limited language proficiency are generally unable to assist their children with their educational efforts. This fact, coupled with the clash of cultures – the "new" culture versus the former indigenous one – represents a clear and present danger to immigrants' family values and mores.

Determinants of Health

At every stage of a person's life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. These factors are known as determinants of health. Determinants of health include income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills as well as healthy child development. Others are biology and genetic endowment, health services, gender, culture, social exclusion and immigration experience. However, only a few of these determinants will be elaborated upon here.

Employment/Working Conditions

Unemployment, underemployment, stressful or unsafe work are known to be associated with poorer health. However, as is the case with any general population, they are known to affect immigrants differently. These primarily serve as obstacles to immigrants' health improvement.
People who have more control over their work circumstances and fewer stress related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities. There is also evidence from the second report on the health of Canadians that employment has a significant effect on a person's physical, mental and social health. The connection between employment and health is obvious. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. It is well known that when a person loses these benefits, the effects can be debilitating on both the health of the individual and his or her family.

People who are without employment have a reduced life expectancy and suffer significantly more health problems than people who have a job. Conditions at work (both physical and psychosocial) and workload can have intense effect on people's health and emotional well being.
It has been shown that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families as well as their communities (2).

Gender

Sex is a biological variable that narrows down to being a man or a woman. Being a man or a woman is associated with specific roles in a society. Gender is a broader term that encompasses sex. Gender refers to the assortment of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. The norms that a society has regarding gender or sex influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.

Being a man or a woman also influences health care utilization and the nature and extent of health improvement barriers. For instance, there is a much greater expectation for women than men to present themselves for medical care or consultation. Women particularly are dependent on the health care system to ensure, control or terminate their fertility. Healthy and sexually active women aged below 50 and especially those between 50 and 59 years are expected to have a Pap smear and a mammogram. They also consult their doctor about the risk of osteoporosis at

50 and obtain a bone density test if 65 and older. Thus, there is always the likelihood of perpetuating the view that women are not only over-users of the system relative to men but also fall sick more than men. Typically, this misconception is made regardless of the inadequate analysis of the anatomy and physiology of a woman's body, which makes her a likelier and heavier user of health care resources.

Culture

Socio-economic environment can cause people to face additional health risks. Dominant cultural values in turn influence social and economic environment. The former contributes to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

Social Inclusion as a Determinant of Health

The concept of social exclusion focuses on the structures and dynamic processes of inequality among groups in society (19). Social exclusion also refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources. Inequalities relating to social exclusion arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion. Social exclusion takes four dimensions. These include exclusion from civil society, exclusion from social goods, exclusion from social production and economic exclusion.

Both individuals and communities experience social exclusion. Areas of social exclusion include adequate housing, employment, other social services, as well as stigmatization experience, isolation from civil society, higher health risks and lower health status. Groups vulnerable to social exclusion include Aboriginal peoples, immigrants and refugees, people with disabilities, single parents, children, youth and women in disadvantaged situations, older people and unpaid caregivers. Others are gays, lesbians, bisexuals, transgendered people, and minority groups of different backgrounds. It has been argued that poverty is one of the numerous factors that affect social exclusion (20)

Immigration as a Health Determinant

Analyses of immigration as a health determinant always seek to disentangle the factors that contribute to the changes in immigrants' health after their arrival in Canada. Because potential immigrants are screened on medical and other health-related criteria before they are admitted to the country, they are usually healthier than the Canadian-born population. Apart from the official medical screening, most applicants that seek to come to Canada are likely to be individuals with the stamina and motivation to undertake the rigours that immigration entails. Immigration researchers refer to this phenomenon as self-selection. Compared to native-born Canadians, however, immigrants lose their superior health advantage over time.

Immigration is a process that consists of a long series of cumulative stresses that have the potential to place excessive demands on the resources of immigrants and their families (21). Subsequently, such process affects immigrants' health. For instance, there is evidence that

suggests that socio-economic factors are important to self-reported health status and presence of chronic conditions for both immigrants and non-immigrants, but more so for immigrants (22).

Purpose of Study

The purpose of this study, which utilised CCHS 1.1 data, was to investigate the influence of some social and demographic factors on health improvement barriers of Alberta immigrants. The social and demographic factors or independent variables considered in the study include cultural/racial origin, length of residence in Canada, job status over past year, sex and income adequacy. Cultural/racial origin is considered under two categories, namely, white and visible minority. Length of residence in Canada is considered under 0 to 9 years and 10 years or more while sex, of course, is under male and female. Job status over past year has four response options, namely, job all past year, without work – looking (not looking), had job – looking, and other.

By investigating such variables as cultural/racial origin, length of residence in Canada, employment status, sex and income adequacy vis a vis health improvement barriers, this study has led to findings that will facilitate the appraisal of current immigration health policies in Alberta. It is also hoped that the recommendations of the study will help in developing health programs, which are better suited to the needs of immigrants.

Description of Study Variables

The dependent variable of this study is health improvement barrier of Alberta immigrants. The Canadian Community Health Survey (CCHS) data from which the study derived its data measured barrier to improving health with five-point response scale: yes, no, not applicable, don't know, refusal and not stated. However, for the purpose of using logistic regression, only response options of yes and no were considered. Thus, dichotomous data set was used. It was also reasoned that not applicable, don't know, refusal options were not as necessary as the yes and no options.

The independent variables of this research are social and demographic factors that are assumed to influence immigrants' barrier to improving health. The variables include cultural/racial origin, length of residence in Canada, job status over past year, sex and income adequacy. Cultural/racial origin is considered under two categories, namely, white and visible minority. Length of residence in Canada is considered under 0 to 9 years and 10 years or more while sex, of course, is under male and female. Job status over past year has four response options, namely, job all past year, without work – looking (not looking), had job – looking and other.

Method of Study, Data Source and Description

This study is a survey research that utilized secondary data. Cross-sectional data from the Canadian Community Health Survey (CCHS) – Cycle 1.1 (2000) were analyzed. The CCHS is a repeated, cross-sectional household-level survey. The CCHS Cycle 1.1 was conducted by Statistics Canada to provide cross-sectional estimates of health determinants, health status and health system utilization for 133 health regions across Canada. The sample comprised 125,574 individuals aged 12 years and older at the time of data collection, in 2000–2001. This included

14456 individuals from the province of Alberta. Of the 14456 Alberta respondents, 1815 were immigrants.

The focus of this study on Alberta is based on the fact that not much immigrant health research in Canada covers Alberta province. Many times it is provinces like Ontario, British Columbia and some others that are featured. This may be because Alberta is not so much a destination point for immigrants coming to Canada. However, available records show that net migration rose in Alberta in the mid- 1980s through the early 1990s and then dropped. It rose again in about 1995 and has maintained an upward trend ever since (23). The age distribution of Alberta's population differs slightly from the age distribution of Canada's population. Since Alberta has smaller proportions of older persons, the average age of Albertans is lower than the average age of Canadians residing outside Alberta. The age distribution of the province is also unique (23).

The foregoing, coupled with other factors such as the assumed low level social networks in the province of Alberta points to the need to further study the health of immigrants living in the province. Despite the fact that almost two out of three Albertans aged 15 and above reported in 1996/97 that their health was very good or excellent, the high rating of the province on such health indices as suicide justifies efforts to further study the health of Alberta immigrants.

Data Analysis

Crosstabulations were generated and frequency procedures also used to create tables. The study also obtained odds ratios as a basis for discussion. Proportions were also obtained as presented in Table 3.

Results

The focus of this study is mainly on immigrants in Alberta. However, for the purpose of providing good bases for comparison and discussion, data segments for immigrants were compared with the Canadian-born population in Alberta. The results of the analyses are hereby presented. Only significant results are interpreted.

Barriers to Improving Health

In Table 1, the logistic regression results for Alberta immigrants in respect of barrier to improving health show that immigrants without work and looking or not looking are .61 times less likely to report barrier to improving health than immigrants with job all past year. Results in Table 2, however, indicate that, in looking at the entire Alberta population sample, non-immigrants are .85 times less likely to report barrier to improving health than immigrants. In contrast, females are 1.23 times more likely to report barrier to improving health than males.

With regards to reason for immigrants not receiving care, it has been shown in Table 3 that waiting too long is the most pronounced reason with a 0.33 proportion of yes to total. This is followed by feeling/being inadequate (0.16), cost, and not available when require (0.14 each) and not available in the area (0.09) respectively. The least pronounced reasons for not receiving health care were other reason and language reason (0.00 each), personal/family responsibility (0.01) and transportation problem and dislikes doctor/afraid (0.02 each) in that order.

TABLE 1

Logistic Regression for Alberta Immigrants
Dependent Variable: *Barrier to Improving Health*

Independent Variables	**# of cases n = 1815**	**%**	**OR**	***p* value**
Sex				
Male	433	47.17	1.00	
Female	485	52.83	.88	.42
Cultural/racial origin				
White	588	65.84	1.00	
Visible minority	305	34.15	1.10	.56
Length/time in Canada since immigration				
0-9 years	181	19.72	1.00	
10 years or more	737	80.28	.94	.77
Income adequacy				
Low income	118	13.92	1.00	
Middle or high income	730	77.00	.98	.94
Job status over past year				
Job all past year	476	57.28	1.00	
Without work – Looking (Not Looking)	178	21.42	.61	.01*
Had job – Looking	166	19.98	1.03	.88
Other	9	1.08	.45	.27
Marital Status				
Married	525	57.25	1.00	
Common Law	28	3.05	1.25	.58
Widowed/Separated/Divorced	169	18.43	1.10	.66
Single	195	21.26	.79	.24

*Statistically significant @ 0.05 level

TABLE 2

Logistic Regression for General Alberta Population
Dependent Variable: *Barrier to Improving Health*

Independent Variables	**# of cases n =14456**	**%**	**OR**	***p* value**
Immigrant Status				
Yes	777	10.53	1.00	
No	6599	89.47	.85	.03*
Sex				
Male	5592	49.67	1.00	
Female	5667	50.33	1.23	.00*
Marital Status				
Married	3776	51.19	1.00	
Common Law	570	7.73	.97	.75
Widowed/Separated/Divorced	1057	14.33	1.33	.00*
Single	1973	26.75	.88	.03*
Income adequacy				
Low income	1145	10.17	1.00	
Middle or high income	10114	89.83	.98	.81
Job status over past year				
Job all past year	4715	63.92	1.00	
Without work – Looking (Not Looking)	1038	14.07	.00	.75
Had job – Looking	1567	21.24	1.01	.90
Other	56	0.76	.80	.41

*Statistically significant @ 0.05 level

TABLE 3
Reason for Immigrants not Receiving Care

Reason	**Response**		***Total***	***Proportion of Yes/Total***
	Yes	**No**		
Care not received - wait too long	74	147	221	0.33
Care not received - felt/be inadequate	36	185	221	0.16
Care not received – cost	32	189	221	0.14
Care not received - not available when require	30	191	221	0.14
Care not received - not available in the area	19	202	221	0.09
Care not received - didn't get around it	17	204	221	0.08
Care not received - too busy	14	207	221	0.06
Care not received - decided not to seek	10	211	221	0.05
Care not received - didn't know where	7	214	221	0.03
Care not received - dislikes doctor/afraid	5	216	221	0.02
Care not received - transportation problem	4	217	221	0.02
Care not received - personal/family responsibility	2	219	221	0.01
Care not received - language problem	1	220	221	0.00
Care not received - other reason	1	220	221	0.00
Total	252	2842	3094	

Discussion

It appears that having job all past year create barriers for Alberta immigrants to improve their health. This reasoning stems from the present research's finding that Alberta immigrants without work and looking or not looking are less likely to report barrier to improving health than Alberta immigrants with job all past year. For the general Alberta population however, the study has shown that non-immigrants are less likely to report barrier to improving health than immigrants. Immigrants are generally poorer and less knowledgeable about available opportunities. Many of them encounter language and other cultural problems. Social exclusion among them includes lack of access to social, economic, political and cultural resources. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion (19,20).

Barriers to improving health are not limited to immigration status. This study has found that barrier involves gender as well. Females are more likely to report barrier to improving health than males. Based on this realization, it could be argued that women's reported heavy use of health services is as much an ability to overcome the barriers that they face as the actual need to take care of their health problems. Concerning health research on immigrant and refugee women, research (24) has observed that sex and gender are particularly important health determinants to consider. This is important when considered on the basis that policies can create bias against women.

As well, there are barriers that women face in access to services. This is apart from the fact that the cultural conflict that may occur for women immigrating from countries with different gender-role expectations cannot be underestimated. Thus, research (24) further points to the need to clarify the significance of gender as a determinant of health alongside other social characteristics, such as socio-economic status, paid and unpaid work, age, exposure to stressors. An overview of migration and health research found that the family and job responsibilities of many immigrant women make it difficult for them to use existing health care resources (2).

Previous research (25) has suggested that culturally sensitive health care must take into account the gender-specific experiences and needs of women within each ethnic or immigrant group for users and providers. According to Weinfeld, the concept of ethnic match can be conceptualized along three dimensions: the ethnic origin of professional personnel; the ethnic auspices of the organization delivering care; and the actual practice. This model could be extended to include sex/gender, though this raises some issues for research and practice. Research (26) indicates that, in order to develop culturally responsive health care, it is necessary to focus not only on health care providers, but to look at the social and cultural context of health care organizations and the broader social and cultural environments.

Conclusion

This study utilized Cycle 1.1 of the Canadian Community Health Survey (CCHS) to examine the health improvement barrier of immigrants in Alberta. Apart from health the health improvement barrier, which was the dependent variable, some social and demographic independent variables including cultural/racial origin, length of residence in Canada, job status, sex and income adequacy were also investigated. Findings generally revealed or confirmed a complex interplay of job status, sex and immigrant status, which affect immigration health access experiences in Alberta, Canada.

Job status, immigrant status and sex differently influenced the outcomes of the study. This has led to the conclusion that in order to understand the issues that affect the health and welfare of immigrants, the issues need to be treated holistically rather than discretely. As well, ensuring the success of health and welfare efforts presupposes that immigrants and residents for whom health projects and policies are meant, and who know what they want more than anybody, should always be carried along as a matter of necessity.

Recommendations

Based on the findings of this study, the following recommendations have been made:

1. This study found that Alberta immigrants without work and looking or not looking are less likely to report barrier to improving health than immigrants with job all past year. This presupposes that being employed all year round presents some barriers to improving health among Alberta immigrants employed all year round. In the light of this, government and other employers of labour and providers of health services should put machinery in place to remove health improvement barriers that seem to be associated with regular employment in Alberta. This could be achieved partly by conducting additional research on how to address health barriers for immigrant groups. In particular, further research is necessary to determine how to address the needs of sub-groups within the community. These may include the young, elderly, homeless, and those affected by mental health disorders.

2. Females face more barriers to improving health than men. But they are more frequent users of health services in Canada (27). Expectedly, they are more likely than males to report good health. While removing health-improvement barriers experienced by the genders, government should as well deliberately initiate action aimed at persuading the male and female subpopulations to maximally utilize health services. Some of the health improvement barriers that relate to culture (of immigrants) and which need to be removed are language, education, disabilities, and race among others. These need to be eliminated for the benefit of immigrants who experience them the most.

3. Non-immigrant groups are less likely to report barriers to improving health than immigrants. This indicates the difficulties that many immigrants face as they seek to improve their health. Their experiencing of the difficulties might just be related to social and economic realities that immigrants uniquely face. In talking about peculiarities, the manifestation of social exclusion variables readily comes to mind. Therefore, government needs to further understand the health improvement challenges of immigrant groups with a view to tackling them in a sustainable manner. Studies on barrier and access issues have echoed concerns raised by settlement organizations and groups representing disadvantaged populations in general. Therefore, more research should be conducted to further explore lack of access and the need for appropriate services. There is need to build partnerships with community-based organizations/immigrant groups in order to address potential cultural bias in research. This will ensure appropriateness and accessibility of the research.

4. It is further recommended that more efforts should be made to increase understanding by health care providers and plans of barriers to care and the consequences of delayed or denied services. This may come partly by way of providing training and materials to lay health educators, who will teach, inform and promote awareness on various health issues in a linguistically and culturally competent manner.

5. As well, particularly vulnerable immigrant groups like the disabled might do better if granted more autonomy regarding their health care. Closely linked to this is the need for increased knowledge and skills on the part of health care providers and plans with respect to disability and its associated challenges.

6. In line with the view expressed elsewhere (11), it is also suggested that government should utilize the expertise available through credible community-based organizations (CBOs) for assistance in primary research activity. Expanding outreach by community-based entities funded to address disparities within the immigrant community will also yield positive results. The same goes for the development and funding of Health Care Advocates Initiatives for vulnerable immigrant groups.

7. In other health jurisdictions like California in the United States, efforts have been made to initiate and/or expand English language tutorial programs for linguistically deficient immigrant groups (11). The idea behind such move is that better mastery of language (English) would reduce immigrants' sense of alienation and increase their self-confidence and ability to interact with their children and society at large. Also in California, public

hearings have been organised along with other steps taken to promote awareness of immigrant issues, to engage decision makers – in the public and private sectors – to facilitate the removal of legal, cultural and linguistic barriers to health care, employment, education, transportation, and housing. All these go hand in hand with town meetings where health authorities and health providers rob minds with the community, particularly those stakeholders who participated in a given study, on the findings and recommendations.

Limitations of Study

This study, like any other, has a number of limitations. The first limitation is in the area of limited sample size and the second is in the fact that the study utilized secondary data and as a result is unable to establish cause and effects among variables of interest. Also worthy of mention are the data gaps that the Canadian Community Health Survey (CCHS) data, like any secondary data, has. For instance, this study would have examined length of stay in Canada at more than two levels, but only two levels, namely, 0-9 years and 10 years and above were available for consideration. Job status and cultural/racial origin categorizations were also limited. Due to some of the aforementioned shortcomings, generalizing the findings of the study might as well pose some limitations.

Furthermore, the CCHS data are self-reported or proxy-reported, and the degree to which they are inaccurate because of reporting error is poorly understood or not even known at all. Again, no independent source was available to confirm respondents' claims. In the same vein, terms like length of residence might be difficult to understand because immigrants would have either reported their cumulative or discrete periods of residence without the researcher utilizing the data knowing.

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References

1. CDC (2004). Access to Health-Care and Preventive Services among Hispanics and Non-Hispanics --- United States, 2001--2002. *MMWR Weekly*, October 15, 53(40);937-941.
2. Health Canada (1999). Canadian Research on Immigration and Health: An Overview.
3. Pérez, C.E. (2002). Health Status and Health Behaviour among Immigrants. *Supplement to Health Reports*, Volume 13.
4. Canada Health Act (1984). http://www.parl.gc.ca/information/library/PRBpubs/944-e.htm.
5. Immigration and Refugee Protection Act 2001. http://laws.justice.gc.ca/en/I-2.5/index.html
6. Chen, J., Ng, E. & Wilkins, R. (1996). The Health of Canada's Immigrants in 1994-95. *Health Reports*, 7(4): 33-45.
7. McKay, L., Macintyre, S., and Ellaway, A. (2003). Migration and Health: A Review of the International Literature. Glasgow: Medical Research Council Social and Public Health Sciences Unit.
8. Lou, Y.G. (2004). An empirical study of the "healthy immigrant effect" with Canadian Community Health Survey. Presentation at Canadian Population Society 2004 Annual Meetings, University of Manitoba, Winnipeg, 3 June.

9. Hyman, I. (2004). Setting the stage: reviewing current knowledge on the health of Canadian immigrants: what is the evidence and where are the gaps? *Can J Public Health.* 2004 May-Jun;95(3):I4-8.
10. Stephenson, P.H. (1995). "Vietnamese refugees in Victoria, B.C.: An overview of immigrant and refugee health care in a medium-sized Canadian urban centre." *Social Science and Medicine,*40(12): 1631-42.
11. The California Endowment (2005). Language Barriers & Health Access Issues of Black Immigrants of African Descent: Giving Voices to the Voiceless. Summit Health Institute for Research and Education, Inc. March 2005.
12. Carl, J.E. (ed.) (1996). *Perspectives on Racism and the Human Services Sector: A Case for Change.*Toronto: University of Toronto Press.
13. Cairns, D. (1993). "The role of the dental hygienist in a multicultural society: Review of literature 1988-1993." *Probe,* 27(5): 177-81.
14. Anderson, A.B. (1993). "Review essay: The significance of ethnicity in Canada." *Ethnic and Racial Studies,* 16(4): 719-26.
15. Ontario Women's Health Bureau (1993). *Immigrant, Refugee and Racial Minority Women and Health Care Needs: Report of Community Consultations.* Toronto: Ministry of Health.
16. Legault, G., Gravel, S. Sylvie, S. et al. (1997). "Adaptation of services to new immigrant families: Perceptions of families and practitioners." *Canadian Journal of Community Mental Health,* 16: 67-85.
17. Saldov, M. (1991). "The ethnic elderly: Communication barriers to health care." *Canadian SocialWork Review,* 8(2): 269-77.
18. Boyd, Monica (1992). "Reading skills of the immigrant population." *Canadian Social Trends* (Autumn): 22-4.
19. Galabuzi, G. (2002). *Social Exclusion.* A paper and presentation given at The Social Determinants of Health Across the Life-Span Conference, Toronto, November 2002.
20. Raphael, D. (2001). *From increasing poverty to societal disintegration: How economic inequality affects the health of individuals and communities*, in H. Armstrong, P. Armstrong and D. Coburn (Eds.). *Unhealthy Times: The Political Economy of Health and Care in Canada*. Toronto: Oxford University Press.
21. Folkman, S., & Lazarus, RS (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21, 219-239.
22. Dunn, J.R.& Dyck, I. (2000) Social determinants of health in Canada's immigrant population: results from the National Population Health Survey. *Social Science & Medicine*, 51: 1573-1593.
23. Alberta Health and Wellness (2003). Health Trends in Alberta: Working Document.
24. Mulvihill, M.A., Mailloux, L. & Atkin, W. (2001). Advancing Policy and Research Responses to Immigrant and Refugee Women's Health in Canada. The Centres of Excellence in Women's Health.
25. Vissandjée, Bilkis, Nicole Leduc, Jean Renaud et al. (1998). *Promotion, prévention : le temps de séjour fait-il une différence pour les femmes sud-asiatiques ayant immigrées au Québec.* Montreal: Centre d'excellence pour la santé des femmes. Quoted in Health Canada (1999). Canadian Research on Immigration and Health: An Overview.
26. Anderson, J., S. Tang and C. Blue (1999). "Health systems renewal: Writing in cultural plurality" (Research on immigration and integration in the Metropolis Working Paper Series #99-08). Vancouver: Research on Immigration and Integration in the Metropolis.

27. Kazanjian, A., Morettin, D., Cho, R. (2004). Health Care Utilization by Canadian Women. *BMC Women's Health*, Vol: 4 Issue: Suppl 1 Pages/record No.: S33.