Barriers and Solutions to Healthcare Access for Immigrants in Canada

Obstacles et solutions à l'accès aux soins pour les immigrants au Canada

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Abstract

Canada has higher rates of immigration than many high-income countries. Provinces' health systems have been slow to adapt new policies and practices to accommodate the newcomers. New immigrants are left to "shoehorn" themselves into health systems that were not designed for their languages, culture or preferences for care. For immigrants, language barriers impede communication, undermine the clinician-patient relationship and discourage healthcare-seeking behaviours. New policies are needed to break down barriers, so provinces' health systems do not exacerbate health inequalities.

Résumé

Le Canada connaît des taux d'immigration plus élevés que de nombreux pays à revenu élevé. Les systèmes de santé provinciaux ont tardé à adapter les politiques et pratiques pour

accueillir les nouveaux arrivants. Les nouveaux immigrants doivent « se débrouiller » dans des systèmes de santé qui n'ont pas été conçus pour leur langue, leur culture ou leurs préférences en matière de soins. Pour les immigrants, les barrières linguistiques entravent la communication, nuisent à la relation clinicien-patient et découragent la recherche de soins. De nouvelles politiques sont nécessaires pour éliminer les obstacles afin que les systèmes de santé des provinces n'exacerbent pas les inégalités en matière de santé.

Introduction

The Government of Canada is expanding immigration and planning on welcoming over 350,000 new permanent residents each year from 2025 to 2027 (Government of Canada 2024). These record-high levels of immigration will result in major shifts in the Canadian demographic landscape, with immigrants projected to comprise a major portion of the population by 2041 (Statistics Canada 2022). Under the *Canada Health Act* (1985), provincial and territorial governments are responsible for providing equal access to publicly funded healthcare services for all insured residents regardless of immigrant status. However, having equal access to immigrants is not always the case. Immigrants to Canada are more likely to have experienced difficulties accessing physician-based services (Ahmed et al. 2016).

The "Healthy Immigrant Effect" suggests that immigrants arrive healthier than their non-immigrant counterparts, but this advantage declines over time. This hypothesis posits that immigrants tend to arrive in good health and use fewer healthcare resources than non-immigrants due to a complex interaction between socio-economic, linguistic and cultural factors (Ahmed et al. 2016). These factors have been shown to impact quality of care, navigation of healthcare services and rapport with healthcare providers (HCPs; Schouten et al. 2020). Once arrived in Canada, however, immigrants experience poorer adherence to treatments, worsening health status over time, inappropriate use of emergency departments and reliance on non-evidence-based medical treatments (Ahmed et al. 2016; Wang et al. 2019). Not addressing the barriers that immigrants face in accessing care may cause inappropriately low use of primary and specialist physician services, poorer adherence to preventative care and decreased utilization of mental health services than non-immigrants (Ahmed et al. 2016; Kalich et al. 2016).

While immigrants as a group face common barriers to healthcare access, it is essential to recognize their heterogeneity (Statistics Canada 2022). Different immigrant categories, including economic immigrants, refugees and family-sponsored immigrants, experience distinct challenges based on language proficiency, socio-economic status and settlement location. For instance, skilled workers entering through programs such as the Federal Skilled Worker Program (Government of Canada 2025a) or Provincial Nominee Program (Government of Canada 2025b) must demonstrate official language proficiency, yet their family members may still face linguistic barriers (Government of Canada 2024). Immigrants

settling in urban areas with established cultural communities often encounter more culturally tailored healthcare services, whereas those in rural regions may face greater difficulties accessing language-concordant care. These variations must be accounted for in policy solutions to ensure equitable healthcare access.

Canada's provincial policy makers need to implement policies to ensure equal opportunities for accessing publicly funded healthcare and means for overcoming economic, linguistic and cultural disparities that immigrants face. Otherwise, provincial governments will face a surge in demand for healthcare among aging immigrants owing to avoidable poor health outcomes, which will contribute to declining performance of their health systems. This paper will articulate problems faced by immigrants in accessing healthcare and provide options to reduce these barriers through a policy lens.

Barriers to Healthcare Access

Language proficiency – barriers

Lower rates of healthcare utilization among immigrants have been partially attributed to the social divide patients experience due to perceived or actual language deficits (Lebrun and Dubay 2010; Payán et al. 2022; Wang and Kwak 2015). New immigrants report fear and frustration with being misunderstood during medical encounters (Kalich et al. 2016). The challenges in articulating symptoms in the English or French language, coupled with a limited grasp of medical terminology, contribute to suboptimal healthcare experiences among immigrants who are not fluent in the official languages of their new country (Payán et al. 2022). This challenge is most noticeable within the context of fee-for-service payment models for physicians, which create incentives for brief clinical encounters that impede comprehensive information exchange and provide less opportunity to pose questions and advocate for preferences, potentially undermining their confidence in the clinical decision-making (Wang et al. 2019).

Limited proficiency in the official languages of the country in which healthcare is received also poses challenges in navigating the healthcare system through difficulties understanding follow-up instructions and how best to access care in a timely and safe way (Pandey et al. 2022). For example, written or verbal instructions given by office staff on symptom monitoring and when to seek medical care are often provided in English or French only, potentially leading to patient harm. Other instructions from providers, such as how to book further appointments, transit to the healthcare clinic and parking directions, require basic language proficiency.

Immigrants with limited English proficiency frequently turn to informal networks such as friends, religious leaders and communities of the same culture to gather health information (Wang et al. 2019). As a result, immigrants with limited English proficiency often depend on family members or friends to accompany them during healthcare visits at higher

rates than non-immigrants (Schouten et al. 2020). This reliance carries the burden of multiple individuals sacrificing time, forgoing workplace income and compromising confidentiality when discussing sensitive medical issues.

Language proficiency – solutions

Research regarding immigrants' access to healthcare has echoed the need for linguistically competent care and highlighted the value of language-concordant providers with transcultural knowledge (Etowa et al. 2021; Payán et al. 2022). A solution to bridging the language proficiency gap between HCP and immigrant is the use of trained medical interpreters. This service has been shown to not only be beneficial but also cost-efficient across multiple healthcare settings (Brandl et al. 2020). Other translational services ranging from smartphone-based translation applications to artificial intelligence software may supplement medical interpreters in a variety of clinical situations depending on availability of time and resources (Khander et al. 2018). Physician remuneration models should be adapted to accommodate patients who require language and cultural support and enhance the use of medical interpreters and translational services.

Provision of a comprehensive range of translational services is needed, not just for the health encounter, but also for administrative tasks around the appointment. This includes support for visit scheduling, appointment reminders and checking results of investigations, all factors shown to improve clinician-patient communication and overall satisfaction with care (Levine et al. 2022). Policy solutions must be tailored to different immigrant groups.

Cultural incongruence – barriers

Immigrants often retain health beliefs that diverge from the way "Western" medicine is predominantly practised in Canada (Schouten et al. 2020). Many immigrants embrace a holistic perspective, emphasizing social identity, family values, nutrition and existential purpose alongside physical and mental well-being (Weerasinghe and Mitchell 2007). Death and suffering may also be seen as penance from higher powers, to be endured in isolation or to be corrected through spiritual redemption leading to late presentations of treatable conditions (Ahmed et al. 2016), potentially leading to further harm of the individual (Saleem et al. 2019). These divergent views on the value of preventive medicine as a priority may reflect that "Western" medicine has been viewed as a last resort and only after spiritual or holistic options have been exhausted (Saleem et al. 2019). Examples include the use of coining and cupping in Chinese and South Asian cultures or use of "hot and cold medicines" in Middle Eastern cultures to aid in spiritual cleansing.

Immigrants have reported significant differences in non-verbal communication during healthcare encounters, impacting rapport-building with physicians, nurses, clinic staff and other allied health professionals (Pandey et al. 2022). Unintentional displays of rudeness or cultural insensitivity by healthcare professionals may make immigrants uncomfortable. For instance, the use of first names with elders, common in Western culture, may be perceived as

disrespectful in cultures that traditionally emphasize social hierarchies (Ahmed et al. 2016). Among cultures centred on modesty, patients may also hesitate to advocate for themselves and downplay the severity of their symptoms, which may hinder timely healthcare utilization (Ahmed et al. 2016; Kalich et al. 2016; Wang et al. 2019). As an example, East Asian or Middle Eastern patients have reported fear being considered incapable, impolite or intrusive of other's time, leading to a more passive role in healthcare encounters (Dastjerdi et al. 2012). Culturally specific bodily expressions, such as non-verbal cues in Filipino culture or head-shaking in Indian cultures, can also create confusion during patient-provider communication, impacting clinical decision-making (Saleem et al. 2019). However, it is important to recognize that within any cultural group, there exists a range of behaviours and preferences, and assumptions about passivity or reluctance may not be universally applicable.

Cultural practices may impact healthcare utilization through immigrants' reliance on alternate practices not offered in Western medicine. Several South Asian and Middle Eastern cultures view mental illness and chronic pain as punishments from God, turning to faith healers over mental health professionals (Wang et al. 2019). Chinese immigrants may choose to engage in traditional medicine and have mistrust for Western medicine practice due to perceived business-oriented motives (Wang et al. 2019). Preferences for same-gender providers and interpreters are strong among Middle Eastern and South Asian immigrants, which can lead to hesitancy to seek care even among those with severe symptoms (Ahmed et al. 2016; Saleem et al. 2019).

Cultural incongruence – solutions

Communication skills that reflect cultural competencies can be attained through cultural dexterity training, as demonstrated with cultural safety training for Indigenous communities (Turpel-Lafond 2020; Udyavar et al. 2018). Cultural dexterity curricula have been successfully established within department-level organizations by involving senior leadership, identifying systemic barriers to their provision and establishing buy-in at the system level (Udyavar et al. 2018). Moreover, cultural dexterity should be complemented by cultural humility, recognizing that each patient's beliefs and practices are dynamic and individualized. Instead of dismissing preventive medicine as non-evidence-informed, HCPs could foster a more inclusive and open-minded approach to patient care that integrates Western medicine. Furthermore, providers need to recognize culture-specific preferences, such as addressing elderly patients by their last names, prioritizing physical inquiries before delving into mental or social aspects and maintaining a respectful distance during interactions, which demonstrates cultural sensitivity and respect for the patient's values and traditions while remaining flexible in response to individual preferences (Ahmed et al. 2016; Kalich et al. 2016; Wang et al. 2019).

A broadening of patient-centred models of care that incorporates family-centred communication may improve the mutual understanding among immigrants from family-oriented cultures. Family members provide emotional support for the patient, advocate on their behalf

and provide information that is relevant to their treatment, while professional interpreters have the skills only for accurate interpretation and communication in a coordinated manner with the HCP (Schouten et al. 2020). However, it is essential to ensure that individual autonomy is respected in family-centred care. Practitioners should not default to involving family members in decision-making without first confirming the patient's preferences.

Implications for Clinical Practice and Provincial/Territorial Policies

A number of policy options are proposed to address the aforementioned barriers and solutions:

1. *Improve the utilization of trained medical interpreters in hospitals and clinics:* Ministries of health (MoH) should be the steward of the provision of translational services in their provinces' and territories' hospitals and physician clinics, establishing: (i) minimum service requirements, (ii) guidelines for appropriate timeliness of access to translational services and (iii) monitoring of the quality and effectiveness of translational services provided. The MoH should also be responsible for executing the policy, tailored to the local population's language needs.

   Privately managed clinics require a more nuanced approach, as the provision of services and supplies is often financed by physician practices. In these circumstances, the MoH should still fund or provide translational services that uphold minimum service requirements that are free of charge to the clinic and patient. Examples include phone or internet-based translation services that can be accessed by HCPs on site and used during the clinical encounter. Assessing the timeliness of access and effectiveness of the translational services will require a partnership between the MoH and private clinics for quality monitoring of services in the clinics.
2. *Train clinicians and office personnel to effectively use translational services:* As stewards of their health systems, provinces and territories should ensure that translational services that reflect the diverse language and cultural needs of the immigrants' communities are effectively used by HCPs. Community or local authorities should ensure that hospital staff, physicians and community-based providers are trained regarding the effective application of translational services. Compensation for training time for physicians to acquire skills or experience in translational services can be overseen by provincial governments and integrated into existing payment models or incentivized through continuous medical education (CME) credits.

   Provinces' physician payment models need to be modernized to improve opportunities for immigrants to overcome economic, linguistic and cultural differences that affect outcomes from healthcare. Current fee-for-service compensation models do not differentiate service provision based on whether translation services are used; fee modifier codes can be implemented to reflect extra time used for patients requiring translation services. For physicians remunerated with salary-based models, remuneration can be "tiered" to

reflect higher proportions of a physician's patient roster who are immigrants and with limited proficiency in Canada's official languages.

3. *Ensure that healthcare navigation processes are inclusive of different languages:* It is essential to offer translation services that extend beyond the actual healthcare encounter and include administrative tasks, such as appointment scheduling and accessing personal health information. Instructions for making appointments and further information seeking must be made available in multiple languages. Ensuring that these standards are met at the level of individual institutions may be best accomplished through province-level evaluations dedicated to upholding language-friendly health system navigation.
4. *Implement cultural dexterity training to foster trusting healthcare relationships:* The MoH should be the steward of the provision of standardized, relevant and sustainable models of cross-cultural training that reflect local immigrant populations. An example is the Provider Awareness Cultural Dexterity Toolkit for Surgeons curriculum used in surgical training programs in the US. Training will incorporate the cultural health beliefs and non-traditional healing methods based on local demographics. Quality and effectiveness of training will be assessed by the MoH through continuous feedback from clinicians as well as measures of patients' experiences with care. As mentioned earlier, compensation for training time for physicians can be overseen by provincial governments or incentivized through CME credits.
5. *Increase culturally diverse representation among healthcare personnel:* The MoH should establish policies to ensure the hiring of healthcare personnel with culturally diverse backgrounds that reflect the local population. This involves maintaining up-to-date data on the most common countries of origin for new immigrants. In addition, the MoH should disseminate these statistics to regional health authorities, hospitals and other publicly funded healthcare organizations tasked with hiring HCPs who share similar cultural backgrounds and preferences for care with their catchment areas' recent arrivals.

A tailored approach is essential to effectively serving the healthcare service needs of diverse immigrant populations facing unique challenges based on visa category, settlement location and cultural background. Rural locations pose additional barriers for provinces and territories to overcome; recruitment or training of culturally diverse healthcare personnel may be particularly challenging and may have to rely more heavily on remote translation services.

Conclusions

Multi-dimensional linguistic and cultural incongruence challenges are a growing problem for provinces' and territories' healthcare delivery systems that need attention by government and policy makers to minimize avoidable poor health outcomes among immigrants. Language translation is necessary but not sufficient to address the problems underlying immigrants'

barriers to accessing healthcare. Healthcare services more tailored to cultural and linguistic differences, especially in primary care, may result in more timely preventative care or earlier intervention for health conditions.

Canada has accepted the new arrivals and must be prepared for additional public spending so the newcomers do not receive "second-tier" healthcare. Provincial MoH need to take a leadership role in developing, implementing and evaluating robust policies to address inequities in access due to language and cultural differences.

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References

Ahmed, S., N.S. Shommu, N. Rumana, G.R.S. Barron, S. Wicklum and T.C. Turin. 2016. Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review. *Journal of Immigrant and Minority Health* 18(6): 1522–40. doi:10.1007/s10903-015-0276-z.

Brandl, E.J., S. Schreiter and M. Schouler-Ocak. 2020. Are Trained Medical Interpreters Worth the Cost? A Review of the Current Literature on Cost and Cost-Effectiveness. *Journal of Immigrant and Minority Health* 22(1): 175–81. doi:10.1007/s10903-019-00915-4.

Canada Health Act (R.S.C., 1985, c. C-6). Government of Canada. Retrieved Feb 7, 2026. <https://laws-lois.justice.gc.ca/eng/acts/c-6/>.

Dastjerdi, M., K. Olson and L. Ogilvie. 2012. A Study of Iranian Immigrants' Experiences of Accessing Canadian Health Care Services: A Grounded Theory. *International Journal for Equity in Health* 11(1): 55. doi:10.1186/1475-9276-11-55.

Etowa, J., Y. Sano, I. Hyman, C. Dabone, I. Mbagwu, B. Ghose et al. 2021. Difficulties Accessing Health Care Services During the COVID-19 Pandemic in Canada: Examining the Intersectionality Between Immigrant Status and Visible Minority Status. *International Journal for Equity in Health* 20(1): 255. doi:10.1186/s12939-021-01593-1.

Government of Canada. 2024, October 24. #ImmigrationMatters: Canada's Immigration System. Retrieved February 7, 2026. <https://www.canada.ca/en/immigration-refugees-citizenship/campaigns/immigration-matters/system.html>.

Government of Canada. 2025a, October 7. Express Entry: Federal Skilled Worker Program. Retrieved February 7, 2026. <https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/express-entry/who-can-apply/federal-skilled-workers.html>.

Government of Canada. 2025b, December 11. Immigrate as a Provincial Nominee. Retrieved February 7, 2026. <https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/provincial-nominees.html>.

Kalich, A., L. Heinemann and S. Ghahari. 2016. A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada. *Journal of Immigrant and Minority Health* 18(3): 697–709. doi:10.1007/s10903-015-0237-6.

Khander, A., S. Farag and K.T. Chen. 2018. Identification and Evaluation of Medical Translator Mobile Applications Using an Adapted APPLICATIONS Scoring System. *Telemedicine and E-Health* 24(8): 594–603. doi:10.1089/tmj.2017.0150.

Lebrun, L.A. and L.C. Dubay. 2010. Access to Primary and Preventive Care Among Foreign-Born Adults in Canada and the United States. *Health Services Research* 45(6p1): 1693–719. doi:10.1111/j.1475-6773.2010.01163.x.

Levine, S., R. Gupta, K. Alkwatli, A. Almoushref, S. Cherian, D.F. Jimenez et al. 2022. Telehealth Perceptions Among US Immigrant Patients at an Academic Internal Medicine Practice: Cross-Sectional Study. *JMIR Human Factors* 9(3): e36069. doi:10.2196/36069.

Pandey, M., R. Kamrul, C.R. Michaels and M. McCarron. 2022. Identifying Barriers to Healthcare Access for New Immigrants: A Qualitative Study in Regina, Saskatchewan, Canada. *Journal of Immigrant and Minority Health* 24(1): 188–98. doi:10.1007/s10903-021-01262-z.

Payán, D.D., J.L. Frehn, L. Garcia, A.A. Tierney and H.P. Rodriguez. 2022. Telemedicine Implementation and Use in Community Health Centers During COVID-19: Clinic Personnel and Patient Perspectives. *SSM – Qualitative Research in Health* 2: 100054. doi:10.1016/j.ssmqr.2022.100054.

Saleem, A., K.J. Steadman and J. Fejzic. 2019. Utilisation of Healthcare Services and Medicines by Pakistani Migrants Residing in High Income Countries: A Systematic Review and Thematic Synthesis. *Journal of Immigrant and Minority Health* 21(5): 1157–80. doi:10.1007/s10903-018-0840-4.

Schouten, B.C., A. Cox, G. Duran, K. Kerremans, L.K. Banning, A. Lahdidioui et al. 2020. Mitigating Language and Cultural Barriers in Healthcare Communication: Toward a Holistic Approach. *Patient Education and Counseling* 103(12): 2604–08. doi:10.1016/j.pec.2020.05.001.

Statistics Canada. 2022, October 26. Immigrants Make up the Largest Share of the Population in Over 150 Years and Continue to Shape Who We Are as Canadians. Retrieved December 12, 2025. <https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026a-eng.htm>.

Turpel-Lafond, M.E. 2020, November. *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care*. Retrieved December 12, 2025. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>.

Udyavar, R., D.S. Smink, J.T. Mullen, T.S. Kent, A. Green, A.F. Harlow et al. 2018. Qualitative Analysis of a Cultural Dexterity Program for Surgeons: Feasible, Impactful, and Necessary. *Journal of Surgical Education* 75(5): 1159–70. doi:10.1016/j.jsurg.2018.01.016.

Wang, L. and M.-J. Kwak. 2015. Immigration, Barriers to Healthcare and Transnational Ties: A Case Study of South Korean Immigrants in Toronto, Canada. *Social Science and Medicine* 133: 340–48. doi:10.1016/j.socscimed.2014.11.039.

Wang, L., S. Guruge and G. Montana. 2019. Older Immigrants' Access to Primary Health Care in Canada: A Scoping Review. *Canadian Journal on Aging* 38(2): 193–209. doi:10.1017/S0714980818000648.

Weerasinghe, S. and T. Mitchell. 2007. Connection Between the Meaning of Health and Interaction With Health Professionals: Caring for Immigrant Women. *Health Care for Women International* 28(4): 309–28. doi:10.1080/07399330601179794.