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Exploring Healthcare Access Challenges Among South Asian Migrants in Australia: A Mixed-Method Study

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ABSTRACT

Issue Addressed: Healthcare access disparities, particularly among migrant populations, are escalating. This research focuses on exploring aspects related to healthcare access disparities in the rapidly growing South Asian communities in Australia, which bear a disproportionate burden of chronic diseases.

Methods: This study employed an exploratory sequential mixed-method approach (qualitative followed by quantitative), with five focus group discussions (six to eight participants each) and an online survey ($n = 460$). NVivo and SPSS were used for qualitative and quantitative analysis, respectively.

Results: The study participants are from South Asia, including Afghanistan, Bangladesh, Bhutan, India, the Maldives, Pakistan, Nepal and Sri Lanka. Thematic analysis of focus group discussions identified factors influencing healthcare service utilisation among migrants, including a preference for home remedies over doctor consultations, language barriers, limited access to relevant information, high costs of specialist and dental care, dissatisfaction with rushed doctor interactions and system-related concerns. One in six survey respondents encountered challenges in accessing timely healthcare, with the most frequently reported barriers being prolonged waiting times (72%), out-of-pocket expenses (48%), and limited awareness and availability of services (36%). Migrants with multiple chronic diseases faced the highest barriers to accessing timely healthcare (57.8%), with significantly higher odds of encountering these barriers than those with no or one chronic condition (OR = 0.436, 95% CI = 0.222–0.856).

Conclusions: South Asian migrants face challenges to access affordable, timely, patient-centred healthcare. A robust collaboration between services, healthcare providers and the community is essential for sustainable solutions.

So What?Reducing waiting times and language barriers, improving awareness of available services and enhancing access to affordable specialist and dental services are imperative to foster equitable healthcare outcomes for Australia's diverse population.

1 | Introduction

Health outcomes and healthcare access disparities among migrant populations are growing concerns in developed countries [1]. In 2021, permanent migration to developed nations, including Australia, Canada, the United States and New Zealand, surged by approximately 22% [2]. This increase in migration has been associated with higher rates of chronic diseases and lower utilisation of healthcare services among migrant populations in these countries [2].

According to the World Health Organization (WHO), accessible health services should be free from undue barriers like cost, language, culture, or geography [3]. Primary care entry should be routine, spanning home, community, workplace, or health facilities, excluding specialist or hospital levels [3]. Yet, migrant populations in developed nations face unique complexities in community service delivery and barriers to healthcare access, such as financial challenges, language barriers, confronting new health risks and adjusting to the cultural and social aspects of healthcare services in host countries [2, 4, 5]. On a broader scale, strained healthcare resources post-migration influxes can impede service provision [6]. Healthcare providers' inadequate cultural responsiveness may exacerbate the challenge [7], while neglecting cultural factors can increase healthcare outcomes inequalities for migrants [8]. Preventive care is underutilised by some migrant groups, who may face barriers to accessing or understanding the benefits of such services. This pattern is observed in Australia and elsewhere, where cultural and structural barriers limit the uptake of preventative healthcare services [4, 9]. Cultural perspectives on health, coupled with discrimination, can divert migrants from formal healthcare to informal options [8, 10]. Discrimination and xenophobia from healthcare providers further discourage migrants from accessing healthcare services [10].

Australia, renowned for its multiculturalism, houses a populace where over half are either first-generation migrants or have immigrant parents [11]. In recent years, there has been a notable increase in migration from South Asia compared to other prominent migrant populations in Australia [11]. The South Asia region includes countries belonging to the South Asian Association of Regional Cooperation (SAARC), namely Afghanistan, Bangladesh, Bhutan, India, the Maldives, Pakistan, Nepal and Sri Lanka [12]. From 2006 to 2021, Australia experienced substantial migration growth from four South Asian countries, with India and Sri Lanka ranking 2nd and 10th, respectively, among the top 10 countries of birth [11]. Despite seeking improved living conditions, South Asian migrants often experience difficulties in host countries, such as language barriers, difficulties adapting to a new culture and social isolation [13]. Such difficulties, common among culturally and linguistically diverse (CALD)[1] communities, significantly impact their overall health, societal integration and access to healthcare systems [7]. For instance, there is a notable prevalence of chronic diseases and risk factors among South Asian migrants, who exhibit higher rates of diabetes and heart disease in comparison to the Australian-born population [14]. Physical inactivity and inadequate intake of fruits and vegetables are also more common among first-generation South Asian migrants than among the Australian-born population [12, 15]. Despite the heightened risk of chronic diseases, South Asian migrants in Australia exhibit lower rates of accessing health services [5, 16]. Consequently, there is a growing need to ensure access to culturally safe health services that meet the needs of diverse population groups [2, 5].

South Asian migrants in Australia frequently encounter challenges when seeking care, including anxiety and confusion when navigating the healthcare system, long waiting times, high costs of private healthcare and communication difficulties [17, 18]. However, current research provides limited insights into the health practices of this population, extending to an insufficient understanding of their health-seeking behaviours and access to services in critical situations [19, 20]. Furthermore, while the barriers this population faces when seeking care have been previously explored, facilitators to accessing healthcare are largely unknown, highlighting a significant knowledge gap in the literature [21]. In an attempt to contribute to the growing body of literature that focuses on how to improve health outcomes for South Asian migrants, this study aims to explore healthcare access and utilisation patterns among first-generation South Asian migrants and their perspectives on seeking care in Australia, with the view to identify factors contributing to their experiences, including facilitators to accessing healthcare.

2 | Methods

2.1 | Study Design

An exploratory sequential mixed methods research design was used in this study. The use of an exploratory sequential mixed methods approach allowed for a more nuanced exploration of healthcare access and utilisation among first-generation South Asian migrants in Australia, with an understanding of the personal context within which these experiences occur [22]. The study has two components: focus group discussions (FGDs) and an online survey. The FGDs draw from critical realism, which posits that reality is mediated by culture and language [23, 24] and were conducted first to identify themes and components that informed the design of the survey. Following the FGDs, we included specific aspects in the survey, such as considerations when choosing a doctor for oneself or family members, reasons for not obtaining healthcare services, and questions about the use of private health insurance among participants. This triangulated approach ensured that the survey captured a comprehensive range of factors affecting healthcare access and utilisation, providing a richer and more reliable understanding of the challenges faced by South Asian migrants in the Australian healthcare system. The themes in the FGDs identified the factors associated with healthcare access and utilisation in migrants, while the survey informed the prevalence of the factors associated with health seeking and utilisation among South Asian migrants residing in Australia. This study adheres to the Guidelines of the ethical review process of the University of Queensland and the National Statement on Ethical Conduct in Human Research. Ethics approval for FGDs and Online survey was obtained from the Human Ethics Research Committee of the University of Queensland (reference number: 2019001535).

2.2 | Participants

The study included adult migrants who were born in South Asian countries and had established permanent residency or citizenship in Australia. Asylum seekers were not included in the study due to differences in their representation within the healthcare system, including legal and financial barriers to accessing healthcare. While we acknowledge that grouping people from multicultural backgrounds can be problematic, we thought that within the context of our research combining the cultural and socioeconomic diversity of South Asian migrants would enable us to capture a broad spectrum of perspectives

and experiences, enhancing the comprehensiveness and applicability of our analysis of healthcare access and utilisation patterns among South Asian migrants in Australia. All participants provided informed consent before participating in the focus groups or completing the survey. They received comprehensive details about the study, encompassing its objectives, procedures, potential risks and benefits, to ensure informed consent. Additionally, participants were given the option to withdraw from the study at any point if they chose not to proceed.

2.3 | Recruitment

Participants were recruited using multiple recruitment methods to reach a wide range of individuals from the South Asian migrant population, ensuring the capture of diverse perspectives and experiences. Two of the authors (AK and MN), being first-generation South Asian migrants themselves, utilised their networks to recruit participants. Social media platforms Facebook, WhatsApp, LinkedIn and Twitter were utilised to reach out to potential participants. Email lists provided by community organisations were also used as a means of recruitment. Snowball sampling, a technique where existing participants are asked to invite their friends and family to participate, was employed to expand the participant pool [25]. Potential participants were also approached at cultural centres, community gatherings, Asian grocery stores and restaurants through their organisers. They were then provided with an online link to express their interest. These strategies allowed for a diverse range of participants to be recruited, capturing a broader representation of South Asian migrants living in Australia who may not be active on social media or connected to specific associations. To protect against coercion, we employed voluntary participation.

2.4 | Data Collection—FGDs

Five face-to-face FGDs were conducted between September 2019 and March 2020 at the University of Queensland. Separate FGDs were conducted for men ($n=2$) and women ($n=3$) with respect to South Asian cultural norms that allowed the participants to feel more comfortable when expressing their opinions or views in a same-sex gathering [20]. Each FGD consisted of six to eight participants, and the duration of the discussions ranged from 55 to 85 min. The first author (MN) was responsible for contacting, organising, and conducting the FGDs. All FGDs were audio recorded. Open-ended guided questions were used as prompts to stimulate discussion about healthcare access utilisation (Appendix A). These guided questions were developed through a process of testing and refinement, including two induction meetings and a pilot FGD. Follow-up questions were also asked to ensure a thorough exploration of the participants' experiences and to gather a detailed understanding of their concerns and perceptions. It was not possible to conduct FGDs in the native languages of South Asian migrant participants due to the variety of languages participants spoke (e.g., in a single FGD there would be participants collectively speaking four to five different languages) [13]. The FGDs in this study were also conducted in English due to logistical considerations, primarily related to limitations or challenges related to the availability of participants within the allotted resources and time frame. Participants were assured that there were no right or wrong answers and that all opinions were appreciated and confidential. Data collection ceased when the gathered data held sufficient information power to contribute new perspectives and enhance our understanding of the topic of interest [26]. Participants did not receive any financial incentives for participating in the study. Each focus group comprised individuals from various South Asian ethnic backgrounds, enhancing data collection with diverse perspectives and experiences on healthcare access and utilisation among South Asians.

2.4.1 | Data Analysis

The audio recordings of the FGDs were fully transcribed by the first author, ensuring participant anonymity using pseudonyms during transcription. We used Braun and Clarke's descriptive approach to thematic analysis to analyse the FGD data [27]. Such an approach is flexible, and it was well suited to identify patterns of meaning while considering participants' sociocultural contexts. While thematic analysis is flexible, our analytical process included data familiarisation (e.g., initial reading of transcripts and team discussions) (MN, NC and AK), coding (e.g., MN and NC coded the transcripts with the research question in mind), generating and reviewing themes (MN and NC met at two occasions to develop theme candidates) and refinement of themes and results more broadly through (re)writing (MN, NC, AK and TKA) [27]. For the facilitation of this analytical process, NVivo, Version 12 software, was employed. NVivo, Version 12 software, facilitated efficient organisation, coding, and management of qualitative data during this analytical process. The research team includes MN and AK from South Asian backgrounds (Pakistan and Bangladesh), TKA from South Africa with over 10 years in Australia, and NC from Brazil, who has lived in Australia for 9 years and recently gained permanent residency. All authors combined their extensive experience in conducting research within the Australian healthcare system with their perspectives as immigrants and patients in Australia. Reflexivity was enacted through reflexive notes and team discussions about their personal experiences as South Asian immigrants and immigrants more broadly.

2.5 | Online Survey

An online survey was developed, mainly informed by the FGDs. To ensure the accuracy and effectiveness of the survey instruments, a pilot study was conducted on the online survey with South Asian immigrants. The survey was administered between 1 November 2020 and 30 March 2021. The survey was distributed in the English language and interpretation/translation was made available on request. Demographic data collected included age, gender, marital status, educational attainment, income, employment status and country of birth. Part of the survey assesses factors that enable or hinder healthcare access among South Asian migrants living in Australia (Appendix B).

Survey responders reported if they had been diagnosed with any chronic diseases, answering 'yes', 'no' or 'don't know' for

each. The study calculated the prevalence of multiple chronic diseases by summing 'yes' responses, categorising outcomes as no chronic disease, one chronic disease, or multiple chronic diseases. Participants were assessed about their preferred approach to treating themselves when they experience illness or sickness. The question posed was, 'What is your preferred way to treat yourself when you are feeling unwell/sick?' In response, they were presented with a range of options and asked to indicate their preferences by selecting from the following choices: visiting a doctor, utilising self-medication (self-medicating without getting advice from a physician for either diagnosis or treatment), employing home remedies (a non-medical treatment to attempt to cure or treat an ailment with common household items or foods), or relying on traditional medicines (i.e., sum of the knowledge, skills and practices based on the theories, beliefs and experiences of different cultures). Survey responders were asked specific questions related to the factors they consider when selecting a doctor for themselves or their family by asking 'Which factors do you consider when choosing a doctor for yourself or your family?' A list of potential factors based on previous studies conducted among South Asian migrants was provided for selection, with the opportunity to select multiple items from the list as applicable to their decision-making process [6, 7, 17, 21, 28]. Knowledge of various healthcare services was evaluated by asking 'Do you know where and how to access different healthcare services (e.g., mental health services, physical therapies, etc.)?' The response options provided were 'yes', 'not sure' or 'no' to indicate knowledge about accessing different healthcare services.

Healthcare utilisation was assessed by posing a question: 'During the past 12 months, was there ever a time when you needed healthcare services but did not receive them?' Participants who responded affirmatively to the non-receipt of needed services were further asked about the specific factors by asking, 'If YES, what was the reason?' Participants were provided with a comprehensive list of factors, derived from prior research studies, from which they could select their responses.

2.5.1 | Statistical Analysis

Data were cleaned and analysed using SPSS V26. Descriptive statistics (e.g., mean, standard deviation, range and percentage) were computed for all variables. Binary logistic regression analysed associations between sample characteristics (age, gender, education, income, employment status, country of birth, language spoken at home, English language proficiency and chronic disease status) and the likelihood of encountering barriers to accessing timely healthcare services.

3 | Results

3.1 | Qualitative Results

Five FGDs were conducted with South Asian migrants ($n = 29$; 18 females) aged 27–50 years in Brisbane, Australia. All participants had resided in Australia for more than 5 years. Over half (52%) of participants held a bachelor's degree and 69% of them were employed on a full-time basis (Table 1).

We identified four themes and related subthemes that characterised healthcare access among South Asian migrants residing in Australia: (1) Preferring home remedies over doctor consultations, unless antibiotics are needed; (2) Waiting times, lack of access to relevant information and costs make access to healthcare difficult; (3) Health insurance and cultural alignment enable access to healthcare, and (4) Frustration stemming from doctors' non-caring attitude and a flawed healthcare system. We discuss these themes under the headings below, using pseudonyms to anonymise participants.

3.2 | Theme 1—Preferring Home Remedies Over Doctor Consultations, Unless Antibiotics Are Needed

Participants expressed a preference for utilising home remedies for health issues perceived as simple or minor. Some participants emphasised the inclination toward home remedies for common ailments: 'I will prefer home remedies but if we want some antibiotics we go to our doctor' (Mahi). These home remedies were seen as accessible, natural and cost-effective solutions for everyday health concerns, often rooted in their cultural heritage. Some participants also mentioned a cultural inclination toward home remedies, often passed down through generations, as a part of their cultural heritage. For example, Ramsha explained:

> You just called your mom and said, 'Mom, I am not feeling well'. She replied, 'Oh yeah, take honey with black pepper, and you will be fine'. She suggested other [traditional] home remedies that might work [for general ailments].

Self-medication was also viewed as a common practice among participants and their communities. As Moazzam stated: 'I know my body well and I know when my body needs home remedy or when my body needs a doctor consultation. I think self-medication is the way for me'. This sentiment reflected their belief in their ability to gauge their own health conditions and make informed decisions about self-treatment based on prior experiences or collective knowledge within their community. However, the decision to visit a general practitioner was influenced by the need for accurate diagnosis, a doctor's prescription for antibiotics, or access to advanced therapies. As Sans said: 'I will go to doctor if I want to do a blood test, otherwise its manageable at home'. Overall, participants shared their decision-making approach, in managing their health concerns which involved trying home remedies for simple health issues and seeking the assistance of a general practitioner for complex ones.

3.3 | Theme 2—Waiting Times, Lack of Access to Relevant Information and Costs Make Access to Healthcare Difficult

3.3.1 | Sub-Theme: Waiting Times

Participants reported challenges in obtaining appointments with healthcare providers, indicating a limited availability of healthcare professionals in their area. Waiting times for appointments were

TABLE 1 | Participants characteristics of the five focus group participants ($n = 29$).

Pseudonyms	Age (range)	Sex	Duration of stay in Australia	Country of birth	Employment status	Highest educational qualification
Beenish	39	Female	≤ 5 Years	Pakistan	Full-time	Postgraduate degree
Chander	45	Male	≤ 5 Years	India	Part-time	Bachelor
Chaudhary	60	Male	≤ 5 Years	Pakistan	Job-less	Bachelor
Dvarika	29	Male	≤ 5 Years	Sri Lanka	Full-time	School or intermediate certificate
Erum	35	Female	≤ 5 Years	Pakistan	Full-time	Bachelor
Fahmida	37	Female	≤ 5 Years	Bangladesh	Job-less	Bachelor
Ghazala	30	Female	≤ 5 Years	India	Part-time	School or intermediate certificate
Habibullah	39	Male	≤ 5 Years	Afghanistan	Full-time	School or intermediate certificate
Harshani	48	Female	≤ 5 Years	Sri Lanka	Part-time	Bachelor
Jhanvi	29	Female	≤ 5 Years	Bangladesh	Part-time	School or intermediate certificate
Lodhi	60	Male	≤ 5 Years	Bangladesh	Full-time	Bachelor
Madhu	43	Female	≤ 5 Years	India	Housewife	Bachelor
Mahi	33	Female	≤ 5 Years	India	Housewife	Bachelor
Mayone	37	Female	≤ 5 Years	Sri Lanka	Job-less	School or intermediate certificate
Moazzam	34	Male	≤ 5 Years	Pakistan	Full-time	Bachelor
Mahika	37	Female	≤ 5 Years	Nepal	Housewife	School or intermediate certificate
Nadia	33	Female	≤ 5 Years	Bangladesh	Housewife	Bachelor
Naina	54	Female	≤ 5 Years	India	Part-time	School or intermediate certificate
Nora	48	Female	≤ 5 Years	Afghanistan	Part-time	Bachelor
Ramsha	27	Female	≤ 5 Years	Pakistan	Housewife	Bachelor
Rukhsar	50	Female	≤ 5 Years	Bangladesh	Full-time	Postgraduate degree
Sana	47	Female	≤ 5 Years	Pakistan	Full-time	Postgraduate degree
Sajid	44	Male	≤ 5 Years	Bangladesh	Full-time	Certificate
Umar	52	Male	≤ 5 Years	Afghanistan	Full-time	Bachelor

(Continues)

TABLE 1 | (Continued)

Pseudonyms	Age (range)	Sex	Duration of stay in Australia	Country of birth	Employment status	Highest educational qualification
Urmila	33	Female	≤5 Years	India	Housewife	School or intermediate certificate
Waqas	45	Male	≤5 Years	Pakistan	Full-time	Postgraduate degree
Wannish	33	Female	≤5 Years	Nepal	Part-time	Bachelor
Zahid	51	Male	≤5 Years	Afghanistan	Full-time	Bachelor

described as lengthy, with participants mentioning waiting periods of 3 months or more for highly recommended specialists. They specifically expressed frustration with the long waiting times for health services for children, indicating that it negatively impacts the progress and development of children in need of these services. As described by Fahmida, 'I was looking for a speech therapist for my son and people with good reviews have 3 months waiting time'.

3.3.2 | Sub-Theme: Lack of Access to Relevant Information

Participants described challenges in obtaining accurate and specific information about healthcare services when needed. Lack of knowledge about reputable providers and uncertainty about where to find the most suitable and cost-effective services were cited as important barriers to seeking care. For example, Zahid mentioned: 'It's difficult to get information about healthcare services, like what is the best place for physio, especially for new people'. Beenish also highlighted the confusion surrounding the government health insurance program (Medicare): 'Some people always get confused about what is covered or not covered on Medicare, and they are calling friends to get information'. This reliance on friends for information suggests a need for clearer and more accessible resources about healthcare coverage.

Most of the participants mentioned seeking out 'Desi' doctors, meaning healthcare professionals from their own heritage background or with a similar cultural understanding. 'Desi' doctors were perceived as potential sources of information and guidance, particularly regarding cost-effective healthcare options, as discussed by Sana:

> It is difficult to get exact information about healthcare when needed. Then people search for a Desi doctor who can advise where we can do these tests without cost, and sometimes the waiting list is very long.

3.3.3 | Sub-Theme: Costs

Participants expressed concerns about the financial burden of seeking healthcare services that are not covered by Medicare. The issue arises when individuals must pay out-of-pocket for services they receive, especially when seeing a private specialist or accessing specialised care. Mayone mentioned:

> Being under cover of Medicare you have a lot of those benefits, you know, but the issue comes in when you go to see someone privately and recommended to some specialist and when the money comes out of your pocket that's how it starts and that's how we start ignoring it.

Dental care, in particular, was mentioned as a low priority due to the perception of high costs and potential financial burden. This perception of high costs in dental care can lead individuals to delay or avoid seeking dental services, potentially compromising their oral health. The following excerpt from Wannish offers an example:

> When you think to go to a private doctor, it's going to question my money. I think I am okay; I might just wait, especially with dentistry and things like that. For us, it would be the last thing to go to a dentist.

Participants also discussed the challenges of balancing healthcare expenses with other priorities with financial commitments in a new country. Some individuals expressed a desire for a better quality of life, leading them to overlook healthcare costs or choose more affordable options. This tendency often resulted in delayed or neglected necessary medical care, as participants sought ways to manage their financial obligations. Balancing immediate financial concerns with long-term health and well-being was seen as a critical factor in decision-making. Ghazala revealed the complex interplay between financial considerations and healthcare choices:

> We will be like, Oh, I know I will send my kids to a better school, I will have a luxurious lifestyle (...), but I would not go to a doctor because that's going to cost me a few thousand dollars. I mean, it is a huge factor, but again, we need to learn how to prioritise.

3.4 | Theme 3—Private Health Insurance and Cultural Alignment Enable Access to Healthcare Services

3.4.1 | Sub-Theme: Having Private Health Insurance

Private health insurance was perceived as providing financial protection and peace of mind, knowing that medical expenses for various conditions would be covered. Dvarika recommended: 'But I would highly recommend [private] health insurance as it covers a lot of health issues that are good for your health'.

Participants highlighted the importance of private health insurance in facilitating early detection and diagnosis of diseases. They mentioned cases where individuals without health insurance experienced delayed diagnoses and longer waiting times for tests and treatments. Chaudhry explained:

> Yes, one of my office mates had breast cancer that was not diagnosed at an early stage due to her ignorance and the waiting list. If you have (private) health insurance, you can detect your disease at a very early age, which would be more curable. The waiting list without insurance for the test is very long.

3.4.2 | Sub-Theme: Cultural Alignment Enables Access to Healthcare Services

Participants underscore the significance of aligning healthcare services with cultural norms and values to improve accessibility. They emphasised the importance of culturally sensitive practices, comprehension of traditional beliefs, and effective communication in bridging the access gap for their communities. They stress the value of having a general practitioner who speaks their language, considering it essential for clear communication of health issues, understanding medical guidance, and establishing trust with healthcare providers. For instance, Sana explains: 'I go for a general practitioner, especially who is from my community, someone who knows my language'.

Participants highlighted the importance of peers' opinions in their decision-making process. They often sought recommendations through informal conversations or directly reached out to friends who had similar health concerns. Seeking advice from friends was seen as a reliable and trusted source of information, providing first-hand experiences and insights into the quality of care provided by different doctors. For example, Ramsha indicated: 'I choose a doctor by asking the reviews from my friends which doctor is good'.

Participants also expressed a preference for doctors from their own cultural background, referring to them as 'Desi' doctors. Cultural familiarity, shared values, and a perceived understanding of their bodies were identified as reasons for this preference. Participants expressed concerns about the knowledge of Australian doctors regarding the specific range of antibiotics needed for individuals from their cultural backgrounds. They mentioned that the use of high doses of antibiotics in their home country may have resulted in a different antibiotic resistance profile, making low doses less effective. Participants believed that 'Desi' doctors would have a better understanding of their antibiotic needs due to their familiarity with cultural practices, health concerns and potential resistance patterns. Likewise, Naina discussed,

> If I have a choice between an Aussie doctor and a Pakistani or Indian, I will prefer a 'Desi' doctor because they understand our bodies. Australian doctors may not be familiar with the range of antibiotics we require. I believe that in our own country, we used to take very high doses of antibiotics, which may not have been good. However, due to this practice, lower doses of antibiotics are now less effective.

3.5 | Theme 4—Frustration Stemming From Doctors' Non-Caring Attitude and a Flawed Healthcare System

3.5.1 | Sub-Theme: Doctors Do Not Seem to Care

Participants expressed dissatisfaction with doctors who appeared more focused on following protocols rather than providing personalised care to patients who were ill. Beenish said, 'You know, it's really frustrating when I see a doctor for the first time, and they don't give me proper time and prescription. Instead, they ask me to come back'. Some participants described brief interactions with doctors, where minimal time was spent on examination, and doctors quickly wrote prescriptions or referrals. As Lodhi stated: 'Some doctors are really good, but most doctors do not take responsibility. They just attend to you for 5 min, write something on paper, and that's it'. Some participants also observed that doctors appeared more focused on computer screens and administrative tasks during appointments, leading to a perceived lack of thorough examination and limited patient engagement. Erum mentioned: 'They are, some doctors just focusing on the computer than the examination. Only follow protocols and send referrals'.

3.5.2 | Sub-Theme: Flawed Health System

Study participants noted a lack of public understanding of the health system, with a perception of healthcare services being free and clean but highlighting hidden costs and the need for improvement. Some respondents, based on their professional experience, highlighted difficulties in identifying discrepancies as ordinary individuals and the challenges faced when navigating the system while being sick. Chaudhary explained: 'People think that hospital is clean, facilities are good, so everything is good, but the reality is the opposite sometimes. Even sometimes it is difficult to make a good diagnosis'.

Participants questioned healthcare professionals' competence and quality, citing discrepancies between expected standards and actual practice and challenges in accurate diagnoses,

TABLE 2 | Sociodemographic characteristics of the analytical sample of online survey ($n = 413$).

	N	%
Sex		
Male	216	53.5%
Female	188	46.5%
Age (years)		
18–30	37	11.97
31–40	135	43.69
41–50	83	26.86
> 50	54	17.48
Country of birth		
Pakistan	137	35.1
India	120	30.8
Sri Lanka	36	9.2
Bangladesh	34	8.7
Afghanistan	32	8.2
Bhutan	15	3.8
Nepal	14	3.6
Maldives	2	0.5
Employment status		
Full-time work	200	50.9
Part-time/casual work	100	25.4
Unemployed	93	23.7
Marital status		
Married/de facto relationship/living with a partner	294	74.1
Single	68	17.1
Widowed	1	0.3
Divorced/separated	34	8.6
Highest educational qualification		
Certificate	44	11.1
Bachelor/diploma	155	39.1
Postgraduate degree	197	49.7
Gross annual household income (AUD)		
≥ $0–$36 399	75	23.5
$36 400–$93 599	137	42.9
$93 600+	107	33.5
Chronic diseases status		
No disease	33	11.5
One chronic disease	142	49.7
Multiple chronic diseases	111	38.8
Language spoken at home		
English	73	18.7
Other than English	318	81.3
English language proficiency		
Basic	20	5.2
Conversational	81	21.0
Fluent	144	37.4
Proficient	140	36.4

despite seemingly good hospitals. Some respondents encouraged community individuals to seek second opinions, suggesting that knowledge and awareness play a vital role in advocating for one's health needs. Sajid said:

> The overall health system is a bit faulty, sorry, I must say this. They often talk about costs in percentages, like saying the government covers 70% and you pay 30%, but the actual cost is only half of what's claimed, around 50%.

Participants also expressed dissatisfaction with the private insurance system, saying that it frequently requires people to pay a portion of the costs out of their own pockets and that it frequently does not fully cover all procedures. Umar discussed his dissatisfaction:

> I think the insurance system is not fully covered. In many procedures, they ask for some percentage of money from your pocket, which was not the case when I used to work for a pharmaceutical company as an auditor. It is difficult to catch them as a normal man. And when you are sick, you cannot think this much.

3.6 | Quantitative Results

3.6.1 | Participants' Characteristics

The online survey involved a total of 460 migrant participants. The respondents consisted of both females (47%) and males (53%), with a mean age of 41.0 years and a standard deviation of ±10.3 years (Table 1). Most participants (74%) were married or living with a partner. In terms of country of origin, 35% of respondents were from Pakistan, 31% were from India and 44% were from other South Asian countries. Nearly half of the respondents had completed postgraduate degrees, while 39% had completed bachelor's degrees. Just over half (51%) of

participants worked full-time. Around 20% of the participants have private health insurance. A significant portion of the participants (42%), belonged to the middle-income category, reporting an annual income range between A$36400 and A$93600 (Table 2).

3.6.2 | Healthcare Access

Over half of the participants preferred doctor visits when ill, with 17% opting for self-medication, 16% for home remedies, and 8% for traditional medicines (Figure 1). Nearly one-fourth of the participants indicated a lack of knowledge about available healthcare services. A majority (65%) experienced timely access to healthcare services, while 17% reported unmet healthcare needs, and 18% were uncertain about whether they would receive the necessary services or not (Figure 1).

3.6.3 | Healthcare Access Enablers and Barriers

Figure 2 illustrates the factors promoting visits to a doctor and the obstacles faced by migrants in healthcare access. The study revealed that factors facilitating doctor visits included the provider's high level of expertise (61%), availability of bulk billing (58%), positive recommendations from friends (39%), having a same-sex practitioner (25%) and sharing the same cultural or country background (18%). The most frequently cited hindrance to accessing healthcare services when needed was extended waiting times (72%), followed by concerns about the cost of healthcare (48%).

3.6.4 | Associations Between Access to Timely Healthcare and Participants' Characteristics

Table 3 presents the factors associated with timely healthcare access among migrants. Participants with multiple chronic conditions reported the highest percentage of unmet healthcare needs (57.8%), compared to those with no or one chronic condition (42.2%). The likelihood of experiencing barriers to timely healthcare access was significantly higher for participants with multiple chronic conditions, with an odds ratio of 0.436 (95% CI = 0.222–0.856, $p = 0.016$).

Employment status also impacted healthcare access. Unemployed participants reported the highest percentage of unmet healthcare needs (39.7%), followed by part-time or casual workers (36.5%) and full-time workers (23.8%). The odds of facing barriers to timely healthcare access were lower for part-time or casual workers (OR = 0.428, 95% CI = 0.223–0.821, $p = 0.011$) compared to unemployed individuals. In contrast, the odds for full-time workers (OR = 0.871, 95% CI = 0.431–1.760, $p = 0.701$) did not indicate a significant association with timely healthcare access.

3.6.5 | Integrated Insights From Qualitative and Quantitative Data

The integration of quantitative and qualitative data revealed nuanced insights into healthcare access among the participants (Table 4). Quantitatively, 59% of the respondents reported a

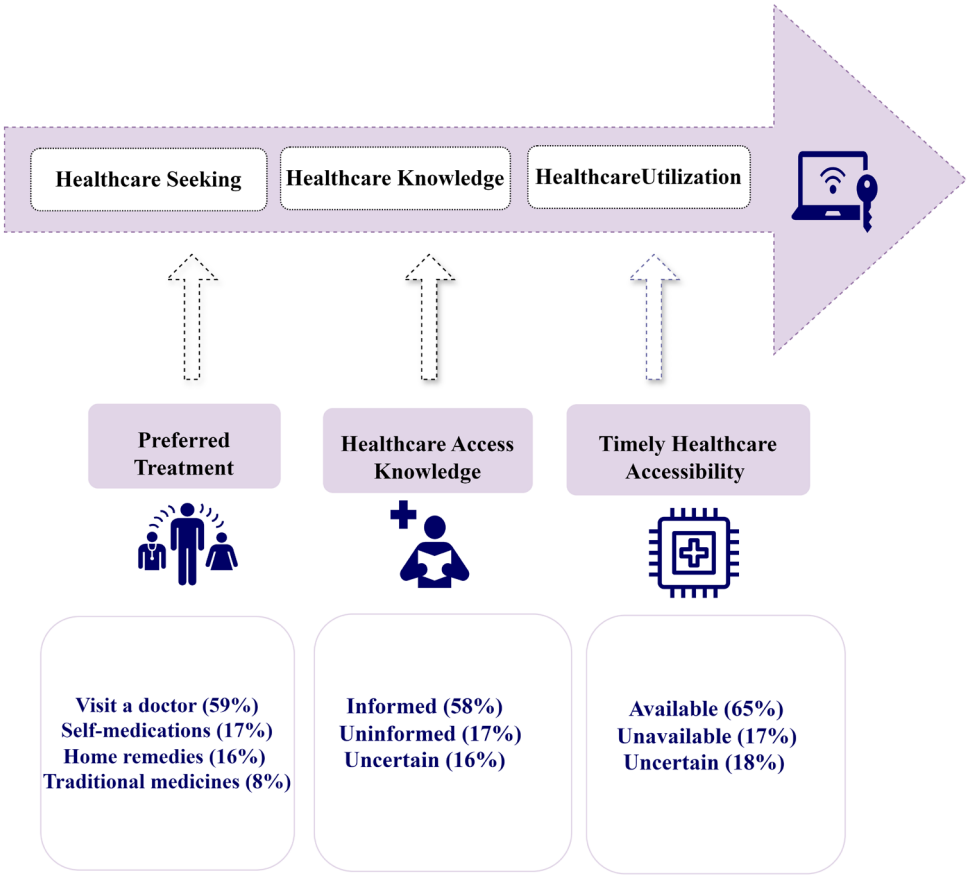

FIGURE 1 | Timely healthcare access among South Asian migrants in Australia.

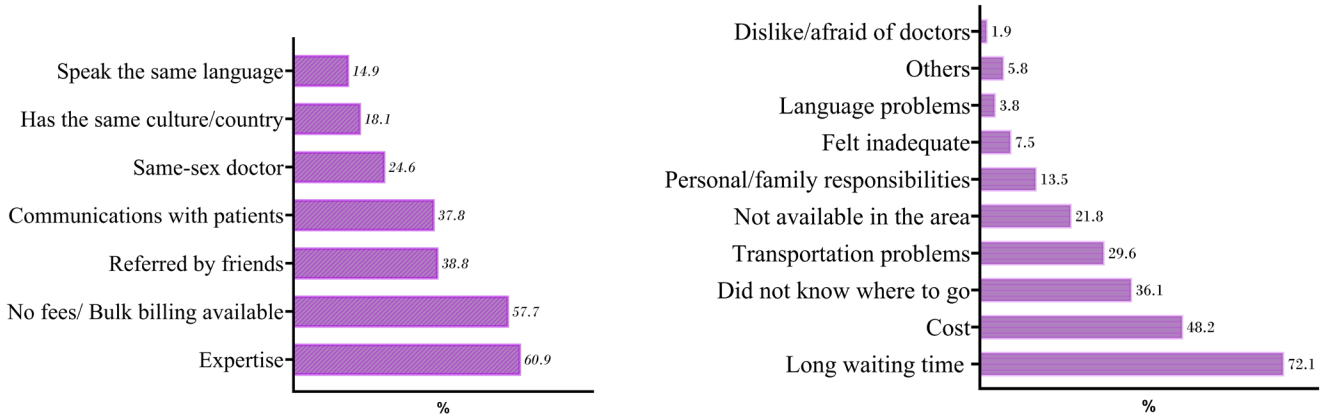

FIGURE 2 | Barriers and enablers to receiving timely healthcare services among South Asian migrants in Australia.

TABLE 3 | Factors associated with timely healthcare access among migrants.

Variables	% of participants facing challenges in receiving required health services	OR	(95% CI) Lower	(95% CI) Upper	*p-value*[##]
Chronic diseases					
Multiple chronic diseases[a]	57.8	1.0			
No/one chronic disease	42.2	0.436	0.222	0.856	**0.016**
Employment					
Unemployed[a]	39.7	1.0			
Part-time/casual	36.5	0.428	0.223	0.821	**0.011**
Full time	23.8	0.871	0.431	1.760	0.701

Note: Sex, age, country of birth, marital status, educational qualifications, English language proficiency and income levels did not show a significant univariate association with the outcome variable at the 20% significance level. Values in bold indicate p value < 0.05. ##p value is based on binary logistic regression.
Abbreviation: OR, odds ratio.
[a]Reference value.

preference for visiting a doctor, 17% preferred self-medication and 16% favoured home remedies. This aligns with qualitative findings, where participants described a reliance on home cures and traditional medicines, turning to professional healthcare primarily when antibiotics or specialised treatments were needed. Barriers to healthcare access, particularly long waiting times (reported by 72% of the participants) and financial constraints (48%), were prominent themes in both datasets. Qualitative accounts emphasise extended waiting periods for specialist care and the postponement of necessary treatments, particularly dental services, due to high costs. Additionally, 36% of the participants cited a lack of knowledge about available services, which is echoed in qualitative narratives describing confusion around Medicare coverage and reliance on informal networks for healthcare information. Although cultural alignment with healthcare providers was valued by 18% of respondents, other factors, such as provider expertise (61%) and the availability of bulk billing (58%), were deemed more critical in enabling healthcare access. Furthermore, frustrations with perceived non-caring attitudes from providers were strongly reflected in qualitative data, reinforcing the quantitative finding that provider competence was a key determinant of healthcare satisfaction.

4 | Discussion

This study utilised a mixed-method approach to explore healthcare access among South Asian migrants in Australia and provide insights into their decision-making processes. Although participants seemed to value using home remedies, traditional medicines, and self-medicating where possible, most survey respondents expressed a preference for visiting a doctor when experiencing health issues. Waiting times, costs of healthcare and lack of knowledge about available services were important barriers to seeking care, with approximately one in six online survey respondents experiencing difficulty accessing timely healthcare, particularly those with multiple chronic diseases. Having private health insurance, recommendations from peers and cultural alignment with practitioners were important facilitators, indicating important targets for improving healthcare access for South Asian migrants.

Similar to the results from a mixed-methods study by Subedi et al. [21], our study indicated traditional home remedies are valued by many South Asian migrants. Previous literature has discussed that such remedies are preferred due to cultural

TABLE 4 | Integration of qualitative and quantitative data.

Integrated insights	Qualitative themes and quotes	Quantitative data
Self-medication, home cures and traditional medicines are valued by many	Preferring home remedies over doctor consultations, unless antibiotics are needed: 'I know my body well and I know when my body needs home remedy or when my body needs a doctor consultation. I think self-medication is the way for me'.	– 59% preferred visiting a doctor – 17% preferred self-medication – 16% preferred home cures – 8% preferred traditional medicines
Waiting times, lack of knowledge about healthcare services and cost are important barriers to accessing healthcare	Waiting times, lack of access to relevant information and costs make access to healthcare difficult: 'I was looking for a speech therapist for my son and people with good reviews have 3 months waiting time [allied health]'. 'When you think to go to a private doctor, it's going to question my money. I think I am okay; I might just wait, especially with dentistry and things like that. For us, it would be the last thing to go to a dentist'. 'Some people always get confused about what is covered or not covered on Medicare, and they are calling friends to get information'.	– 72% cited long waiting times – 48% cited financial constraints – 36% lacked knowledge about available services at the time of need
Cultural alignment matters	Private health insurance and cultural alignment enable access to healthcare: 'It is difficult to get exact information about healthcare when needed. Then people search for a Desi doctor who can advise where we can do these tests without cost, and sometimes the waiting list is very long.'	– 18% preferred practitioners with same cultural background, but other factors were highlighted as enablers to access more frequently than cultural alignment, such as the provider level of expertise (61%) and availability of bulk billing (58%)
Frustration with non-caring attitude of providers	Frustration stemming from doctors' non-caring attitude and a flawed healthcare system: 'Some doctors are really good, but most doctors do not take responsibility. They just attend to you for 5 min, write something on paper, and that's it'.	– High provider expertise (61%) was considered important by most survey participants

upbringing, perceived safety and self-efficacy in health management, aiding in overcoming barriers like time and financial constraints [19, 21]. While acknowledging their limitations in treating complex conditions, it is crucial that healthcare providers take a culturally sensitive approach and consider including these remedies in treatment plans, as doing so may increase South Asian migrants' trust in them, prompting them to feel safe and potentially improving uptake of treatments, with relevance for health outcomes [21, 29].

Both the qualitative and quantitative results indicated prolonged waiting times and high costs discouraged participants from seeking care. For instance, the survey indicated that 17% of participants do not receive the services they need, and 18% were uncertain about receiving timely care, especially those with multiple chronic diseases. This is largely similar to the findings of previous research [4, 5] and it is not surprising considering the current landscape. Despite Australian health services having good coverage and higher quality than other countries, long waiting times for public services persist, with those from low socioeconomic status being disproportionally affected [28]. Improving social determinants of health (e.g., reducing economic disparities, improving living and working conditions) could address these ongoing challenges [5]. Likewise, offering alternative care pathways [30] for those on waiting lists (e.g., using community health workers) could be helpful.

Participants' lack of knowledge about available healthcare services was also identified as a significant barrier to seeking care. Australia's complex healthcare system poses challenges for migrants unfamiliar with its workings [6]. For instance, limited understanding can lead to care delays or inappropriate choices [31]. Language barriers exacerbate such an issue, hindering effective communication with providers or understanding written materials, especially for migrants who do not have English as their first language [6]. Overall, this finding emphasises the importance of community outreach and educational programmes [31] and the provision of culturally responsive healthcare information in multiple languages to foster comprehensive knowledge about health issues, treatment options and available services [29]. Community-based bi-lingual health workers, culturally sensitive health promotion videos and the establishment of community point-of-care services for people with chronic disease could also help to address the lack of information about health services that might be available [30].

Our results highlight the dissatisfaction among South Asian migrants with healthcare providers who demonstrate disinterest or rushed behaviour during consultations. Doctors might focus on following the 'protocol' and prescribing medications due to time constraints, as well as to potentially avoid legal issues. Yet, this 'rushed' approach may compromise the quality of care, leading to potential misdiagnoses or inadequate treatment options. To address this issue, healthcare professionals should strive to strike a balance between protocol adherence and empathetic patient care [32], particularly considering the importance participants place on feeling heard and cared for. Such an approach could involve providing care in a culturally responsive care manner (i.e., healthcare providers reflecting on their own culture, remaining open and celebrating the patient's culture) [33], actively listening to patients' concerns and discussing the potential benefits, costs and risks of treatment options. Within this context, self-reflection, acknowledgement of the limits of competencies [34] and efforts to recognise and mitigate unconscious biases in provider–patient interactions are essential [35]. Healthcare systems can support this by offering cultural responsiveness training [30] and implementing measures to alleviate provider workload and time constraints. Additionally, involving South Asian populations in healthcare policy development could contribute to inclusivity and culturally sensitive practices in healthcare [21, 29].

4.1 | Strengths and Limitations

This research shed light on the insufficient availability of healthcare services when needed, underscoring the necessity for identifying suitable strategies to ensure optimal access to healthcare among migrant populations. Yet, the study has limitations that warrant attention. First, both the FGDs and surveys were conducted in English, which may have excluded valuable insights from participants with limited English proficiency. The participants in the focus groups were predominantly characterised by higher educational attainment and employment status, which may have influenced the findings. To address this limitation, future research should consider conducting FGDs in multiple languages to ensure the inclusion of individuals from diverse socioeconomic backgrounds. Additionally, the reliance on online surveys may have introduced barriers related to computer literacy, potentially limiting the sample size and failing to fully represent the broader South Asian diaspora in Australia. The survey also did not cover different aspects of the use of healing practices, such as Ayurvedic medicine, traditional medicines, home remedies and self-medication. Future research should prioritise longitudinal studies to comprehend healthcare access and utilisation trends among migrants. The evaluation of healthcare provider perspectives is also crucial to identify challenges and opportunities in providing optimal care for diverse groups.

4.2 | Implications of the Findings

Social networks and peers influenced health seeking, with relevance for targeting community-level strategies to positively influence the quality and relevance of information acquisition and sharing. In fields such as immunisation and screening programmes these strategies have been shown to be pivotal [36]. Given that some participants expressed the preference for healthcare providers from similar cultural and linguistic backgrounds, diversifying the workforce and integrating staff from South Asian backgrounds into it may help improve access to healthcare services. Likewise, the provision of culturally responsive care and cross-cultural health workforce might enhance healthcare delivery [5]. Potential system and policy level strategies could involve including South Asian migrants in the design and implementation of public health programs, as well as embedding culturally responsive care in academic curriculum to improve future healthcare professionals' ability to deliver services to South Asians' and people from multicultural backgrounds more broadly.

4.3 | Conclusions

This mixed-methods study provided important insights into South Asian migrants' experiences accessing healthcare in Australia. Both the qualitative and the quantitative data underscore the perceived value of traditional medicine and home remedies. Barriers such as extended waiting times and the high costs of healthcare were highlighted as important in both the FGDs and the survey, along with a lack of awareness regarding what health services are available. The frustration stemming from healthcare providers' attitudes emphasises the importance of providing care in a culturally responsive and patient-centred manner. Overall, this study highlights the multifaceted nature of South Asia migrants' experiences accessing healthcare, emphasising the need for multimodal interventions to address current challenges.

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Ethics Statement

This study was performed in line with the principles of the 1964 Declaration of Helsinki and its later amendments. The study received ethical approval from the Human Ethics Research Committee of the University of Queensland, Australia (reference number: 2019001535).

Consent

Informed consent was obtained from all individual participants included in the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Endnotes

[1] We acknowledge the ongoing debate about the term CALD, which has been criticised for homogenising unique cultures and undermining acknowledgement of cultural diversity while placing white/English speakers as the default. Despite being problematic this term is widely used in the literature so hence why we are using it here.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.