Older Immigrants' Access to Primary Health Care in Canada: A Scoping Review

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RÉSUMÉ

Le vieillissement et l'immigration ont significativement transformé la composition démographique au Canada, et les immigrants y représentent une proportion croissante de la population adulte plus âgée. L'accès adéquat aux services de santé est essentiel au bien-être et à l'inclusion sociale de cette population. Cet examen de la portée porte sur les connaissances actuelles concernant l'accès des immigrants d'âge avancé aux médecins omnipraticiens et à leur consultation, considérant que ces médecins jouent un rôle central dans la prestation de soins de première ligne, dans les soins préventifs et les soins de santé mentale. Le modèle en 5 étapes d'Arksey et O'Malley a été utilisé pour effectuer des recherches dans une grande variété de bases de données pour des articles publiés en anglais dans des revues avec comité de pairs concernant ce sujet dans le contexte canadien. Un total de 31 articles répondant aux critères d'inclusion ont été examinés en détail. Ces articles ont été classés en fonction de l'information disponible sur leurs auteurs, la population à l'étude, la méthodologie, le domaine de la santé et les obstacles mentionnés. Trois thèmes principaux ont émergé de cet examen de portée : l'accès et l'utilisation des soins de première ligne, la promotion de la santé et le dépistage du cancer, ainsi que l'utilisation des services de santé mentale. Les immigrants d'âge avancé font face à des obstacles en termes d'accès aux soins et ceux-ci seraient liés à la littératie en santé, à la langue, à la culture, aux croyances en matière de santé, aux inégalités spatiales et à des circonstances structurelles. L'examen de la portée présente de manière détaillée l'accès aux soins des personnes âgées immigrantes au Canada, et permet de dériver des implications sur les politiques qui permettraient de répondre à leurs besoins qui sont non comblés dans le domaine de la santé.

ABSTRACT

Aging and immigration have significantly shaped the population composition in Canada, where immigrants make up increasingly large proportions of the older adult population. This scoping review examines the existing knowledge surrounding older immigrants' access to, and utilization of, primary care physicians, who play a pivotal role in the delivery of primary care, preventive care, and mental health care. We applied Arksey and O'Malley's five-stage framework to search databases for Canadian-based, peer-reviewed English-language articles on the topic and examined 31 articles in detail. Three focus areas emerged: access and utilization of primary care, health promotion and cancer screening, and utilization of mental health services. Older immigrants face intertwining access barriers related to health literacy, language, culture, health beliefs, spatial inequality, and structural circumstances. The review provides a thorough understanding of the status of access to care among older immigrants in Canada, and yields policy implications to address their unmet health needs.

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Background

The global population is rapidly aging. According to the United Nations (2015), adults over the age of 60 accounted for 9.9 per cent (607 million) of the world's population in 2000. This share increased substantially, to 12.3 per cent (901 million), in 2015, with projected increases to 16.5 per cent in 2030 and 21.5 per cent in 2050. The older population, whose age cut-off may vary in different contexts and regions, is growing faster in urban areas, and the aging process is most advanced in developed countries. In Canada, older persons are the fastest-growing age group. In 2016, 16.9 per cent of Canada's population was aged 65 or older, compared to 7.6 per cent in 1961, and for the first time the number of older people surpassed the number of children (0–14 years). The older population is projected to make up a quarter of Canada's population by 2036 (Statistics Canada, 2016).

International migration is another global trend that has shaped the demographic landscape worldwide, particularly in major immigrant-receiving countries such as Canada, the United States, the United Kingdom, and Australia. Canada has seen an increasing influx of newcomers, particularly from Asia and the Middle East (Statistics Canada, 2016). Although immigrants represent 21 per cent of Canada's total population, they make up 30 per cent of the country's older population (65 years and older) (Statistics Canada, 2011). In major urban centres, immigrants make up large proportions of the overall older adult population. In the Toronto Census Metropolitan Area, for example, immigrants account for 48 per cent of the total population but 70 per cent of the population over age 65 (Statistics Canada, 2011).

Immigrants living and aging in a foreign country face many settlement challenges, creating a demand for essential services such as health services (Dean & Wilson, 2010; Joo & Lee, 2016; Tsoh et al., 2016; Zhou, 2012). They often underutilize health services and encounter multiple access barriers related to language, culture, health beliefs, cost, lack of health insurance, location (e.g., availability and distance), and socioeconomic status (Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Thomson, Chaze, George, & Guruge, 2015; Wang & Kwak, 2015). These barriers to health care access could have a great impact for aging immigrants because of their advanced years, decreasing mobility, and low socioeconomic status, which may further affect their health status (Dean & Wilson, 2010; Subedi & Rosenberg, 2014).

Older immigrants with a longer length of residence in their host country than newcomers in general show a higher prevalence of self-reported health status and chronic diseases compared to non-immigrants and younger immigrants (Creatore, Moineddin, Booth, Glazier, & Manuel, 2012; Kennedy, Kidd, McDonald, & Biddle, 2015; McDonald & Kennedy, 2004). However, a healthy immigrant effect among newcomer older adults is somewhat evident (Gee, Kobayashi, & Prus, 2004). Recent immigrants including older immigrants usually arrive in the country healthier than the Canadian-born population and long-term older immigrants (Gee et al., 2004; Laroche, 2000; Wang & Palacios, 2017). In the first six months to two years after arriving, older immigrants begin to experience physical and mental health problems due to migration and settlement challenges and stress related to cultural differences, discrimination, environmental adaptation, dietary changes, or difficulties with the health care system (Ahmed et al., 2016; Sanou et al., 2014; Thomson et al., 2015). After approximately 10 years living in Canada, they experience further health decline, and their health status becomes inferior to that of their Canadian-born counterparts (Ahmed et al., 2016; Gee et al., 2004; Guruge et al., 2015a; Sanou et al., 2014).

As one of the five principles of the Canada Health Act (CHA), *accessibility* is meant to guarantee that provincial health insurance plans "provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (Government of Canada, n.d.). The underlying sentiment of accessibility in the CHA is to ensure equal access to medically necessary services for all Canadians regardless of their age, immigration status, or socioeconomic status (Ahmed et al., 2016; Wilson & Rosenberg, 2004). However, a recent review by Kalich, Heinemann, and Ghahari (2016) found many health care barriers facing immigrants in Canada, affecting both their ability to access care and the quality of care they receive. Other studies have identified both individual and structural barriers facing immigrants in accessing primary health care or mental health services (Ahmed et al., 2016; Crawford, Ahmad, Beaton, & Bierman, 2016; Thomson et al., 2015). To date, no review has focused specifically on older immigrants, arguably the most vulnerable among the immigrant population.

In Canada, the emphasis on "aging in place" is often coupled with inadequate and constraining funding and staffing challenges for long-term care (Brazil, Maitland, Ploeg, & Denton, 2012; Heckman, Kelley, Stolee, & Strachan, 2014; Williams et al., 2016). This has led to an increased dependence on primary health care, delivered mainly by primary health care physicians (PHPs) or family physicians to older adults living in home or community settings. However, shortages of physicians – in particular, family physicians – have been a long-standing and pressing issue in Canada due

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to the country's aging population, aging physicians, and physician maldistribution in different geographic areas (Dove, 2009; Heckman et al., 2014; McElroy, 2004; Pong, 2008; Silver, 2017). These factors collectively put older immigrants at a disadvantage with respect to accessibility of timely, quality, and culturally competent health care.

The purpose of this scoping review is to summarize the existing research and knowledge concerning older immigrants' access to, and utilization of, health services in Canada. The focus is primary health care delivered mainly through PHPs, who also play an important role in managing mental health care and other specialized areas such as cardiovascular and diabetes care as well as monitoring, screening, and preventive care. Thus, relevant research on accessing mental health services, health promotion, and chronic disease prevention is also included in the review, to gain a comprehensive understanding of barriers, challenges, and facilitators in terms of older immigrants' access to care in Canada. Services that are typically not covered by provincial (universal) health insurance plans – such as optometry, dentistry, and therapies that require extended health insurance – have been excluded from the review.

The review provides a thorough understanding of the status of access to health services among older immigrants in a publicly funded health care system. It yields implications for developing public health policies that address the unmet health needs of older immigrants. The findings will contribute to our knowledge of the adequacy of the Canadian health care system in providing needed care to older immigrants in the context of "aging in place".

Methodology

The study used the five-stage framework for conducting a scoping review outlined by Arksey and O'Malley (2005): (1) identifying the research question, (2) identifying relevant studies, (3) reviewing and selecting relevant studies for the final review, (4) charting the data or key information from the studies under review, and (5) summarizing and reporting the results. The broad research question used to guide the review was as follows: What are the experiences of older immigrants in Canada in accessing primary health care? We conducted the search using the library database of the authors' institution, which collectively searches a large number of electronic databases, including Summon, MEDLINE, PubMed, Proquest, Scopus, Google Scholar, Web of Science, PsycInfo, ERIC, and Health Systems Evidence. In Canada and many other developed countries, "older adults" are those aged 65 years and older. The World Health Organization (WHO) and some developing countries where life expectancy is shorter than in Canada use various age cut-offs for defining older adults (e.g., 55 and older, 60 and older) (World Health Organization, n.d.). As many older immigrants in Canada come from developing nations, a 55-and-older cut-off is deemed appropriate, as it reflects the cultural differences in viewing aging and older populations (Turcotte & Schellenberg, 2006).

Our inclusion criteria for the search results were as follows: (a) articles written in English, (b) peer-reviewed, (c) focus on older immigrants' access to care, and (d) Canadian context. We conducted four rounds of keyword search or until the relevance was saturated. The first search used a combination of keywords, including seniors OR older adults AND immigrant AND Canada AND primary health care OR primary physician. A total of 200 records were generated. After screening by title, we deemed 91 of these to be relevant. The keyword search was then updated to include "barrier" as a keyword. However, this yielded the same search results. The second keyword search included health services AND seniors OR older adult AND immigrant AND barrier. A total of 200 records were generated, 79 of which were related to the research question. Combining the relevant records from the first and second searches and removing duplicates yielded 161 relevant records. A third search used the following keywords: barrier OR access to health care AND older OR senior AND immigrants. It yielded 96 new and relevant records. A fourth search included the following keywords: barrier OR access to health care AND older AND spatial OR distance. It also yielded 200 results, although the relevance was saturated at 100 results, including three duplicates and 41 relevant new articles. In total, we chose 298 articles for in-depth review. Although no minimum year limit was put on the search results, all of the selected articles were published between 2002 and 2017.

The in-depth review process (see Figure 1) consisted of two steps: (a) screening of all 298 articles by abstract, and (b) reading of all remaining articles in full. Consultation with two experienced researchers in the field generated six more articles, resulting in 304 articles to be screened by abstract. After screening by abstract, 97 articles remained for full reading. The reference lists of the 25 most relevant articles (of the 97) were scanned, yielding an additional 67 relevant references. After screening by abstract, only 25 were deemed relevant. Therefore, we read 122 articles in full, 31 of which met the inclusion criteria and were included in the scoping review. In an effort to collate the articles in the scoping review, we charted all 31 selected articles based on author information, study population (ethnicity/origin, age, sample size, location), methodology (method, design, analysis), health topic, and barriers (see Table 1).

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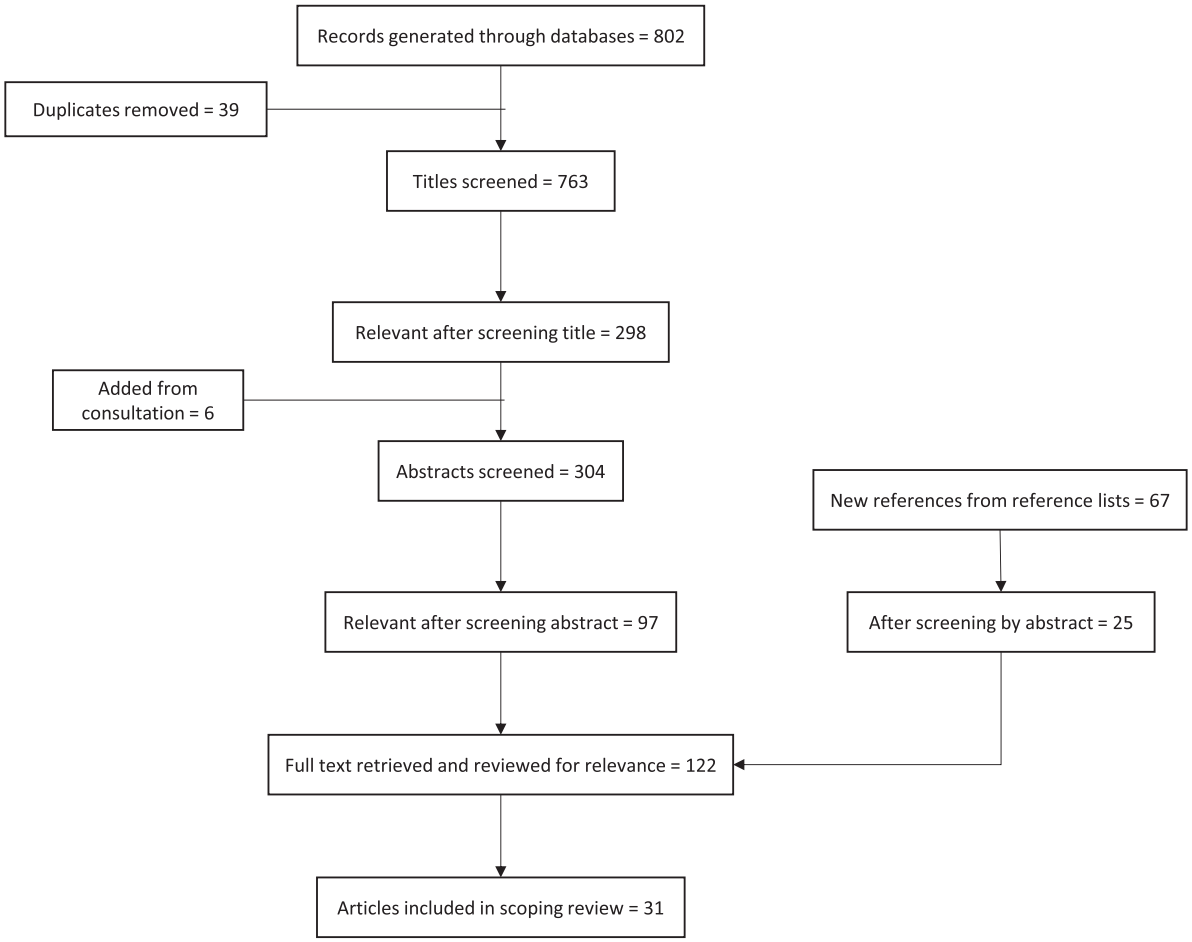

Figure 1: Research methods for scoping review

Results

Overview of Selected Studies

Of the 31 studies we included in the scoping review, 10 per cent (n = 3) were based on data collected from one study (Lai & Surood, 2010; Lai & Surood, 2013; Surood & Lai 2010). All three studies were included in the analysis because they were based on different aspects of health care access and service utilization. Approximately 29 per cent (n = 9) focused on women, 55 per cent focused on seniors only (n = 17), and 16 per cent involved service providers. In these studies, older immigrants were defined differently, as age 50 and older, 55 and older, or 65 and older, or using vague terms such as "elderly" or "older adults".

All of the studies were Canadian-based. Sixteen were set in Ontario (n = 16; 44%), with nine (n = 9) focusing on the Greater Toronto Area and one (n = 1) comparing urban and suburban Ontario. Eight of the studies (n = 8; 22%) were set in Alberta, with seven (n = 7) focusing on Calgary. Other study settings included Montreal (n = 2); British Columbia (n = 2); and St. John's, Newfoundland, and Labrador (n = 1). Seven studies used large data sets across Canada (n = 7). One study (n = 1) used data from seven Canadian cities: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal. In terms of study population, several studies (n = 14; 39%) focused on broad, region-encapsulating groups such as South Asian (n = 10), Hispanic and Latin American (n = 3), West Asian (n = 3), and Arabic immigrants (n = 4; 11%). Other studies examined country-specific groups such as immigrants from China (n = 9; 25%), South Korea (n = 1), Vietnam (n = 1), France (n = 1), and Iran (n = 1). A few studies (n = 7; 19%) were comparative, examining the immigrant versus the non-immigrant population. Nine studies (n = 9; 25%) included more than one immigrant group; these covered a range of some 23 different groups (see Table 1).

Approximately 39 per cent (n = 14) of the studies employed qualitative methodology, 30 per cent (n = 11) used a quantitative approach, and 30 per cent (n = 11) used a mixed-methods approach. Sample sizes ranged from 8 to 1,700. In the researchers' analyses, approximately 69 per cent of the studies (n = 25) used primary data collected from interviews or questionnaires, 25 per cent (n = 9) used secondary data, and 6 per cent (n = 2)

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Table 1: Summary of articles included in the review

Author(s) & Year	Study Population	Methodology	Focus	Barriers Mentioned
Ahmad & Stewart (2004)	*Ethnicity/origin:* South Asian *Age:* 25–60 *Sample:* 54 women *Location:* Toronto, Canada	*Method:* qualitative *Design:* cross-sectional survey *Analysis:* logistic regression	Factors influencing utilization of breast examination services among South Asian immigrant women.	Perceived barriers (related to health literacy, health belief, time/priority, discomfort in examination) and age are found to influence using clinical breast examination through family physicians.
Amankwah et al. (2009)	*Ethnicity/origin:* Chinese, South Asian, Latin American, Southeast Asian, West Asian, Japanese, Korean, Filipino, Arab *Age:* 18–65 *Sample:* women from CCHS *Location:* Canada	*Method:* quantitative *Design:* cross-sectional survey *Analysis:* logistic regression	Assessing why visible minority women in Canada do not participate in cervical cancer screening.	Health beliefs and language affect cervical cancer screening. Older immigrants are less likely to have used the service. A culturally appropriate cervical cancer screening intervention program is needed.
Asanin & Wilson (2008)	*Ethnicity/origin:* Pakistan, India, China, Romania *Age:* 15–65+ *Sample:* 53 people *Location:* Mississauga, Canada	*Method:* qualitative *Design:* cross-sectional focus groups *Analysis:* thematic analysis	Exploring perceptions of access to care to explain low health care utilization among the immigrant population.	Barriers include geographic (unfamiliar with public transit systems), socio-cultural (language barriers) and economic inaccessibility. Community agencies are needed to assist in making physicians more accessible for immigrants and culturally/linguistically appropriate care is needed.
Chow (2010)	*Ethnicity/origin:* Chinese *Age:* "seniors" *Sample:* 147 older adults *Location:* Calgary, Canada	*Method:* mixed *Design:* cross-sectional questionnaire *Analysis:* logistic regression, factor analysis	Factors impacting the physical and mental health of Chinese older adults in Canada.	Cultural barriers and language barriers identified as reasons seniors may not participate in the Canadian healthcare system. Cultural beliefs about aging influence the decision to seek care. Culturally appropriate and linguistically appropriate healthcare services are needed.
Chow (2012)	*Ethnicity/origin:* Chinese *Age:* "elderly" *Sample:* 127 older adults *Location:* Calgary, Canada	*Method:* mixed *Design:* cross-sectional interview *Analysis:* Regression	Identifying the factors that contribute to overall life-satisfaction for Chinese older adults.	Geographic and cultural access to services identified as barriers. Service needs include ethnic nursing homes, ethnic senior centres, and transport and homemaker services.
Crawford et al. (2015)	*Ethnicity/origin:* Arab, Chinese, South Asian, Vietnamese *Age:* 40+ *Sample:* 82 women *Location:* Canada	*Method:* qualitative *Design:* cross-sectional focus groups and individual interviews *Analysis:* thematic analysis	A qualitative examination of immigrant women's experiences with a peer health educator and the impact his has on breast cancer screening practices.	Structural barriers (such as the availability of information on cancer screening) as well as language barriers were identified. The peer health educators' involvement in the same culture/language was proven effective.
Donnelly (2006)	*Ethnicity/origin:* Vietnamese *Age:* 49–78 *Sample:* 15 women, 6 providers *Location:* Canada	*Method:* qualitative *Design:* cross-sectional interview *Analysis:* thematic analysis	Exploring the participation of Vietnamese-Canadian women in breast and cervical cancer screening.	Cultural values as a barrier to participation, as well as values concerning the patient–physician relationship. Education and outreach programs needed in order to raise awareness of the importance of screening practices.

Continued

Table 1: Continued

Author(s) & Year	Study Population	Methodology	Focus	Barriers Mentioned
Gesink et al. (2014)	*Ethnicity/origin:* 'immigrant' *Age:* n/a *Sample:* 121 adults, 19 providers *Location:* Urban/Suburban Ontario, Canada	*Method:* qualitative *Design:* cross-sectional focus groups *Analysis:* thematic analysis	Determining the under- and never-screened population in Ontario.	The under- and never-screened populations comprise vulnerable populations, including immigrants. Barriers for immigrants receiving preventive care were identified as stigma or cultural taboo, communication barriers, and health beliefs.
Gupta et al. (2002)	*Ethnicity/origin:* South Asian *Age:* 18–60 *Sample:* 124 women *Location:* Toronto, Canada	*Method:* qualitative *Design:* cross-sectional questionnaire *Analysis:* T-tests, bivariate analysis	Identifying whether acculturation level or educational attainment impacts South Asian women's knowledge of cervical cancer screening.	Barriers to screening identified as a lack of knowledge, health beliefs (many women deemed Pap tests unnecessary) and discomfort. Low levels of acculturation associated with low prevalence of having had a Pap test.
Kirmayer et al. (2007)	*Ethnicity/origin:* Caribbean, Vietnamese, Filipino *Age:* n/a *Sample:* 1700 people *Location:* Montreal, Canada	*Method:* qualitative *Design:* cross-sectional survey *Analysis:* logistic regression	Determining immigrants have low usage of mental health services in Canada with universal health care, as they do in the United States.	Immigrant status and cultural background as barriers to accessing mental health services. Specifically, patient perception that physicians are not interested in the social aspects of the issues as well as the cultural stigma of receiving mental health care.
Koehn (2009)	*Ethnicity/origin:* Vietnamese, Hispanic, Punjabi *Age:* 65+ *Sample:* 56 older adults, 26 providers *Location:* Vancouver, Canada	*Method:* qualitative *Design:* cross-sectional focus group *Analysis:* candidacy framework	Assessing the access-related concerns to health care for ethnic minority older adults.	Barriers to health care identified as language barriers, immigration status, and limited knowledge of the health care system. A need for professional interpreters and language-specific health care providers was identified.
Koehn et al. (2016)	*Ethnicity/origin:* South Asian *Age:* 53–87 *Sample:* 100 older adults *Location:* Suburb in British Columbia, Canada	*Method:* qualitative *Design:* cross-sectional interview and focus groups *Analysis:* thematic analysis	Assessing the ways the Seniors Support Services for South Asian Community project have impacted utilization of health promotion and recreation services.	Barriers to services include language barriers, transportation, health literacy, knowledge of the health care system, time, and geographic proximity.
Lai & Chau (2007)	*Ethnicity/origin:* Chinese *Age:* 55+ *Sample:* 2214 Chinese older adults *Location:* Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, Montreal; Canada	*Method:* mixed *Design:* cross-sectional interview *Analysis:* logistic regression	Assessing predictors of service barriers faced by older Chinese immigrants.	Barriers were identified as being female, single, lack of transportation, a shorter length of residency in Canada, low income, lack of social networks, and "traditional" health beliefs. There is a need for services being provided in various languages that is culturally appropriate.
Lai & Surood (2010)	*Ethnicity/origin:* South Asian *Age:* 55+ *Sample:* 220 South Asian older adults *Location:* Calgary, Canada	*Method:* quantitative *Design:* cross-sectional survey *Analysis: Principle Component Analysis*	Examining the barriers to health service utilization experienced by South Asian older adults.	The barriers for South Asian older adults were identified to include cultural incompatibility (language, cultural attitudes), personal attitudes, administrative/service delivery issues (inconvenient hours), and circumstantial challenges (cost of services, lack of transportation).

Continued

Table 1: Continued

Author(s) & Year	Study Population	Methodology	Focus	Barriers Mentioned
Lai & Surood (2013)	*Ethnicity/origin:* South Asian *Age:* 55+ *Sample:* 220 South Asian older adults *Location:* Calgary, Canada	*Method:* quantitative *Design:* cross-sectional survey *Analysis:* multiple regression	Determining which access barriers (cultural incompatibility, personal attitudes, administrative issues, or circumstantial challenges) have the largest negative impact on physical and mental health.	Barriers included cultural incompatibility, personal attitudes, administrative issues, and circumstantial challenges. Personal attitude revealed worse physical and mental health status. Culturally appropriate strategies should be adopted to help South Asian older adults overcome these access barriers.
Lofters et al. (2010)	*Ethnicity/origin:* 'immigrant' *Age:* 25-69 *Sample:* census *Location:* Ontario, Canada	*Method:* quantitative *Design:* retrospective cohort study, RPDB, DAD, OCR, Ontario Physicians' Claims Database *Analysis:* regression	Examining the rates of cervical cancer screening for women in Ontario.	Screening rates are lowest for older women and immigrant women. South Asian women were identified to have the lowest rates of cervical cancer screening. Cultural beliefs were identified as a possible barrier.
McDonald & Kennedy (2007)	*Ethnicity/origin:* Hispanic, Arab, West Asian, South Asian, Southeast Asian, Filipino, Chinese, Korean, Japanese *Age:* n/a *Sample:* CCHS *Location:* Canada	*Method:* quantitative *Design:* cross-sectional, NPHS (National Population Health Survey) *Analysis:* logistic regression	Analyzing cervical cancer screening practices of immigrant women compared to the native-born population and comparing how screening differs by ethnic background.	It was identified that recent immigrants have very low prevalence of cervical cancer screening, specifically Asian immigrants. Barriers identified include language, and a lack of understanding of the Canadian health care system.
Ng et al. (2014)	*Ethnicity/origin:* 'immigrant' *Age:* 65+ *Sample:* census *Location:* Ontario, Canada	*Method:* quantitative *Design:* cross-sectional, DAD *Analysis:* logistic regression, zero-truncated negative binomial model	Determining odds of hospitalization for immigrant and Canadian-born older adults.	The lower odds of hospital service usage by immigrant older adults was found to be due to cultural beliefs/behaviors and lower health literacy. Recent immigrants are more likely to experience a health decline but less likely to be hospitalized.
Sadavoy et al. (2004)	*Ethnicity/origin:* Chinese, Tamil *Age:* 55+ Tamil, 65+ Chinese *Sample:* 16 physicians, 10-18 older adults per focus group *Location:* Toronto, Canada	*Method:* qualitative *Design:* cross-sectional focus groups *Analysis:* thematic analysis	Determining the barriers to accessing mental health services experienced by Chinese and Tamil older adults.	Barriers identified included a lack of linguistically and culturally appropriate mental health care and a lack of referrals. A need for ethnic mental health workers was identified, especially for ethnic minority older adults.
Stewart et al. (2011)	*Ethnicity/origin:* Chinese, Afro-Caribbean, former Yugoslavian, Spanish *Age:* 55+ *Sample:* 48 immigrants, 26 service providers *Location:* Alberta, Canada	*Method:* qualitative *Design:* cross-sectional interview *Analysis:* thematic analysis	Exploring general service barriers for immigrant older adults in Canada.	Barriers identified included a lack of culturally competent care (language difficulties, discrimination), a lack of transportation, financial issues, health problems, and a lack of social networks. Culturally sensitive programs are needed.

Continued

Table 1: Continued

Author(s) & Year	Study Population	Methodology	Focus	Barriers Mentioned
Sun et al. (2010)	*Ethnicity/origin:* Arab, West Asian, South Asian, Southeast Asian, Filipino, Chinese, Korean, Japanese *Age:* 50–69 *Sample:* CCHS *Location:* Canada	*Method:* mixed *Design:* cross-sectional *Analysis:* logistic regression	Breast cancer screening practices of Asian immigrant women compared to Canadian women.	The main barrier to screening is the inability to speak the official language. Asian immigrant women were found to have lower rates of screening. More efforts are needed for the recruitment of immigrant women to participate in breast cancer screening.
Surood & Lai (2010)	*Ethnicity/origin:* South Asian *Age:* 55+ *Sample:* 220 *Location:* Calgary	*Method:* mixed *Design:* cross-sectional survey *Analysis:* regression, Andersen-Newman service utilization model	Examining the impact of South Asian cultural factors on utilization of health care services.	Cultural incompatibility (including language) as well as a stronger identification with traditional South Asian health beliefs were determined to be barriers to accessing care.
Tiagi (2016)	*Ethnicity/origin:* 'immigrant' *Age:* 18+ *Sample:* CCHS *Location:* Canada	*Method:* quantitative *Design:* cross-sectional *Analysis:* logistic regression, zero-truncated negative binomial model	Comparing health service utilization between recent immigrants, established immigrants, and Canadian-born.	Hypothesis of potential barriers include cultural/linguistic barriers, discrimination in service offices, and a shortage of family physicians. Provincial efforts needed in order to facilitate recent immigrant access to health care services.
Tieu et al. (2010)	*Ethnicity/origin:* Chinese *Age:* 55–87 *Sample:* 53 older adults *Location:* Calgary, Canada	*Method*: mixed *Design:* cross-sectional interview *Analysis:* chi-square test	Analyzing depression literacy among Chinese older immigrants and Canadian-born older adults.	A lack of mental health literacy as well as cultural beliefs/stigma surrounding mental health are the main barriers. Services and support used by Chinese older adults should include mental health education.
Todd et al. (2011)	*Ethnicity/origin:* Chinese *Age:* 50+ *Sample:* 103 women *Location:* Ontario, Canada	*Method:* mixed *Design:* cross-sectional interview *Analysis:* thematic analysis, chi-square test, Fisher's exact test, t-test	Exploring predictors of breast and colon cancer screening for older Chinese immigrant women.	Barriers identified for older Chinese women include a lack of health literacy surrounding screening practices, cultural factors (such as modesty), language/communication barriers, a lack of physician recommendation, and the gender of the physician.
Todd & Hoffman-Goetz (2011)	*Ethnicity/origin:* Chinese *Age:* 50+ *Sample:* 50 women *Location:* Ontario, Canada	*Method:* mixed *Design:* cross-sectional interview *Analysis:* thematic analysis, chi-square test, Fisher's exact test	Exploring the preferences and behaviors of cancer information seeking of older Chinese immigrant women.	Language and limited time with physicians were identified as barriers to accessing cancer information. Cancer information that is in line with cultural norms and languages is needed.
Todd & Hoffman-Goetz (2011)	*Ethnicity/origin:* Chinese *Age:* 50+ *Sample:* 106 women *Location:* Ontario, Canada	*Method:* quantitative *Design:* cross-sectional questionnaire *Analysis:* t-tests, logistic regression	Exploring predictors of health literacy among older Chinese immigrant women.	Language was identified as a barrier as well as being an older woman and having a low level of acculturation. Preventive care and information in Chinese languages is needed in order to improve health literacy.

Continued

Table 1: Continued

Author(s) & Year	Study Population	Methodology	Focus	Barriers Mentioned
Vahabi (2011)	*Ethnicity/origin:* Iranian *Age:* 25+ *Sample:* 50 immigrants *Location:* Toronto, Canada	*Method:* qualitative *Design:* cross-sectional interview *Analysis:* chi-square test, t-test	Analyzing breast cancer screening knowledge and practices among Iranian women.	Barriers to screening and cancer screening information were identified as low health literacy, cultural factors (Iranian women tend to avoid talking about cancer for "fear of bad luck"), language, and low level of acculturation (p. 270).
Wang (2007)	*Ethnicity/origin:* Chinese *Age:* adults *Sample:* 317 survey respondents *Location:* Toronto, Canada	*Method:* mixed *Design:* cross-sectional, survey, census data *Analysis:* gravity-based accessibility measure	Exploring how Chinese immigrants choose between ethnic family doctors and other family physicians.	Spatial inequity was identified for Chinese immigrants to access culturally appropriate care. A spatial mismatch between language-suitable physicians and the settlement pattern of Chinese immigrants was examined.
Wang et al. (2008)	*Ethnicity/origin:* Chinese *Age:* adults including older adults *Sample:* 154 adults *Location:* Toronto, Canada	*Method:* mixed *Design:* cross-sectional, focus groups, census data *Analysis:* thematic analysis	Identifying how immigrants from Mainland China choose physicians and the reasons for why culturally/linguistically appropriate services are utilized.	A strong preference is revealed for Chinese immigrants for Chinese-speaking family physicians due to language and cultural reasons. However, spatial access barriers impede receiving culturally and linguistically appropriate care.
Wang & Kwak (2015)	*Ethnicity/origin:* Korean *Age:* adults including older adults *Sample:* 351 adults *Location:* Toronto, Canada	*Method:* mixed *Design:* cross-sectional, focus group, CCHS *Analysis:* statistical & thematic	Exploring healthcare seeking behaviors of South Korean immigrants as well as their use of transnational care.	Barriers to accessing the Canadian health care system for Korean immigrants include socio-cultural (language, lack of social networks), economic (a lack of health insurance to cover "other" necessary health care) and geographic (spatial mismatch between culturally appropriate health care and the members of society they are meant to serve) barriers.

Note. **CCHS = Canadian Community Health Survey; DAD = Discharge Abstract Database from Canadian Institute for Health Information (CIHI); OCR = Ontario Cancer Registry; RPDB = Registered Person's Database.**

used mixed primary and secondary data. The study researchers used a wide range of secondary data sources, such as the Canadian Community Health Survey (CCHS), the National Population Health Survey (NPHS), the Ontario Physicians' Claims Database, and the Ontario Cancer Registry (see Table 1).

Summary of the Studies

We organized the 36 articles into three focus areas: primary health care access and service utilization, health promotion and cancer screening, and mental health service utilization.

Primary Health Care Access and Service Utilization

Family physicians play a pivotal role in providing primary care to older immigrants and helping them to manage chronic illnesses, which are generally most prevalent among older adults. Several studies focus on health care access among older immigrants from various ethno-racial communities, such as South Asian (Surood & Lai, 2010); Afro-Caribbean, former Yugoslavian, and Spanish (Stewart et al., 2011); and Chinese (Chow, 2012; Lai & Chau, 2007). Older immigrants face intertwining barriers associated with language and discrimination, lack of culturally appropriate programs, lack of awareness of health services that are available, cultural differences in service use, health beliefs, and transportation (Lai & Chappell, 2006; Lai & Surood, 2013; Thomson et al., 2015). Poor access to health services often goes hand in hand with insufficient financial, human, and information resources, as well as a general "inadequate geographical coverage" of services, resulting in resettlement challenges for older immigrants (Guruge et al., 2015a, 2015b). Older immigrants with limited proficiency in the country's official languages may use improvised sign language, use friends or family members as interpreters, or, occasionally, hire someone as an interpreter (Stewart et al., 2011; Surood & Lai, 2010). Some older Vietnamese and Hispanic immigrants have expressed an unwillingness to use family interpreters because they are reluctant to ask family members to take time off work (Koehn, 2009), whereas some French-speaking immigrants have shown a reluctance to use interpretation services during physical examinations for reasons of privacy and accuracy of interpretation (Ngwakongnwi, Hemmelgarn, Musto, Quan, & King-Shier, 2012).

Many older immigrants have developed a reliance on hospital emergency rooms and walk-in clinics as alternatives to using PHPs, not by choice but because of constraints related to the aforementioned barriers. Tiagi (2016) found that recent immigrants were less likely to visit a family practitioner and more likely to visit an emergency room, while the opposite was observed for established immigrants. Therefore, recent older immigrants are at a disadvantage in managing health during the resettlement period. Compared to both recent and established immigrants, Canadian-born populations were found to be more likely to use general practitioner services intensively. Older immigrants in Mississauga, Ontario – specifically, those from China, India, Pakistan, and Romania – were found to rely on walk-in clinics or emergency rooms for health care because general practitioners in their neighbourhood were not accepting new patients (Asanin & Wilson, 2008). As a result, older immigrants with limited mobility are particularly challenged, as they are less likely to travel to other neighborhoods for health care. Although older immigrants may turn to hospital emergency rooms due to a lack of access to PHPs, it should be noted that recently arrived older immigrants in Ontario had lower rates of hospitalization than long-term immigrant and Canadian-born seniors (Ng, Sanmartin, Tu, & Manuel, 2014). This likely reflects the superior health status of older recent arrivals, as well as their unmet health needs and poor health literacy (Ng et al., 2014).

Health Promotion and Cancer Screening

A number of studies explored the barriers to health promotion and preventive care, such as cancer screening, which for older immigrants is primarily delivered or monitored by PHPs. Health illiteracy, language barriers, cultural differences, unavailability of services locally, declining mobility, and lack of transportation act collectively to prevent older immigrants from accessing health promotion programs, seeking cancer information, and participating in cancer screening (Gesink et al., 2014; Koehn, Habib, & Bukhari, 2016; Todd, Harvey, & Hoffman-Goetz, 2011; Todd & Hoffman-Goetz, 2011). Screening for breast and cervical cancers has been studied for different immigrant groups in various Canadian cities and regions. Iranian immigrant women in Toronto specifically and South Asian immigrant women generally were found to be challenged by a lack of knowledge about service location, screening procedures, and where to obtain relevant information (Ahmad & Stewart, 2004; Vahabi, 2011). Sun et al. (2010) found that Asian immigrants used mammogram services much less than non-immigrants and that language was one of the main factors: an Asian immigrant woman who spoke English or French was three times more likely to have ever had a mammogram. A preference for a female physician was an important factor in the use of breast cancer screening for Arab, Chinese, South Asian, and Vietnamese immigrants (Crawford, Frisina, Hack, & Parascandalo, 2015).

In Ontario, cervical cancer screening rates have been especially low for older women in low-income areas and for those who have immigrated recently as older adults (Lofters, Moineddin, Hwang, & Glazier, 2010). Similarly, racialized women have shown low rates of participation in cervical cancer screening compared to white women (Amankwah, Ngwakongnwi, & Quan, 2009). Low screening rates have been seen in various groups, including Vietnamese and South Asian women in Toronto (Donnelly, 2006; Gupta, Kumar, & Stewart, 2002). The barriers and challenges to cervical cancer screening include lack of knowledge about screening practices and the benefits of having a Pap test; cultural differences; language issues; and not having a family physician. McDonald and Kennedy (2007) compared Canadian-born and immigrant populations (Hispanic, Arab, West Asian, South Asian, Southeast Asian, Filipino, Chinese, Korean, and Japanese) with regard to participation in cervical cancer screening. Although immigrant women have lower rates of Pap testing than Canadian-born women, the rates for immigrant women have increased with the number of years spent in Canada. Although screening rates differ by ethnic background, most immigrant women approach the same rates as Canadian-born women after 15 to 20 years in Canada. However, screening has remained low for Asian women who have been living in Canada for 15 to 20 years.

Mental Health Service Utilization

Immigrants in Canada have typically underutilized mental health services (Kirmayer et al., 2007; Thomson et al., 2015). Recent immigrants in Ontario have had lower rates of using mental health services compared to long-term immigrants and native-born Canadians, whereas immigrants from Asia and the Pacific have used mental health services the least (Durbin, Moineddin, Lin, Steele, & Glazier, 2015).

There is a dearth of knowledge regarding older immigrants' use of mental health services, with limited scholarship focusing on large ethnic groups such as South Asians and Chinese. Chinese and Tamil older adults in Toronto have faced difficulties in accessing mental health services as reported by Sadavoy, Meier, and Ong (2004). The challenges include too few mental health workers, limited awareness of mental disorders, reliance on ethnic-specific agencies that do not address mental health, and reluctance of families to acknowledge mental illness due to the cultural stigma associated with it. Health illiteracy, language issues, and health beliefs are considered the main barriers. In a study examining mental health literacy among older Chinese in Calgary, Tieu, Konnert, and Wang (2010) found that only 11.4 per cent of those surveyed were able to correctly identify depression, compared to 74 per cent for the general population. According to Lai and Surood (2013), a number of factors can explain and predict the use of both physical and mental health services among older South Asian immigrants. These are cultural incompatibility, traditional South Asian health beliefs, personal attitudes, administrative problems, and circumstantial challenges. Researchers have recommended strategies for providing culturally competent health promotion, prevention, and intervention as a means to improve the delivery of mental health services to this group.

Intersecting Factors of Access to Health Services

The review identifies a number of intersecting factors that shape older immigrants' access to and use of health services. These factors include health literacy, language and cultural barriers, health beliefs, spatial access, and structural barriers. They influence access to needed health services and are the key areas where recommendations and practical implications can be drawn to enhance delivery of care to older immigrants with unmet health needs. These factors have been summarized in the context of population aging and unequal distribution of health services, while highlighting major trends and difficulties with health care access among older immigrants.

Health Literacy

One of the main barriers to cancer screening for older immigrants, especially women, has been health illiteracy related to the nature of screening, service availability, and service location (Ahmad & Stewart, 2004; Amankwah et al., 2009; Crawford et al., 2015; Donnelly, 2006; Gesink et al., 2014; Gupta et al., 2002; Koehn et al., 2016; Lofters et al., 2010; Todd & Hoffman-Goetz, 2011; Vahabi, 2011). Also, some older immigrants have found the Canadian health care system confusing and hard to navigate when seeking primary health care (Chow, 2012; Lai & Chau, 2007; Ngwakongnwi et al., 2012; Ng et al., 2014; Tiagi, 2016). Lee, Choi, and Park (2014) found older age to be a significant predictor of poor health literacy (2014). They reported that mental health literacy is particularly limited among older immigrants. In addition, any health-service information that is available may not be available in the desired language or may not be compatible with older immigrants' cultural values and traditions.

Cultural and Language Barriers

The growing number of older immigrants in Canada suggests an increasing demand for culturally appropriate health services (McDonald, 2011). This scoping review has identified a common set of barriers related to culture and health beliefs, communication, knowledge about health care resources, and settlement experiences. Increased length of residence in Canada has

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usually led to increased acculturation and health literacy, which in turn should improve screening for breast and cervical cancer among older immigrant women (Ahmed & Stewart, 2004; Vahabi 2011). However, screening rates have remained low for Asian immigrants who have been in Canada for 15 to 20 years, which suggests that cultural values or traditions may be the main barrier to cancer screening (McDonald & Kennedy, 2007).

Proficiency in the receiving country's official language(s) is regarded as a key measurement of acculturation (the process of change in immigrants' culture and value systems that occurs when they are exposed to the host country's mainstream culture). Older immigrants generally have had few opportunities to learn and become proficient in English. Limited proficiency has been a persistent barrier to older immigrants obtaining health information, using screening services, and accessing primary health care and mental health care (Asanin & Wilson, 2008; Crawford et al., 2015; Gesink et al., 2014; Jang, Yoon, Park, & Chiriboga, 2016; Koehn, 2009; Lai & Chau, 2007; Lai & Surood, 2010; Ngwakongnwi et al., 2012; Páez, Mercado, Farber, Morency, & Roorda, 2010; Stewart et al., 2011; Sun et al., 2010; Tiagi, 2016; Todd & Hoffman-Goetz, 2011; Todd et al., 2011; Wang, Rosenberg, & Lo, 2008). Language barriers are related to poor health outcomes among older immigrants. Professional interpreters, family members, and even technologies (e.g., Google Translate) can serve to facilitate communication. However, researchers have found that very often both physician and patient experience discomfort when confidential health information is being discussed with an interpreter, whose translations may be inaccurate or even biased, with potential medical and ethical implications (Ginde, Clark, & Camargo, 2009; Koehn, 2009; Ngo-Metzger et al., 2007; Ngwakongnwi et al., 2012; Sears, Khan, Ardern, & Tamim, 2013).

Cultural competency has been recognized as an important factor in addressing culturally specific health needs, improving quality of care, and reducing ethnic disparities in health status and health care access (Eshleman & Davidhizar, 2006). It is particularly important in the delivery of care to older immigrants who face language barriers and have strong traditional values and health beliefs. Our review indicates that older immigrants in Chinese and South Asian communities find that their traditional health beliefs are not honored in Western health care systems. It also indicates that cultural differences between care providers and patients can affect communication and treatment due to misinterpretation of patients' symptoms and difficulty transmitting mainstream Western medical knowledge to patients from traditional ethnic communities (Lai & Chau, 2007; Wang et al., 2008; Surood & Lai, 2010; Chow, 2012). In this regard, cultural competency has come to mean more than just providing care in ethnic languages through the use of multilingual health practitioners or interpretation services. It also has meant being open to different health beliefs and practices, and actively promoting health, including mental health, to minority groups. Cultural competency is especially pertinent in the delivery of mental health services to communities whose older members may not necessarily acknowledge mental health issues due to the stigma of mental illness.

Geographical Barriers and Spatial Access

Since the frequency of trip-making decreases with age, and since travel is needed in most cases of health care utilization, older immigrants face increasing geographical barriers in accessing health services. Geographical barriers result from spatial discordance (or spatial mismatch) between where culturally appropriate health services (such as those provided by PHPs) are located and where older immigrants reside. They have limited access to care for older immigrants with restricted mobility, no means of transportation, poor health status, and low socioeconomic status (Koehn et al., 2016; Lai and Surood, 2010; Páez et al., 2010; Stewart et al., 2011). Clustering of physicians and health services in high density urban neighbourhoods in proximity to large hospitals results in underserved neighbourhoods in terms of access to culturally appropriate care for older immigrants. For example, older Korean immigrants in Toronto have traveled a greater distance, often by bus, to access Korean-speaking family physicians compared to those who communicate with PHPs in English (Wang & Kwak, 2015). Research conducted from a geographical perspective has found a general spatial discordance between the distribution of PHPs and access to linguistically appropriate PHPs for different immigrant groups in various cities in Ontario (Bissonnette, Wilson, Bell, & Shah., 2012; Wang, 2007). This means that immigrants often must travel out of their neighbourhood to access the small number of culturally appropriate PHPs who accept new patients. Koehn et al. (2016) has found that in low density suburban areas in British Columbia, older South Asian immigrants, particularly women, with limited spatial access to health services and transportation are isolated and must rely on family members for transportation and translation.

Socioeconomic and Structural Barriers

The challenges that older immigrants face in accessing primary health care reflect the general shortage of physicians in Canada as well as a shortage of physicians and other health care providers who speak non-official languages. For example, although an important

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predictor of breast and colon cancer screening is having a doctor's recommendation, immigrants face a structural barrier when seeking a culturally appropriate PHP in close proximity who accepts new patients (Amankwah et al., 2009; Tiagi, 2016; Todd et al., 2011). Even though Canada has a publicly financed health care system, older immigrants still face economic barriers in accessing care. Provincial insurance plans cover only "medically necessary hospital and physician services," and provinces may charge their residents a health care premium to help pay for publicly funded services. Without extended health insurance, which is normally obtained through employment or purchased privately, low-income older immigrants cannot access eye care, dental care, or other essential services, including mental health services.

Financial barriers are reported to be a significant factor for older Korean immigrants in Toronto requiring care not covered by provincial health insurance plans, such as eye care and dentistry, which have been in high demand among older members of the Korean community (Wang & Kwak, 2015). Older Chinese immigrants who are financially disadvantaged have been further disadvantaged by the barriers they encounter when attempting to obtain needed services or resources (Lai & Chau, 2007). Older immigrants of low socioeconomic status or those who have recently arrived are particularly disadvantaged, as they are often excluded from the Canadian pension system because of their limited work years in Canada.

Conclusion and Discussion

As a core issue in research on migration and health, access to health care plays a critical role for older immigrants, who are more vulnerable than both younger immigrants and the non-immigrant population, in health management during the resettlement period. Canada's publicly funded health care system is aimed at ensuring equal access to health care for all, regardless of age and immigration status. Yet older immigrants encounter more barriers to health-service access and have higher rates of self-reported chronic diseases than both younger immigrants and their Canadian-born counterparts (Creatore et al., 2012; Kennedy et al., 2015; McDonald & Kennedy, 2004). This scoping review offers an in-depth analysis of the current literature on the experiences of older immigrants in accessing health services, particularly primary health care, in Canada. The findings of this scoping review reveal that the main barriers to accessing care – including primary health care, preventive services, and mental health care – are related to health literacy, linguistic and cultural differences, spatial access, and structural circumstances. Many older immigrants are socioeconomically disadvantaged and have limited access to Canadian pension plans. Low socioeconomic status not only influences service access, but is a key social determinant of health. The review makes an important contribution to the literature on health-service delivery and immigrant health, as it informs our understanding of the health care experiences of older immigrants, the fastest growing age group in Canada.

The scoping review has several limitations. Only studies published in English were considered. Most of the studies reviewed used primary data sources and were qualitative in their design and analysis. In the literature search process, the reference lists of only 25 studies were searched for additional sources. Most of the studies reviewed focused on men and women collectively, whereas the gender-specific studies focused only on women and their challenges as older immigrants. There were no studies focusing on men. The global gender ratios (as of 2013) are 85 men for every 100 women aged 60 to 79 and 61 men for every 100 women aged 80 and over. The majority of immigrants to Canada tend to be men, rendering the absence of male-based studies a limitation (Guruge et al., 2015b). Only four studies in the scoping review involved service providers, and these studies did not focus solely on the perspectives of service providers but included them with the perspectives of older immigrants.

In terms of region, most of the studies were based in Ontario or Alberta, with some based in British Columbia, Quebec, and Newfoundland and Labrador. No research surrounding older immigrants' health care access was identified for other Canadian provinces or territories. Another limitation concerns the broad scope of the study populations, such as South Asian, with little emphasis on the heterogeneity of various populations and ethnicities within the group (Crawford et al., 2016). Several studies focused on South Asian or Chinese communities, which are Canada's two largest immigrant groups (Koehn, Neysmith, Kobayashi, & Khamisa, 2013). Recent immigrants from other "non-traditional" source countries or regions in East Asia, Southeast Asia, and Africa are underrepresented in the literature (Thomson et al., 2015). However, since Asian immigrants account for 50 per cent of immigrants in most English-speaking countries, this review can be helpful in other political and geographical contexts (Guruge et al., 2015b).

Several future research directions are identified. These include research on geographical access to health care and service distribution; qualitative research from the perspective of service providers; research that focuses on older immigrant men; comparative research on older immigrants living in urban versus rural areas; and research on older recent immigrants from a diverse range

of global regions (e.g., Africa, the Middle East, Eastern Europe, South America) who are underrepresented in the extant literature. We also need research that acknowledges the heterogeneity of certain ethnic groups (such as South Asian) and how this impacts health care access and health outcomes among older members of these groups.

This scoping review focused on immigrants with legal status in Canada and with provincial health care coverage. Future research could examine the experiences of older migrants with refugee, undocumented, or other precarious status. Longitudinal research will be useful in tracking the progression, or lack thereof, of health care access over time among older immigrants. Wang and Kwak (2015) reported that older Korean immigrants engage in transnational health practices, including travel to South Korea for care, importing medications, and consulting service providers in their homeland by phone or email, due to challenges experienced in meeting their health needs in Canada. Future research could investigate the prevalence of transnational health practices among other older immigrant groups and the possible relationship between these practices and barriers to health care access.

The findings of this review will serve to inform policies on and the delivery of health services and programs for older immigrants. Some of the policy implications of the findings include establishment of ethnic nursing homes, full insurance coverage for medical translators under provincial health care programs, and improvements to health literacy education for older recent immigrants, so that they receive adequate and timely information about the Canadian health care system and available resources. Health literacy education will inform older immigrants about the importance and availability of primary health care, mental health services and screening services, and where to go and who to talk to regarding questions related to health services. Efforts to enhance the delivery of culturally competent health care to older immigrants should go hand in hand with services to promote the social inclusion of older immigrants, enhance social support, and reduce exposure to discrimination. Community-based initiatives should consider all older immigrants, especially those in materially deprived neighbourhoods, thereby contributing to the overall well-being of the older immigrant community. The findings of the review also suggest the need to build age-friendly communities where policies, services – including health services – transportation, settings, and structures support and enable the healthy aging of immigrants in both urban and rural environments (Keating, Swindle, & Fletcher, 2011; Neville, Napier, Adams, Wham, & Jackson, 2016).

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