Access to Health Care Services:
East-End Montreal (Quebec) English-Speaking Elderly Experience

By

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R. H. T

DEDICATION

To my late father, a very dedicated single parent who was always there for me, believed and inspired me to be all that I can be.

To my late sister, who always protected and encouraged me in every move. I miss you!

ABSTRACT

To better understand Anglophone elderly experience in accessing health care services in a Francophone area, it is important to look beyond availability of healthcare services near their homes. This study explored factors such as language competence, preference, motivation, reaching and waiting times, as contributors to elderly people's choice.

A questionnaire designed for this study was administered to 199 males and females, aged 55 years and older, recruited from the only Anglophone Seniors' Centre in East-End Montreal. It was found that elderly people with limited French proficiency were more likely to travel out of their area for healthcare services, resulting in significantly longer average travel and waiting times. Of those who would have liked an interpreter, very few were actually able to get one. The most frequently expressed need was for more English or bilingual workers and services.

To improve access and enhance elderly people's quality of life, training and intervention programs need to be developed in collaboration with the government.

RÉSUMÉ

Afin de mieux comprendre ce que vivent les personnes âgées des milieux anglophones lorsqu'elles doivent accéder aux services de soins de santé dans les milieux francophones, il est important de regarder au-delà des services offerts dans leur quartier. Cette étude s'est penchée sur les facteurs qui influencent les choix des personnes âgées, tels que la compétence linguistique, la priorité, la motivation, l'accès et le temps d'attente.

On a administré un questionnaire conçu pour cette étude à 199 hommes et femmes âgés de 55 ans ou plus, recrutés au seul centre d'hébergement pour personnes âgées anglophone de l'est de Montréal. Il a été découvert que les personnes âgées ayant un faible niveau de français sont plus portées à voyager à l'extérieur de leur quartier pour accéder à des services de soins de santé, ce qui entraîne des déplacements et un temps d'attente considérablement plus longs. Quant aux personnes qui auraient aimé utiliser les services d'un interprète, rares sont celles qui ont réussi à le faire. Le besoin ressenti le plus souvent mentionné est d'avoir plus de services en anglais et plus de travailleurs anglophones ou bilingues.

Afin d'améliorer l'accès et de rehausser la qualité de vie des personnes âgées, une formation et des programmes d'intervention appropriés doivent être mis sur pied au niveau de la communauté, cela en collaboration avec le gouvernement.

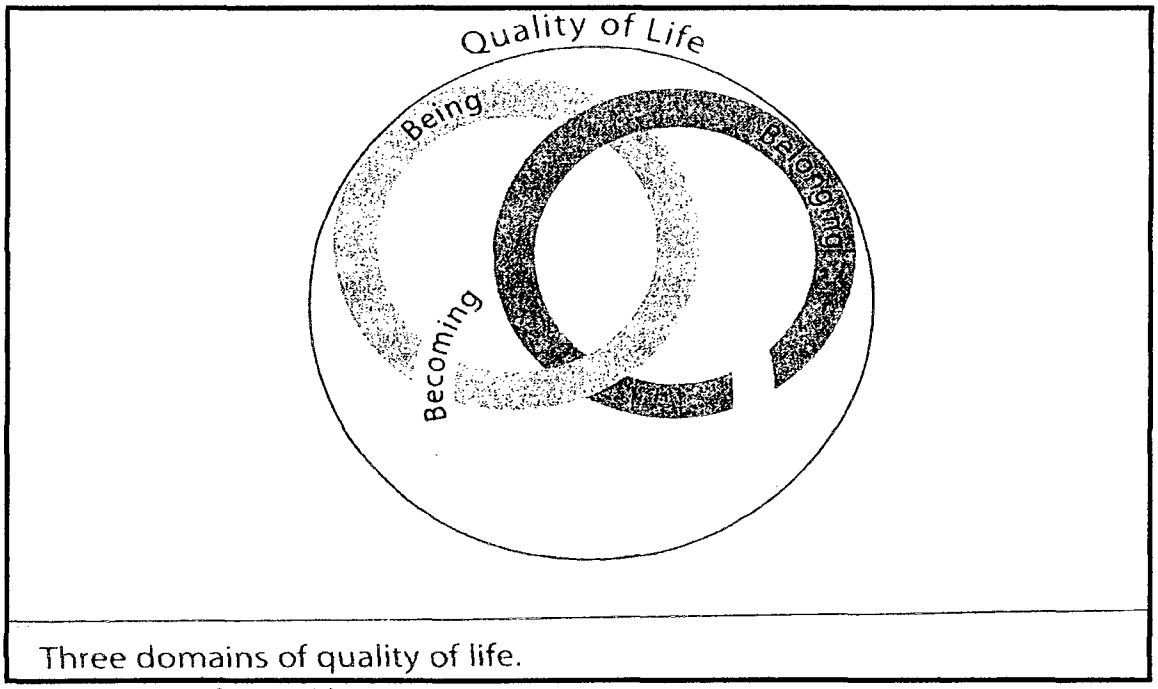
1. INTRODUCTION

"Our health ... is directly tied to our connection with our languages and our culture." (Dokis, 2004)

1.1 Why this Study?

The health, defined as "the bodily, mental and social quality of life of people as determined in particular by psychological, societal, cultural and policy dimensions" (Rootman & Raeburn, 1994), and the well being of a population largely depend on the potential of individuals, that is, on their spiritual, physical, psychological, emotional and social capacities to make their own decisions and to exercise a degree of control over their choices and lives. Hence, access to health care and social services becomes a critical element in one's well being and in the model of one's quality of life (the degree to which a person enjoys the important possibilities of his or her life through the interaction of the three domains of being, becoming and belonging, as illustrated in Figure 1) (Centre for Health Promotion, 1991).

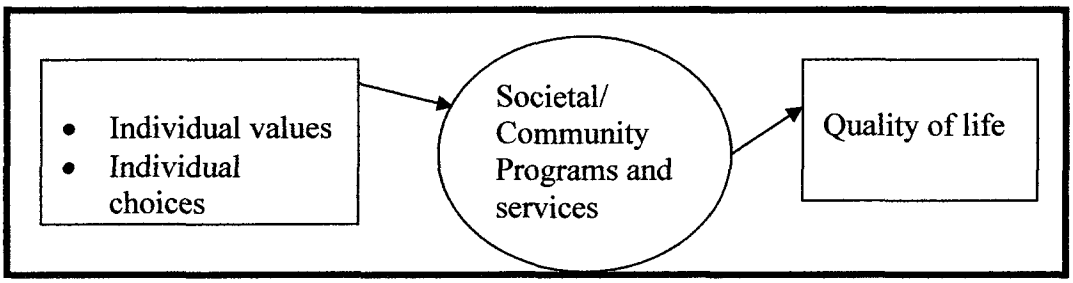
Figure 1: Quality of Life Model: Three Domains



***Source**: Centre for Health Promotion, 1991.*

Elderly people's ability to access healthcare services in a bilingual society is enmeshed with their well being and quality of life because all citizens, and senior citizens in particular, depend on a functional health and social service system in their community that is responsive to their needs in terms of availability, accessibility, timeliness continuity and equity with respect to their well being (Canada Health Act, 1984, 1. Criteria). This strikes at the core of a bilingual society such as Canada's, but most importantly at Quebec and particularly East-end Montreal, leading to the important question of how does such a system work effectively by equally discharging its obligations to its multicultural citizens by ensuring quality and timely access to healthcare services to the elderly. Limited access to health care and other social services to citizens hinders their sustainable well being as well as their quality of life, as described in diagrammatic form in Figure 2.

Figure 2: Quality of Life: Theoretical Diagram



Language as a public good may create arguments in bilingual societies, and governments may encounter linguistic rights challenges when deciding on whose rights to acknowledge and which language to use for human social service delivery. Therefore, Canada and Quebec might not be exceptional. However, the Quebec Province in relation to the federal government is legally a bilingual province that sets the authority and framework for health and social services to be delivered with a sense of equity.

On the other hand, legislatively, Montreal is considered to be a Francophone area, though there are a number of Anglophone and Allophone elderly who have lived in Montreal for many years, and who thus depend on the existing health and social services. Similarly, given the number of Anglophone and Allophone people living in Montreal as a

whole and in East-End Montreal in particular, one must pause and question the level of accessibility and the quality of healthcare services received by elderly people given their condition of vulnerability. Further, there are policies within the health and social services system that are put in place to safeguard users' rights in accessing these services, especially for minority groups, such as the elderly.

Consequently, limited resources and the government's inability to effectively fulfill its obligations call for communities and non-governmental organizations to work together to fill in service delivery gaps. One example of such community efforts is being carried out by Catholic Community Services Inc. (CCS) through its Cultivating Roots Program and in partnership with the Almage Seniors' Community Centre (Almage Centre). CCS was first incorporated in 1932 as the Catholic Welfare Bureau Inc., with a mandate to consolidate the activities of several English Catholic service agencies which existed in Montreal at that time. Today, the Agency is known as CCS-Catholic Community Services Inc.

The Almage Centre is the sole resource for the English-speaking community in East-End Montreal that prioritizes elderly people's needs and strives to empower them through different programs. As indicated by Gibson (1991), empowerment involves "...a *process of helping people to assert control over the factors which affect their lives*" (p. 359). Programs conducted by these two organizations not only engage elderly people in social and economic activities, but also advocate for their linguistic rights and problems relating to other privileges, such as access to health and social services, which hinder elderly people's positive day-to-day quality of life.

Hence, the combination of aging along with language and communication barriers impacts the provision of satisfactory healthcare services to these elderly people. One must then ask, what are the experiences and implications of East-End Montreal's Anglophone and Allophone elderly in accessing healthcare services? What other alternatives are they using to cope with this dilemma? Does the provision of health care in a second language affect the elderly well being? How do health and social services

provide a range of care and services to the elderly of a linguistic minority? How do Anglophones, Allophones and elderly French Montrealers view the provision of health care in a second language? Who is advocating for the Anglophone and Allophone elderly right to access healthcare services in their language of choice?

1.2 Problem Statement

1.2.1 Why East End Montreal?

In Montreal, there are wide variations in the availability of health and social services in English. Services in the western and central parts of Montreal are offered through a network of institutions with historical links to the English-speaking community and continue to be widely available in English. However, the offering of English services outside these limited areas appears to be inconsistent and restricted. Moreover, the ability of English speakers from outside of Montreal to use the services offered by Montreal's "Anglophone" institutions are constrained as administrative measures restrict the ability of clients to choose the institutions where they will be served. Without the investment of resources and some indication of political will, this tendency is unlikely to change (CROP-Missisquoi, 2001).

The island's East End is home to 50,000 English speakers; in 2000, more than four out of every ten patients were unable to receive English service from their local CLSC. Even in Montreal's West Island, where English speakers are the majority in a number of CLSC districts, one in every four callers was unable to get service in English through the Info-Santé health line (CROP-Missisquoi, 2001). This issue is critical as CLSCs are increasingly called upon to play a key role in the delivery of first-line, prevention, and home-care services to some of our most vulnerable citizens, such as elderly people.

1.2.2 Why Anglophone/Allophone?

Language problems are among one of the biggest challenges facing immigrants in the United States (Ponce, Hays & Cunningham, 2006). Language barriers can impede, among other things, access to health care (Flores, 1998; Jacobs, 2005; Timmins, 2002;

Woloshin, 1997) lower the quality of care (Ngo-Metzger, et.al., 2003; Sarver & Baker, 2000; Seid, Stevens & Varni, 2003) and result in dissatisfaction with care (Carrasquillo, Orav, Brnnan, Burstin, 1999; Morales, 1999; Weech-Maldonado, 2003). However, most studies on language barriers focus on children and on adults in their child-rearing years. Thus, very little is known about language challenges faced by elderly people in accessing healthcare services.

Similarly, Lamarre (2002) stated that language in Montreal is used in different types of settings, that is, geographical zones and social networks. Lamarre's study reveals that although Montreal is divided into linguistic zones, this fact does not impede movement; rather, factors such as community and institutional settings contribute to language conservativeness. This situation contributes to the escalation of problems and difficulties faced by the elderly of a linguistic minority when accessing healthcare services in their communities. Therefore, it is interesting to look at the experiences of Anglophone/Allophone elderly as a minority group in a Canadian Francophone minority society (a minority within minority).

1.3 Problem Justification – Literature Review

1.3.1 CROP-Missisquoi Institute study on English-language health and social services

In 2001, the Missisquoi Institute released polling data from the firm CROP on English-language health and social services in each region of Quebec. These data confirm that about 90,000 English-speaking Quebecers live in regions where their access to English-language health and social services is extremely limited. (CROP-Missisquoi, 2001)

In some regions, no real access to English-language health services can be said to exist. For example, in Mauricie-Bois Francs, home to about 6000 English speakers, levels of access to English-language services in different types of institutions range from a high of 40% for hospital overnight services to a low of 4% for hospital emergency room services. The Estrie region, centered in Sherbrooke, is home to a large and vibrant English-speaking population, which has enjoyed historically good relations with its

Francophone neighbours. While medical services provided in a private office are often accessible in English (79%), only 4 in 10 Anglophones who visited an emergency room were served in English, and just over half were able to get served in English through the Info-Santé health line (CROP-Missisquoi, 2001).

CROP-Missisquoi poll confirmed that, provincially, 75% of Francophone Quebecers agree with the statement that their English-speaking *concitoyens* should have access to health and social services in English no matter where they live (CROP-Missisquoi, 2001). In addition, Canada's seniors are diverse; thus, their overall well being and health depend on their location (Government of Canada, 2002). The fact raises an important need for evaluating elderly resilience in pursuing health care services of their choice.

This need is supported by research done by the CHSSN (Statistics Canada, 2001), which has indicated that limited health services to seniors, employment and, perhaps, childcare are the three areas in which Anglophones and Allophones in East-End Montreal lack support compared to Francophone. Furthermore, the study also points out that the language issue is one of the barriers to effective health and social service delivery. (CHSSN, 2004)

1.3.2 CHSSN Baseline Data Report 2003-2004 and 2005-2006.

The reports address general overview of the situation of the English-speaking population in a minority context as well as the particular demographic characteristics and vitality issues which vary tremendously across its 16 administrative health regions. (CHSSN, 2004)

The report indicated that there is a wide difference within the Montreal region: 80.5% of English-speaking respondents in Montreal (west) received CLSC services in English, compared to 38.6% of respondents in Montreal (east) (CHSSN, 2006). Its recommendations were targeted in considering future health and social services initiatives.

1.3.3 McGill University Training and Human Resource Development Project (THRD)

In an effort to improve access to health and social services, a multimillion dollar project was put in place with the goal of ensuring equal access to all; the aim was that English-speaking Quebecers should "*enjoy equitable access in their own language to the range of health and social services offered to the entire population*". The project was designed in collaboration with Health Canada's Consultative Committee for English-speaking Minority Communities and the Community Health and Social Sciences Network (CHSSN) (Reynolds, 2004).

This three-and-a-half year project is implemented by McGill University, in partnership with 16 regions and 29 health and social institutions. It envisages training, retaining, evaluating and researching issues related to the subject matter.
Its main objective is to ensure effective communication in English between English-speaking Quebecers and the health and social services workers who serve their needs, and to step up the participation of English-speaking personnel in Quebec's health and social services system. The project is implemented in four measures: Measure 1: A three-pronged language-training program; Measure 2: A retention and distance support program comprising Measure 3: Seminars and conferences; and Measure 4: An Innovation Fund (Dialogue, 2007).

The project intends to train English-speaking health and social services professionals, ensure effective communication, improve access to healthcare services by training service providers, and ensure that English-speaking Quebecers enjoy equitable access to healthcare services. Similarly, it will encourage English-speaking students in the social sciences and health disciplines to take placements within the English-speaking community in a Francophone province and to use the experience for job consideration (Dialogue, 2007). However, it is too early to evaluate the impact of the project and determine if elderly people in East-End Montreal are already benefiting from the envisaged goal and objectives.

Given the current situation, it is pertinent to know how vulnerable groups, such as elderly people in East-End Montreal, cope with the existing situation, especially when they want to access healthcare services in the language of their choice, whether they are exploring existing alternatives, and how they travel.

1.3.4 Consultations on Access to English-language health and social services in East-end Montreal. (CSSS study).

Four Centres des Santé et Services Sociaux [CSSS] — CSSS d'Ahuntsic et Montréal-Nord, CSSS de la Pointe-de-l'Ile, CSSS de Saint-Léonard et Saint-Michel, and CSSS Lucille-Teasdale, conducted a telephone survey of Anglophone residents aged 0-85+ *[sic]* in their territories. The main objectives were to review the organization of English-language primary care services to improve access to services for English-speaking residents of the Montreal-Nord territory and to support CSSS in improving access to health and social services. The project was funded by the CHSSN from the Primary Healthcare Fund (Health Canada) (CSSS, 2006).

Findings indicated that 20% of East-End Anglophones travelled west of St. Lawrence Boulevard, the traditional dividing line between English and French Montreal, to consult a healthcare professional in English. Among these 20%, the respondents stated that if services become available nearby, 54.2% would still continue travelling west, while 36.8% would appreciate having services closer to their homes. The study also reported that more than 75% of the respondents knew French well enough to consult a healthcare professional in French. Conversely, almost 24% of East-End Anglophones did not know French well enough to consult a healthcare professional in French. The study concluded by showing that the respondents preferred certain services to be offered in English; these included health-related information, emergency medical care, home care and professional services given in their home environment (CSSS, 2006).

Similarly, it was reported in Greater Montreal's Centraide newsletter *Redfeather Forum* in December 2006 and March 2008 that community groups in Montreal and the Province of Quebec have recognized that there is a problem with access to healthcare

services in English, and that measures are being taken to remedy this situation through better organization in the three administrative regions of Montreal, Laval, and the South Shore. The goal is "to establish regional forums that will carry out this mandate on a long-term basis." It was further noted that the Quebec Cabinet had in December 2007 approved access programs for English-language healthcare services. Sponsorship of the former initiative is by the Community Health and Social Services Network (CHSSN), with funding from the Department of Canadian Heritage; the latter programs will gradually come under local CSSSs (Fondation Centraide, 2008).

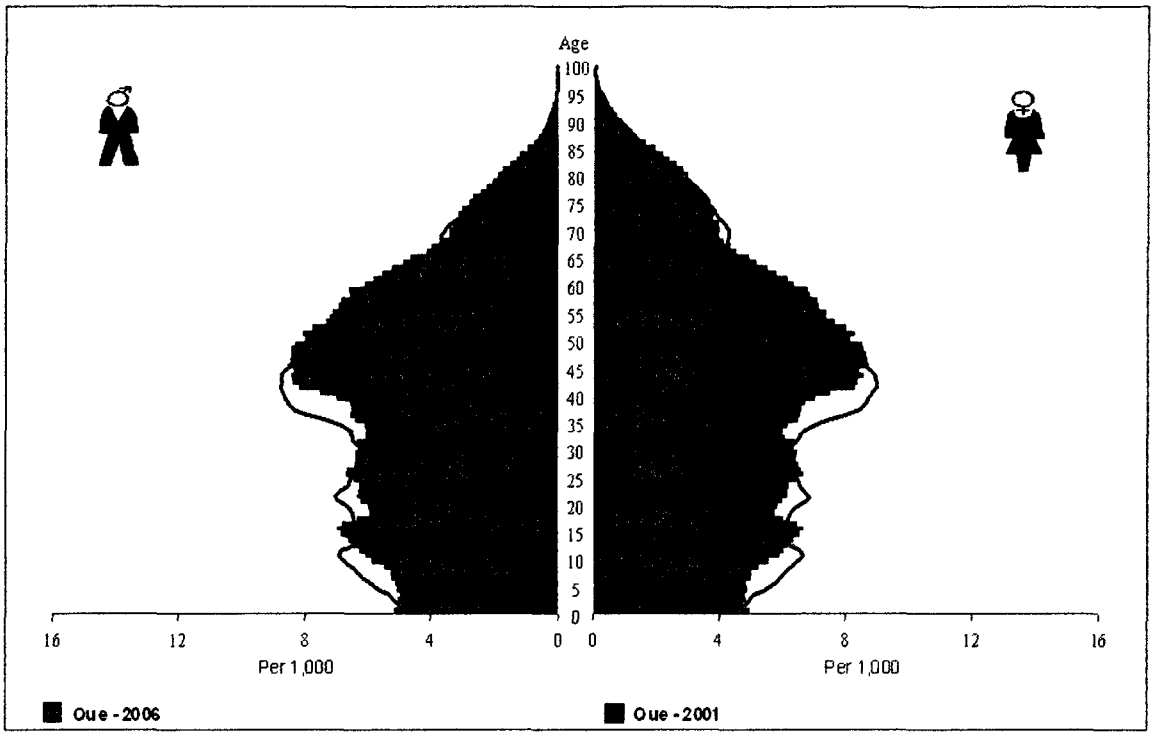
1.3.5 Why elderly people?

"Each of us is aging although at different levels. And as a population, Canada is aging faster than ever before. Today, people aged 65 and over make up some 13 percent of the Canadian population" (Shields & Martel, 2006).

According to a number of studies, Canada is one among the steadily aging countries; this is supported by a Statistics Canada (2003 & 2007, see also Anderson & Hussey, 2000) survey report reflects a decline in fertility and mortality rates. The percentage of seniors is expected to grow even more rapidly as the Baby Boom generation (those born from 1946 to 1965) begins to turn age 65 in 2011. The 65-and-over population made up a record 13.7% of the total population of Canada in 2006. While the proportion of the under-15 population fell to 17.7%, its lowest level ever. Further, the "oldest" seniors (those aged 80+) make up one of the fastest growing segments of the Canadian population. Therefore, Statistics Canada projects that by 2031 seniors will constitute 23% of the population (Statistics Canada, 2001, Statistics Canada, 2007).

Equally, in Quebec, the number of people aged 65 and older will increase during the next twenty years. Currently, Quebec has more than 1 million people aged 65 and over (Figure 3). Seniors made up 14.3% of the province's population, or one out of seven Quebecers (Statistics Canada, 2007).

Figure 3. Age Pyramid of Quebec Population in 2001 and 2006



Sources: Statistics Canada, censuses of population, 2001 and 2006.

Consequently, there will be more elderly people with health conditions that interfere with their autonomy. Furthermore, certain sensory disorders are more prevalent, while diseases of the circulatory system, cancers and respiratory diseases are by far the three leading causes of death in elderly people. In addition, digestive disorders and diabetes are leading causes of increased hospital admissions and frequencies of visits. In this regard, making access to healthcare services easier for the elderly is critical; and this, in turn, leads to a core question of this study.

1.3.6 Why access to health care?

The Canadian *Constitution Acts* (1867-1982), Schedule B, parts I & III, indicate the government's responsibility for its aging population's health, and the Canada Health Act (1984) consolidates and defines the five principles of the publicly funded healthcare system, known as Medicare, as comprehensiveness, universality, portability, public administration, and accessibility (Canada Health Act, 1984). But it does not put emphasis on the importance of language and culture in healthcare provision, especially to special

groups such as linguistic minorities. This results in patchwork coverage arrangements that vary considerably from province to province. However, the Canadian Constitution does not retain any specific federal responsibility for its aging population's health (Department of Justice), thus creating a loophole for the possibility of discriminatory healthcare services to minority groups and people.

Likewise, much emphasis is placed on primary health care with the intention to expand access to services to the community level and to provide the right services from the most appropriate provider in the best setting at the correct time and in the most efficient and economical manner (Government of North West Territories, 2002). There is very little emphasis on services provided to the elderly of linguistic minorities when they need to access healthcare services in their language of choice. The situation is critical for English-language services to the elderly living in Quebec and in East-End Montreal in particular.

Furthermore, research on access to health care is quite extensive among all population age groups; however, there are very few studies which look at factors and reasons why elderly people are prone to experience more difficulties in accessing healthcare services when compared to other age groups, and on how they able to cope with the situation. Much of the existing research looks at age factors as predisposing elderly persons to access difficulties (Shields & Martel, 2006).

1.3.7 Aging implications on the healthcare system

According to Leidl and Stratmann (1998), the elderly population in industrialized countries is considered to be one of the major factors driving the cost of health care upward. Therefore, study results from younger patient samples on their experience in accessing health care in a bilingual society may not adequately reflect the results expected from elderly people. In this regard, there is a need to conduct more studies which will reflect the real situation of the elderly population's experience in accessing health care in multilingual societies.

Canada's aging society results in a reduced work force and increases health care expenditures. Only 6% of all seniors were employed 1997, when compared to 9% in 1976, while more than one in 4 seniors are activity restricted due to long-term health problems (Buckley, 2005; Denton & Spencer, 2000; Evans, 2001; Government of Canada, 2002). Thus, the aging community results in a reduced work force and increased healthcare expenditures. However, it is expected that improvements in socio-economic status, lifestyle, and medical advances will allow for longer and healthier lives, resulting in proportionately less demand on healthcare services for the elderly, but such may not be the case for the linguistic-minority elderly living in Quebec and East-End Montreal in particular.

1.3.8 Language skills and access to health care for elderly people

According to a Statistics Canada (2007) report, the majority of Quebec occupants in all age groups have French as their mother tongue, nearly 10 times the number of Anglophones and Allophones. The data show that Francophones are 4 times bilingual at younger and older ages when compared to Anglophones and Allophones (Statistics Canada, 2007). These high percentages indicate a higher risk on linguistic-minority problems that can influence delivery of social services in the community and among different groups. (Mentel, 1998; Lamarre, 2001). However, there is very limited documented information on the experiences, implications and the effect of language in accessing health care among different groups in bilingual communities, especially among elderly people.

Similarly, there are very few published studies which evaluate the effect of language on access to healthcare services for elderly people in Canada and Quebec (English/French) and on the use of interpreters and the implications on the relationship between the service provider and the receiver. Though, a study by the Canadian Centre for Justice Statistics (2000) indicated that 7% of elders have experienced emotional abuse in the context of health care, and these abuses were manifested in different forms.

However, there a number of studies on the aging population, elderly healthcare systems, and aging implications, but very few studies that focuses on the experiences of

the elderly in minorities and with linguistic barriers, especially when accessing healthcare services in a bilingual society and the implications for their quality of life. Moreover, existing studies regarding experiences in accessing health care in bilingual societies draw results from younger patient samples; thus, they may not adequately reflect the results expected from the elderly.

1.3.9 Language barrier and access to health and social services

Although the CROP-Missisquoi (2001) study, the Canadian Centre for Justice Statistics (2000) and the Community Health and Social Services Network (2004) report provide extensive studies comparing rates of access to health care, including elderly people among the subjects, these studies simply identify factors affecting differing rates of access to health care among individuals from different age groups. However, the studies do not tell us how vulnerable groups, such as the elderly, immigrants and the like are coping with the current situation, and what other choices are out there? Nor do they tell us who are helping them advocate for the rights and navigate through the current situation, or how their limited choices affect their quality of life.

This is an important gap which needs to be explored because, unlike the elderly people's personal health status, variables, including their knowledge of French, lack of interpreters and accompaniment to healthcare facilities, not only affect their ability to use the healthcare services located near their residences, but also force them to make difficult decisions or to travel longer distances, spending a long time commuting or waiting for the healthcare services of their choice.

It follows from these considerations that this topic and the questions it raises need to be reflected upon at this point in time because part of East-End Montreal's elderly community face challenges in accessing health care and social services that it is their right to have, according to the prevailing policies, regardless of their orientation, race or status.

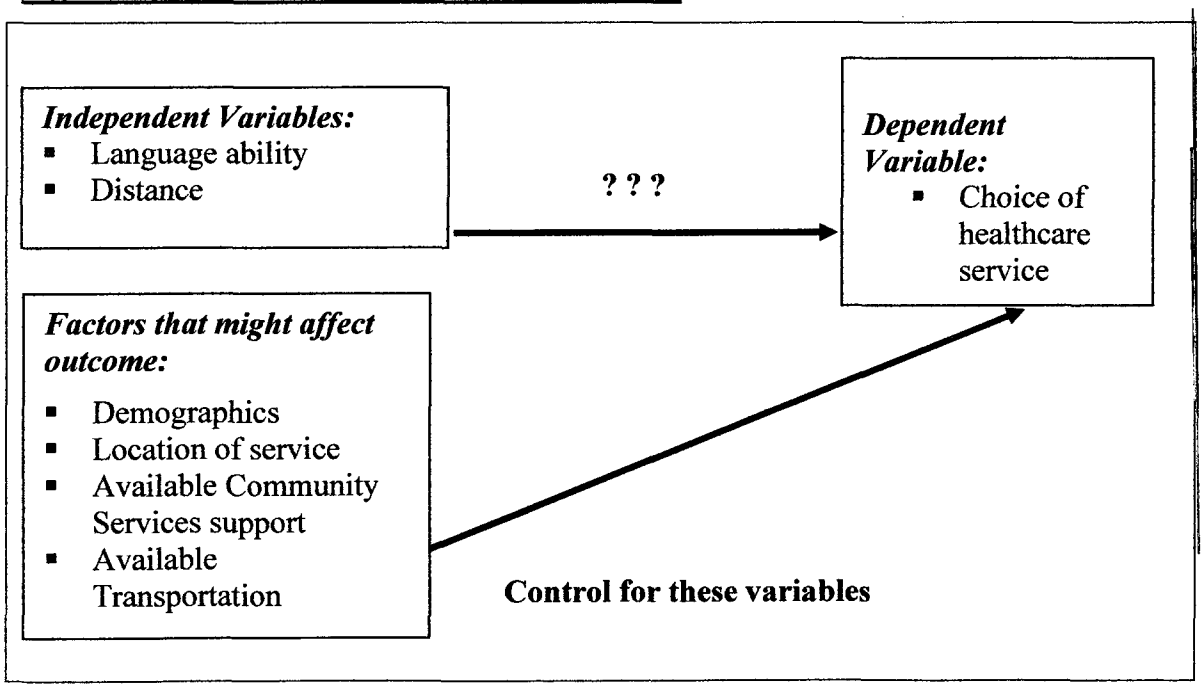
1.4 Study Objectives

Following from the considerations posed by the sources surveyed in the literature review, it emerges that the proposed objectives of this study ought to centre on two aspects:

- To examine the situation of elderly Anglophones/Allophones in East-End Montreal in order to determine how well they are able to access healthcare services and to find out what compromises they have to make in coping with language difficulties and geographical distances, and
- To compare the specific situations of elderly Anglophones/Allophones in this area with the situation of Anglophones generally as reported by the CSSS study (2006).

Figure 4 illustrates how the independent variables, especially language ability and geographical distance, affect the outcome of choice of healthcare service. This is the theoretical model that guides the methodological procedures of the current study.

Figure 4: Health line choices: Theoretical model



2. METHOD

2.1 Design

The study carried out was intended to be non-experimental and descriptive. It comprised a survey of elderly men and women who visited the Almage Seniors' Community Centre (Almage Centre) or who were visited in their homes under the Centre's home support program. Participants were from different ages, religions and ethnic origins. Conducted in English, the survey captures the English-language healthcare needs for Anglophone and Allophone elderly persons, who are minority group in the East-End Montreal population.

The Almage Centre is situated at 8680 Hochelaga, Montreal, Quebec, H1L 2M6, and is the only resource for the English-speaking community in East-End Montreal that prioritizes seniors' needs through assessment and experience. The organization is dedicated to enriching the quality of life of its members aged 50 years and over by providing an atmosphere of friendship and confidence where they can socialize with other people who share similar experiences and interests. Almage lobbies on behalf of its members, English-speaking seniors in the East End, around issues of equal access to health and social services. The Centre promotes the elderly clients' independence and well-being through different programs, such as community meals, educational and recreational activities, French language courses, home support services (visits, calls and medical accompaniments), minibus transportation and health promotion. The Centre's staff and volunteers work with local CLSC's to facilitate effective communication and intervention. It was during the Centre's activities that participants were notified by the staff about data collection both at the Centre and in home settings.

2.2 Sample

- The sample frame consisted of all the Allophone and Anglophone men and women 50-85+ years of age listed in the Centre's register in Montreal, Quebec. The Centre caters for a total of 600 elderly people. One third (200) of targeted sample of elderly men and women intended for this study were at the time of the study living in East-End Montreal.

- To ensure representativeness, 160 elderly men and women were conveniently recruited at the Centre's settings, while 40 subjects from the home support program list were selected by using systematic (interval) sampling; the latter are members of the community who receive home visitation as part of the Centre's support program.

2.3 Questionnaire

A questionnaire was designed for this study with 26 questions broken down into four sections (Appendix 1). For the sake of accuracy and to yield maximum response and applicability to a larger group, the questionnaire was pretested with 10 elderly people at the Almage Centre. Prior to its application, amendments were made to remove ambiguities and to incorporate new ideas, and the final version was used.

1. Healthcare setting and services available. The first section was designed to determine the level of participants' understanding of their surroundings and the available healthcare services in their neighborhood (example: "Where do you live?" which contains 3 questions. Examples of questions in this category are "Is there a CLSC near your home?" "Does it provide health care in English?").
   (CLSC refers to a *Centre Local de Services Communautaires*, local community service centre. In Quebec these are free clinics which are run and maintained by the provincial government.)
2. Health care preference/choice. The second section of questionnaire, which consists of 5 questions, was designed to depict participants' choice of healthcare services and the reasons behind the choice. Sample questions from this category are "Where do you go?" or "Have you been to a CLSC?", "Primary motive?" etc. Some of these questions were adapted from "Consultations on Access to English-Language health and social services in East-End Montreal study" (CSSS, 2006).
3. Proximity, time factor and language used. The third section, consisting of 10 questions, was intended to inquire about participants' means of transport to the healthcare services of their choice, the time spent commuting and waiting, and the ability to use the French language for communication.

4. Demographics. The demographic questions were designed to determine gender, age, marital status, ethnic origin, living arrangement and religion, and how these kinds of diversity influence access to English-language healthcare services. Each answer was coded on frequency and scale and nominal variables.

An additional, open-ended question was included to get subjects' opinions and, thus, to provide further information to determine how access to English-language healthcare services may be a problem for elderly people in the East End.

2.4 Procedure (Data Collection)

Prior to application of the questionnaire, written authorization from the CCS (Appendix 2) and the Almage Centre (Appendix 3) were obtained to enable usage of the organization's facilities and the members' participation in the study. Following receipt of ethical approval from McGill University (Appendix 4), the organization was informed and plans were put in place for the surveys to be distributed.

To facilitate effective distribution and collection of the questionnaires to elderly persons at the Centre and during home support visits, two volunteer research assistants were recruited from the Almage Center. These research assistant/volunteers were given one day's training on data collection skills, the importance of observing neutrality, confidentiality and observing bias.

During the Almage Centre's senior activities and on the home support program, the Centre's director, staff and volunteers introduced me and informed participants about the data collection process. Potential participants were advised orally and in writing by a cover letter attached to each survey (Appendix 5) that should they choose to participate, their responses would remain anonymous, and if they chose not to participate their decision would not interfere with or influence services provided to them by the Almage Seniors' Centre; that participation was voluntary and that they could choose not to participate; that they might withdraw from the study and/or return the survey blank if they decided otherwise after receiving it and felt that they did not want to participate. Participants were also asked not to put any identifying information on the survey and

were informed that the information provided would remain anonymous (a note on the questionnaire).

Respondents were recruited and surveyed during the fall of 2006 and the winter of 2007. Approximately 200 questionnaires were distributed at the Almage Center and in homes in East-End Montreal, Quebec, Canada. To simplify administration of questions to participants who were unable to read and write due to old age and/or other physical disabilities, questions were clearly and loudly read to them and their answers duly recorded. This was done for both home and the Centre's participants. Data for the elderly who come to the Almage Centre and for those receiving home support were collected separately due to their difference in capability and the data collection methods used.

Agency:

A total of 160 surveys were handed out and collected at the Centre by me and the two research assistants during day-to-day Centre activities. Any elderly man or woman who showed up at the Centre to use or to require social services during the period of September – December 2006 was requested to fill in a questionnaire. Some of the questionnaires were distributed during the Centre's special occasions, such as lunch, their bazaar and the annual fundraising activity. Potential respondents were requested to fill in the survey on-site; however, a few asked for and were given the survey to take home to their partners and friends who were not able to come to the Centre.

Home support:

By using the Almage Centre's facilities, 40 questionnaires were delivered to and collected from identified subjects receiving home care support during visitation periods. Structured interviews were used for participants who were unable to fill in the questionnaire because of vision, hand-stability or concentration difficulties. Respondents who were helped to complete the questionnaires at home could not remain completely anonymous: however, their names were not indicated on the questionnaires.

To avoid non-response or attrition, agency tracking was used, and good relationships were developed. (Rubin & Babbie, 2005, pp. 509-512) Participants were

encouraged and given a choice to answer the questionnaire and hand it back the same day or take it home and return it promptly. The researcher and research assistants kept track of the number of questionnaires handled out at the events and counted them as they were returned.

Neither the subjects not the research assistants received any compensation for participating. After the data collection, I communicated with the Almage Centre to thank the coordinator and the volunteers as well as the respondents for their participation, assistance and cooperation.

2.5 Analysis

- During the data collection, inevitably certain questions were not answered or answers were given in a form other than that specified. In these cases certain conventions were used. For English healthcare choice, when answers given spanned two categories (for example, in the borough and downtown) the answers were rounded to the nearest residential proximity. On reaching and waiting time questions, hours were converted into minutes. In terms of demographics, when more than one answer was indicated, for example in age, the highest category was chosen. For example, one respondent choose 2 (65-74) and 3 (75-85), thus 3 was assumed to be his age range.
- Data were analyzed using computer program SPSS version 11.5.
- Several nominal and scaled variables were dichotomized for statistical correlation purposes (Appendix 6).
- For Questions 12 and 18, hours and minutes were converted to minutes.
- Frequency distributions were produced for all categorical variables.
- Categorical variables were cross-tabulated by gender, ethnicity and source of data; values of X^2 were calculated to show statistically significant relationships.
- For two scaled variables, reaching and waiting times, *t*-tests were used to calculate mean scores by source of data and knowledge of French, and to test for statistically significant difference.

- Bivariate correlations were calculated between nominal and scaled variables, using Spearman's rho.
- One-sample X^2 tests were used to compare fits of frequencies for selected variables with percentages as reported in the CSSS (2006) study.
- SPSS ONEWAY procedure was used to compare mean reaching time for various service locations.

FINDINGS

3.1 Description of Sample

Table 1 shows a description of the sample ($N = 199$), comprising 145 females (72.9%) and 54 males (27.1%). This represents a very elderly group of people; almost 60% were over 75 years old. Over half were of British or Irish ethnic origin, and fewer than 60% were Catholic. A majority were born in Canada. The only two significant differences by gender were in marital status and living arrangements; more male subjects were married and lived with someone, while more female subjects were widowed and lived alone. More than 90% of the respondents knew that there was a CLSC near their homes.

Table 2 shows values of selected variables by ethnic origin. No significant difference in French knowledge was found between ethnic groups. However, there were statistically significant differences on a number of demographic factors, such as age, religion and marital status, as shown in bold in the table. For example, relatively more of the British/Irish subjects were over 65 years of age and lived alone.

Table 3 shows significant differences by source of data (agency vs. home). Although most respondents admitted that there was a CLSC near their homes, fewer than 25% said that they went there for healthcare services, and more than 50% reported having to travel west for healthcare services in the past twelve months.

Because of their living situation, respondents interviewed at home were significantly more likely to be accompanied to hospital or clinic, and to use private transportation. They were significantly less likely to report that they would prefer an interpreter.

Table 1. Description of Sample by Gender

	Female		Male		Total	
Question #	*N*	%	*N*	%	*N*	%
1. Where do you live?						
Ahuntsic et Montreal Nord	2	1.4	0	0.0	2	1.0
St. Leonard/St. Michel	29	20.3	13	24.1	42	21.3
LucilleTeasdale	35	24.5	9	16.7	44	22.3
Pointe-de-l'Ile	76	53.1	30	55.6	106	53.8
Montreal Ouest	1	0.7	2	3.7	3	1.5
2. Is there CLSC near home?						
Yes	129	89.0	51	96.2	180	90.9
No	14	9.7	2	3.8	16	8.1
I do not know	2	1.4	0	0.0	2	1.0
3. Does it provide health care services in English?						
Yes	55	39.3	17	35.4	72	38.3
No	65	46.4	27	56.3	92	48.9
I do not know	11	7.9	4	8.3	15	8.0
It depends/Sometimes	9	6.4	0	0.0	9	4.8
21. Marital Status[1]						
Married	**36**	**24.8**	**27**	**50.9**	**63**	**31.8**
Separated/divorced	**31**	**21.4**	**12**	**22.6**	**43**	**21.7**
Widow	**78**	**53.8**	**14**	**26.4**	**92**	**46.5**
23. Ethnic or Cultural Origin						
British & Irish	76	53.9	27	50.0	103	52.8
Other European	51	36.2	22	40.7	73	37.4
American	4	2.8	1	1.9	5	2.6
Asian & M. East	10	7.1	4	7.4	14	7.2
24. Age						
Under 64 years	20	14.4	5	9.4	25	13.0
65-74 years	37	26.6	16	30.2	53	27.6
75-84 years	62	44.6	27	50.9	89	46.4
85+	20	14.4	5	9.4	25	13.0
25. Living Arrangement[2]						
Alone	**78**	**56.9**	**18**	**34.6**	**96**	**50.8**
With someone	**59**	**43.1**	**34**	**65.4**	**93**	**49.2**
26. Religion						
Catholic	88	62.4	27	50.9	115	59.3
Protestant & Anglican	47	33.3	20	37.7	67	34.5
Muslim & Orthodox	6	4.3	6	11.3	12	6.2

[1] $X^2\,(2, n = 198) = 14.60, p < .001$ [2] $X^2\,(1, n = 189) = 7.51, p < .01$ (Fisher's exact test $p = .005$)

Table 1. ***(Continued).***

Question #	Female		Male		Total	
	N	%	*N*	%	*N*	%
27. Were you born in Canada?						
Yes	83	57.20	31	58.50	114	57.60
No	62	42.80	22	41.50	84	42.40
28. How long have you lived in Canada?						
1-30 years	2	3.10	1	4.30	3	3.40
More than 30 years	62	96.90	22	95.70	84	96.60

Table 2. Selected Variables by Ethnic Origin.

Question #	British & Irish		Other European		American		Asian & M.East	
	N	%	*N*	%	*N*	%	*N*	%
1. Where do you live?[1]								
Ahuntsic et Montreal Nord	**2**	**2.0**	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**
St. Leonard/St. Michel	**13**	**12.7**	**23**	**31.9**	**0**	**0.0**	**6**	**42.9**
LucilleTeasdale	**24**	**23.5**	**15**	**20.8**	**3**	**60.0**	**2**	**14.3**
Pointe-de-I'Ile	**63**	**61.8**	**32**	**44.4**	**2**	**40.0**	**5**	**35.7**
Montreal Ouest	**0**	**0.0**	**2**	**2.8**	**0**	**0.0**	**1**	**7.1**
14. Do you know French well enough?								
Yes	29	28.4	20	27.8	2	40.0	5	35.7
Not much	52	51.0	28	38.9	3	60.0	5	35.7
No	21	20.6	24	33.3	0	0.0	4	28.6
21. Marital Status[2]								
Married	**24**	**23.5**	**32**	**43.8**	**1**	**20.0**	**4**	**28.6**
Separated/divorced	**23**	**22.5**	**11**	**15.1**	**2**	**40.0**	**6**	**42.9**
Widow	**55**	**53.9**	**30**	**41.1**	**2**	**40.0**	**4**	**28.6**
24. Age[3]								
Under 64 years	**8**	**8.1**	**12**	**17.1**	**0**	**0.0**	**4**	**28.6**
65-74 years	**23**	**23.2**	**27**	**38.6**	**0**	**0.0**	**1**	**7.1**
75-84 years	**55**	**55.6**	**22**	**31.4**	**4**	**80.0**	**7**	**50.0**
85+	**13**	**13.1**	**9**	**12.9**	**1**	**20.0**	**2**	**14.3**
25. Living arrangements[4]								
Alone	**60**	**61.9**	**26**	**37.1**	**2**	**40.0**	**7**	**50.0**
with Someone	**37**	**38.1**	**44**	**62.9**	**3**	**60.0**	**7**	**50.0**
26. Religion[5]								
Catholic	**45**	**45.5**	**61**	**83.6**	**3**	**75.0**	**4**	**28.6**
Protestant/Anglican	**53**	**53.5**	**9**	**12.3**	**1**	**25.0**	**2**	**14.3**
Muslim /Orthodox	**1**	**1.0**	**3**	**4.1**	**0**	**0.0**	**8**	**57.1**

[1] X^2 (12, n = 193) = 25.20, p < .02; [2] X^2 (6, n = 194) = 13.67, p < .05 [3] X^2 (9, n = 188) = 20.03, p < .02

[4] X^2 (3, n = 186) = 10.20, p < .02 [5] X^2 (6, n = 190) = 98.04, p < .01

Note: Because of low cell frequencies p values should be interpreted with caution.

Table 3. Significant Differences by Source of Data

Question #	Agency		Home		Total	
	N	%	*N*	%	*N*	%
2. Is there CLSC near home?[1]						
Yes	**152**	**95.0**	**28**	**73.7**	**180**	**90.9**
No	**6**	**3.8**	**10**	**26.3**	**16**	**8.1**
I do not know	**2**	**1.3**	**0**	**0.0**	**2**	**1.0**
4. Where do you go for health problem?						
Government/hospitals	88	55.0	22	57.9	110	55.6
CLSC[2]	**32**	**20.0**	**14**	**36.8**	**46**	**23.2**
Private clinic	23	14.4	9	23.7	32	16.2
Go to family doctor	124	77.5	25	65.8	149	75.3
9. Who takes you to the hospital/clinic/doctor?[3]						
Alone	**91**	**57.2**	**8**	**21.1**	**99**	**50.3**
Family/Friend	**67**	**42.1**	**25**	**65.8**	**92**	**46.7**
Almage C. Volunteers	**1**	**0.6**	**5**	**13.2**	**6**	**3.0**
10. What transport do you use?[4]						
Public (Train/Bus)	**73**	**46.8**	**8**	**22.2**	**81**	**42.2**
Private (Drive/Taxi	**65**	**41.7**	**23**	**63.9**	**88**	**45.8**
Almage Centre	**13**	**8.3**	**5**	**13.9**	**18**	**9.4**
All/Walk	**5**	**3.2**	**0**	**0**	**5**	**2.6**
11. In the past year have you gone west for services?[5]						
Yes	**87**	**55.1**	**14**	**36.8**	**101**	**51.5**
No	**71**	**44.9**	**24**	**63.2**	**95**	**48.5**
15. Do you prefer interpretor?[6]						
Yes	**50**	**32.1**	**5**	**13.2**	**55**	**28.4**
No	**106**	**67.9**	**33**	**86.8**	**139**	**71.6**

[1] $X^2(2, n = 198) = 21.36, p < .01$; [2] $X^2(1, n = 198) = 4.88, p < .05$; [3] $X^2(2, n = 197) = 27.47, p < .01$
[4] $X^2(3, n = 192) = 9.45, p < .05$; [5] $X^2(1, n = 196) = 4.07, p < .05$; [6] $X^2(1, n = 194) = 5.37, p < .05$
Note: Because of low cell frequencies *p* values should be interpreted with caution.

3.2 Choice of Healthcare Facilities

Table 4 shows geographical location and transportation factors for choice of healthcare services. There was only one statistically significant difference by gender; significantly more women (20.1%) than men (5.6%) chose private clinics. Over two thirds of respondents chose English-language services in the downtown/Montreal West, compared to 25% who chose Montreal East. Principal reasons given were "my family doctor lives there" (over 70%), or "English services are better there" (35%).

Table 4. Use of Health Care Services: Location and Transportation Factors

Question #	Female		Male		Total	
	N	*%*	*N*	*%*	*N*	*%*
4. Where do you go when you have health problems?						
Government hospital	82	56.9	28	51.9	110	55.6
Community/CLSC	37	25.7	9	16.7	46	23.2
Private Clinic[1]	**29**	**20.1**	**3**	**5.6**	**32**	**16.2**
Family doctor	105	72.9	44	81.5	149	75.3
5. Have you ever been to CLSC for health care services?						
Yes	103	71.5	38	76.0	141	72.7
No	41	28.5	12	24.0	53	27.3
6. If you decide to go to a CLSC. Where do you go?						
D'Ahunstic et Montreal-Nord territory	1	0.7	0	0.0	1	0.5
Saint-Leonard et Saint Michel	34	25.4	15	29.4	49	26.5
Lucille-Teasdale territory	27	20.1	8	15.7	35	18.9
Pointe de L'ille territory	65	48.5	27	52.9	92	49.7
I don't Know/I don't go	7	5.2	1	2.0	8	4.3
7. Where do you go for English-language services?						
Montreal East	36	24.8	14	25.9	50	25.1
Notredam/NDG/CDN	7	4.8	6	11.1	13	6.5
Downtown/Montreal West	102	70.3	34	63.0	136	68.3
8. What is your primary motive for going?						
My family doctor practices there	100	71.9	35	68.6	135	71.1
My Specialist practices there	31	22.3	13	25.0	44	23.0
I was referred there	17	12.2	9	17.3	26	13.6
My Operation was scheduled there	12	8.6	3	5.8	15	7.9
English services are better there	46	33.1	20	38.5	66	34.6
Recommended by famly/friend	5	3.6	0	0.0	5	2.6
Reputation of the hospital	27	19.4	10	19.2	37	19.4
Service is not available near home	8	5.8	3	5.8	11	5.8
Service is near my work/school	1	1.0	2	3.8	3	1.6
9. Who takes you to the hospital/clinic/doctor?						
Alone	68	47.6	31	57.4	99	50.3
Family/Friend	69	48.3	23	42.6	92	46.7
Almage Centre Volunteers	6	4.2	0	0.0	6	3.0
10. What transport do you use?						
Public (Train/Bus)	55	39.30	26	50.0	81	42.2
Private (Drive/Taxi	65	46.40	23	44.2	88	45.8
Almage Centre	16	11.40	2	3.8	18	9.4
All/Walk	4	2.90	1	1.9	5	2.6
11. In the past year, did you travelled outside your CLSC?						
Yes	79	55.60	22	40.70	101	51.5
No	63	44.40	32	59.30	95	48.5

[1] X^2 (1, n=198) = 6.16, p < .02

Table 5 shows language factors that affect the choice of healthcare services. No statistically significant differences were found between the responses of men and women.

Almost three quarters of the respondents reported that there were no English signs at the CLSC to help them navigate though the healthcare system, and fewer than 30% said they knew French well enough to communicate with healthcare providers. Over 25% would have preferred an interpreter, but only 8% actually got one.

Over 10% reported going without medical care because English services were too far from their homes.

Table 5. Use of Health Care Services: Language Factors.

	Female		Male		Total	
Question #	*N*	%	*N*	%	*N*	%
13. Are there English signs to help you at the CLSC?						
Yes	20	15.4	9	18.0	29	16.1
No	93	71.5	38	76.0	131	72.8
I don't know	14	10.8	2	4.0	16	8.9
I don't go/N/A	3	2.3	1	2.0	4	2.2
14. Do you know French well enough to consult consult healthcare professional in French?						
Yes	39	27.3	18	33.3	57	28.9
Not much	70	49	19	35.2	89	45.2
No	34	23.8	17	31.5	51	25.9
15. Do you prefer an interpreter?						
Yes	45	31.7	10	19.2	55	28.4
No	97	68.3	42	80.8	139	71.6
16. Do you actually get interpreter to help you communicate with healthcare workers?						
Yes	12	8.8	3	5.8	15	8.0
No	124	91.2	49	94.2	173	92.0
17. Have you gone without medical care because English services were far from your home?						
Yes	13	9.50	7	13.2	20	10.5
No	124	90.5	46	86.8	170	89.5

Table 6 shows two statistically significant predictors of French-language knowledge: age and birthplace. Older respondents, and those not born in Canada, were much more likely to choose the neutral "not much" category.

Table 6. Significant Predictors of French Language Knowledge.

	Yes		Not Much		No		Total	
Question #	*N*	%	*N*	%	*N*	%	*N*	%
24. Age[1]								
Under 64 years	**8**	**32.0**	**6**	**24.0**	**11**	**44.00**	**25**	**100.0**
65-74 years	**13**	**24.5**	**19**	**35.8**	**21**	**39.60**	**53**	**100.0**
75-84 years	**28**	**32.2**	**45**	**51.7**	**14**	**16.10**	**87**	**100.0**
85+	**5**	**20.0**	**18**	**72.0**	**2**	**8.00**	**25**	**100.0**
27. Were you born in Canada?[2]								
Yes	**45**	**39.8**	**34**	**30.1**	**34**	**30.1**	**113**	**100.0**
No	**12**	**14.5**	**55**	**66.3**	**16**	**19.3**	**83**	**100.0**

[1] X^2 (6, n = 190) = 23.15, p = .001

[2] X^2 (2, n = 196) = 26.57, p < .001

Note: In this table % are of row totals.

Table 7 shows service choice by knowledge of the French language. There were several statistically significant relationships. Respondents with a good knowledge of French were most likely to use healthcare services in Montreal East, and to go alone to the hospital or clinic. This relationship is also graphically shown in Figure 5. Respondents with the least French knowledge were more likely to go for healthcare services with a family member or friend, and to travel to the western part of Montreal to get better English services.

Table 7 : Service Choice by Knowledge of French Language.

	Yes		Not Much		No		Total	
Question #	*N*	%	*N*	%	*N*	%	*N*	%
7. Where do you go for English-language services?[1]								
Montreal East	**18**	**31.6**	**21**	**23.6**	**11**	**21.6**	**50**	**25.4**
Notredam/NDG/CDN	**2**	**3.5**	**3**	**3.4**	**8**	**15.7**	**13**	**6.6**
Downtown/Montreal West	**37**	**64.9**	**65**	**73.0**	**32**	**62.7**	**134**	**68.0**
8. What was your primary motive for travelling to west?								
My family doctor practices there	45	80.4	59	69.4	31	64.6	135	71.4
My specialist practices there	15	26.8	16	18.8	12	24.5	43	22.6
I was refered there	10	17.9	6	7.1	10	20.4	26	13.7
My operation was scheduled there	2	3.6	7	8.2	6	12.2	15	7.9
English service are better there[2]	**9**	**16.1**	**42**	**49.4**	**14**	**28.6**	**65**	**34.2**
Recommendation	0	0.0	1	1.2	4	8.2	5	2.6
Reputation of hospital	9	16.1	13	15.30	15	30.6	37	19.5
Service is not available near home	2	3.6	4	4.70	5	10.2	11	5.8
Services is near my work/school	0	0.0	0	0.00	3	6.1	3	1.6
9. Who takes you to the hospital/clinic/doctor?[3]								
Alone	**41**	**71.9**	**40**	**45.5**	**18**	**35.3**	**99**	**50.5**
Family/Friend	**15**	**26.3**	**44**	**50.0**	**32**	**62.7**	**91**	**46.4**
Almage Centre Volunteers	**1**	**1.8**	**4**	**4.5**	**1**	**2.0**	**6**	**3.1**
15. Do you prefer interpreter?[4]								
Yes	**4**	**7.0**	**36**	**41.9**	**15**	**30.0**	**55**	**28.5**
No	**53**	**93.0**	**50**	**58.1**	**35**	**70.0**	**138**	**71.5**
16. Do you get interpreter?[5]								
Yes	**1**	**2.0**	**12**	**13.6**	**1**	**2.1**	**14**	**7.5**
No	**50**	**98.0**	**76**	**86.4**	**47**	**97.9**	**173**	**92.5**

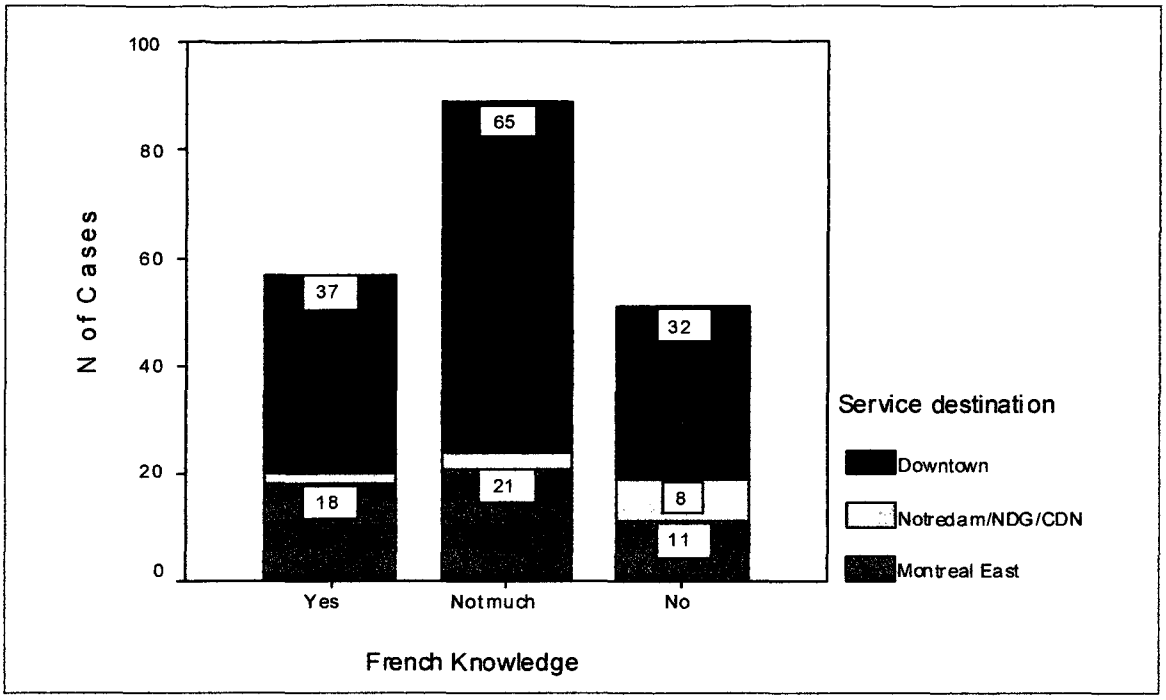
[1] X^2 (4, n = 197) = 10.49, $p < .05$; [2] X^2 (2, n = 190) = 17.60, $p < .001$

[3] X^2 (4, n = 196) = 17.24, $p < .003$; [4] X^2 (2, n = 193) = 20.49, $p < .001$

[5] X^2 (2, n = 187) = 9.07, $p < .02$

Note: Because of low cell frequencies p values should be interpreted with caution.

Figure 5. Service Destination by French Knowledge



3.3 Reaching and Waiting Times

Figures 6 and 7 show the frequency distributions for time taken to reach service destination (reaching time) and time spent waiting for service at the destination (waiting time). Though times appeared reasonable for most respondents, the outliers are disturbing, reporting over 6 hours reaching and 2 hours waiting time for some seniors.

Figure 6. Frequency Distribution: Reaching Time

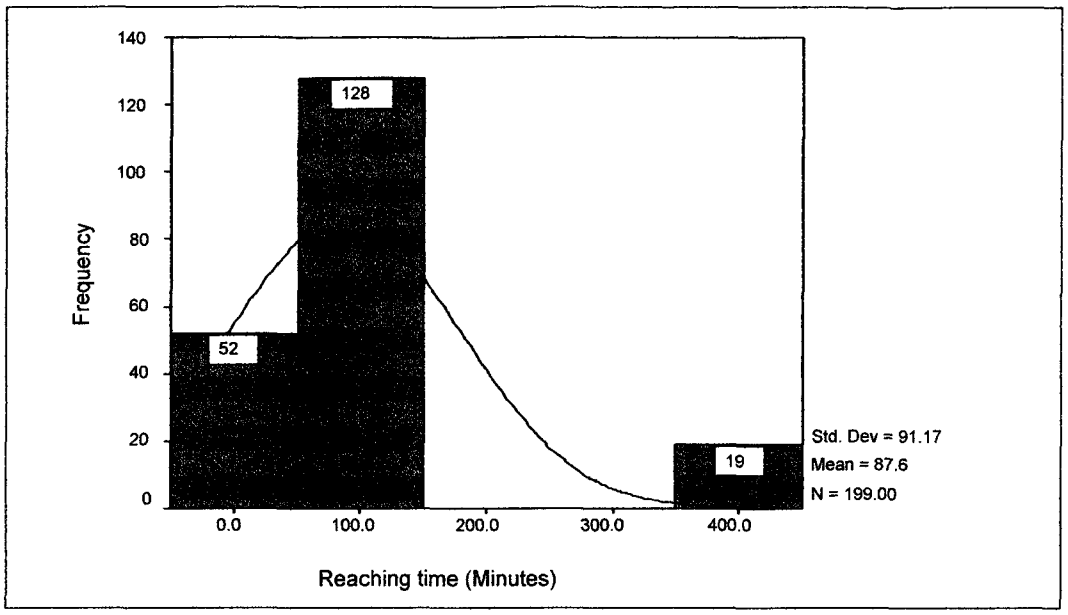


Figure 7. Frequency Distribution: Waiting Time

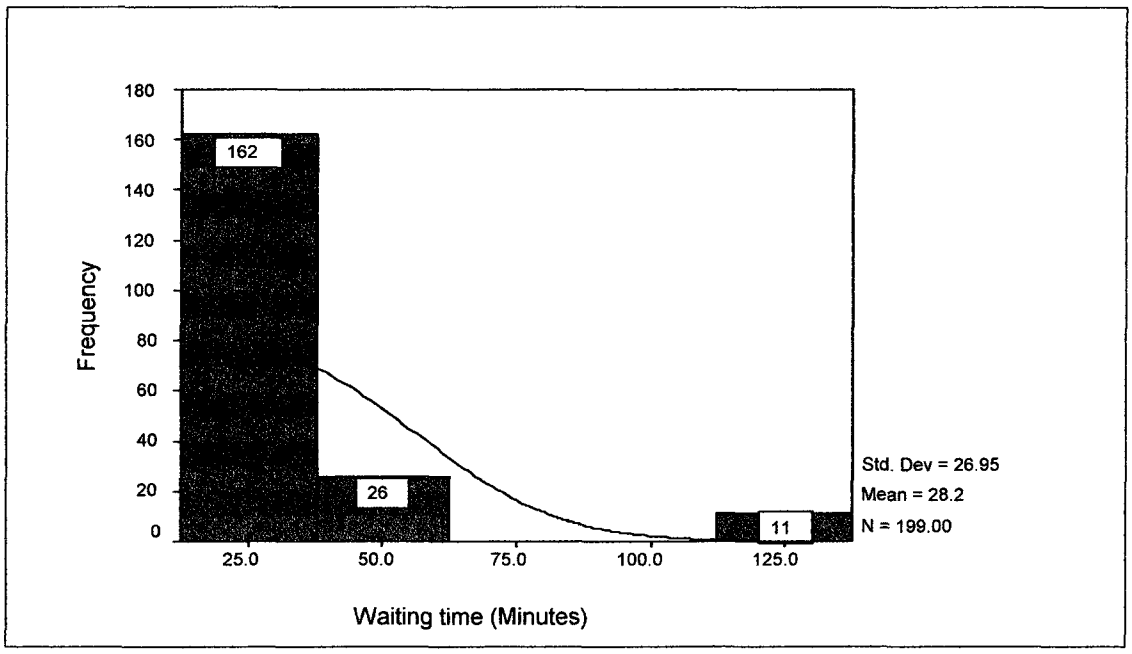


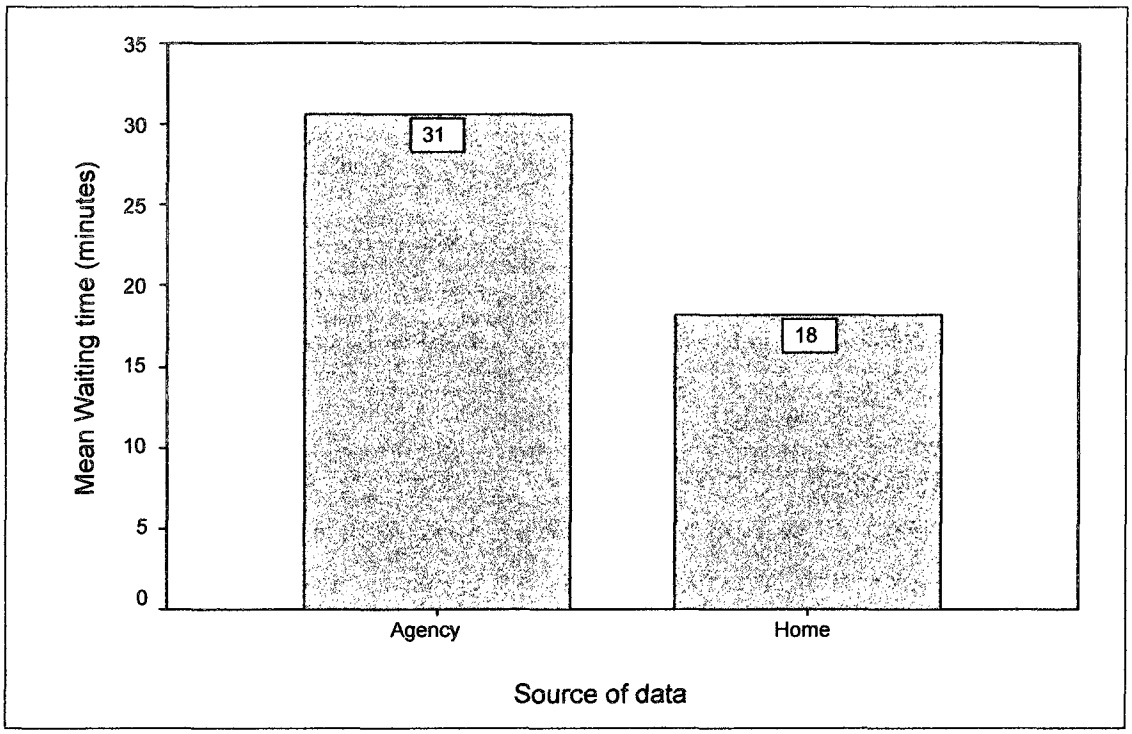
Table 8 shows the relationship between data source and reaching and waiting times. Respondents from the agency reported significantly longer waiting times than home support cases; this difference is illustrated graphically in Figure 8.

Table 8. Reaching and Waiting times by Source of Data

Question #	Agency		Home	
	Mean	*SD*	*Mean*	*SD*
12 How long does it take you to reach English - health care services?	84.60	90.86	100.0	92.6 (minutes)
18 How long does it take you to get English-language services at CLSC?	**30.56**	**29.18**	**18.16**	**8.65** (minutes)

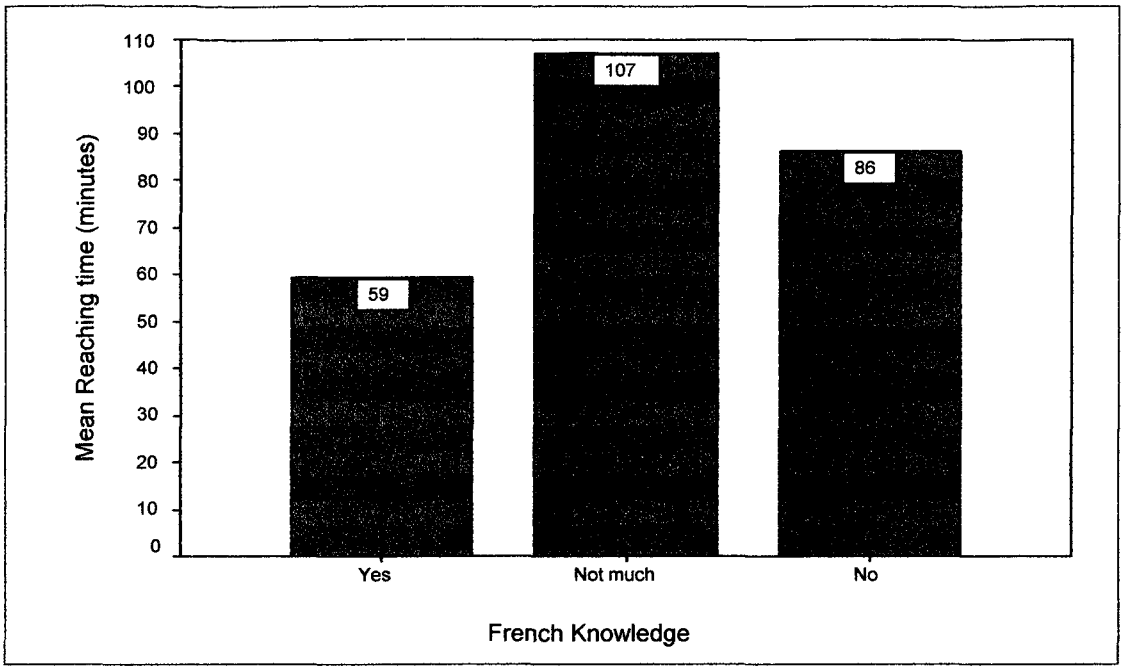
[1] $t(n = 197) = 4.60, P < .001$

Figure 8. Waiting Time by Source of Data



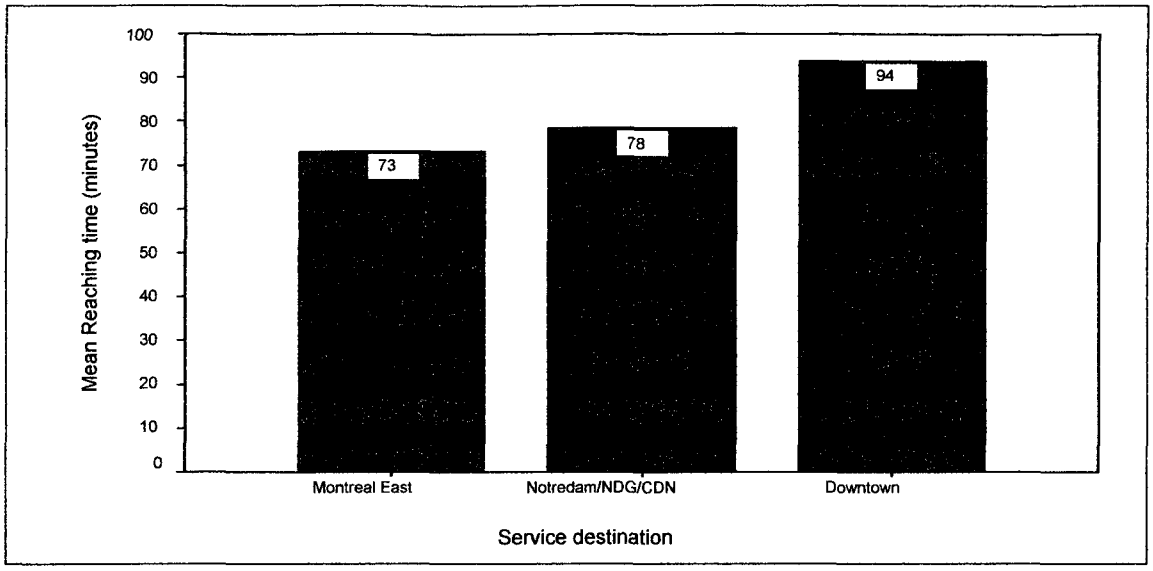
There was a statistically significant relationship between reaching time and French knowledge, reaching time was higher for respondents with less knowledge of French: Spearman's rho (N=197) = .18, $p < .01$. This relationship is illustrated graphically in Figure 9.

Figure 9. Reaching Times by French Knowledge



There was also a relationship between reaching time and service destination; mean reaching times were 94.2 minutes for downtown, 78.9 minutes for the NDG area and 73.2 minutes for Montreal East (see Figure 10). Though these differences are in the expected direction, they do not reach statistical significance. The linking relationship between French knowledge and service destination has already been shown (Table 7).

Figure 10. Reaching time by Service Destination



3.4 Comparison With External Study

It was possible to compare these findings with the earlier study (CSSS, 2006) on four variables: age distribution, knowledge and use of French language, travel outside CLSC territory, and primary motives for travelling. Since only percentage breakdowns – not *N*s – were available for the earlier study, one-sample X^2 procedures were used. All the following differences were highly statistically significant.

Table 9 shows a comparison by age category of the current study ($N = 199$) with the CSSS study ($N = 1{,}811$). Since no percentage breakdown was available for the total CSSS sample, separate comparisons were made for the regions with sufficiently large *N*s. For all three Montreal East regions, the proportion of elderly subjects was much higher in the current study than in the CSSS study.

Table 9. Comparison with CSSS Study: Age Categories.

	St-Leonard/St-Michel[1]			Lucille Teasdale[2]			Point de l'Ile[3]		
	CSSS	**CS**		**CSSS**	**CS**		**CSSS**	**CS**	
	%*	*N*	*%*	*%*	*N*	*%*	*%*	*N*	*%*
Age									
Under 64 years	**80.2**	**7**	**17.1**	**83.5**	**3**	**7.1**	**86.66**	**14**	**13.7**
65 - 74 years	**9.7**	**13**	**31.7**	**9.44**	**7**	**16.7**	**9.49**	**31**	**30.4**
75 - 84 years	**4.58**	**17**	**41.5**	**5.81**	**23**	**54.8**	**4.31**	**45**	**44.1**
85 +	**0.99**	**4**	**9.8**	**1.26**	**9**	**21.4**	**0.65**	**12**	**11.8**

[1] X^2 (3, n = 41) = 185.53, p < .001; [2] X^2 (3, n = 42) = 340.50, p < .001

[3] X^2 (3, n = 102) = 686.96, p < .001

Note: CS indicates data from current study.

* Did not add to 100% in CSSS report

Table 10 shows the comparison for the knowledge and use of the French language. The percentage of respondents with no knowledge of French was almost twice as high in the current sample. This difference is also shown graphically in Figure 11.

Table 10. Comparison with CSSS study: Knowledge and Use of French Language.

	CSSS	**Current study**	
Question #	%	*n*	%
14 French Knowledge			
Yes	75.5	57	28.9
Not much/DNK/DNA	0.6	51	25.9
No	23.9	89	45.2

[1] X^2 (2, n = 197) = 2193.58, p < .001

Note: (DKN=Do Not Know and DNA=Do Not Apply)

Figure 11. Comparison with CSSS Study: Knowledge and Use of French Language

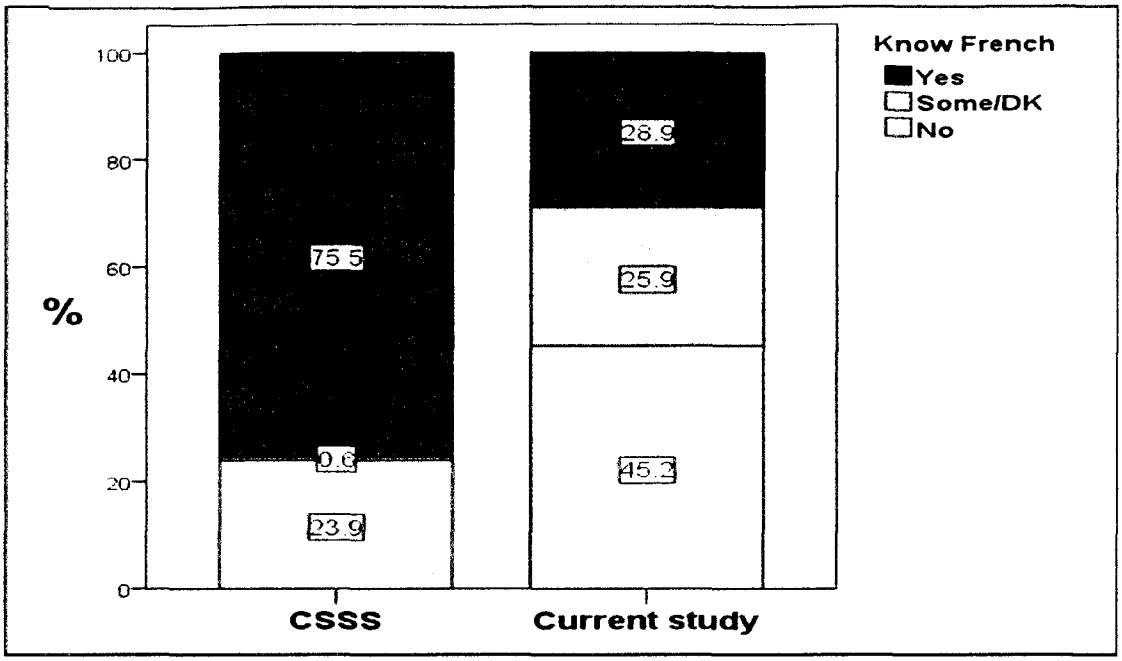


Table 11 shows the comparison for travel outside CLSC territory for English healthcare services. In the current study over 50% of respondents reported having to travel west for English healthcare services, compared with only 20% in the CSSS study. This difference is also shown graphically in Figure 12.

Table 11. Comparison with CSSS Study: Travel Outside CLSC Terittory.

	CSSS	Current study	
Question #	%	*n*	%
11. In the past year have you gonewest for services?[1]			
Yes	**20.0**	**101**	**51.5**
Sometimes/DNK/DNA	**0.07**	**0**	**0**
No	**79.3**	**95**	**48.5**

[1] X^2 (1, n=196) = 120.06, p < .001

Note: Because of low cell frequencies p values should be interpreted with caution.

Figure 12. Comparison with CSSS Study: Travel Outside CLSC Territory.

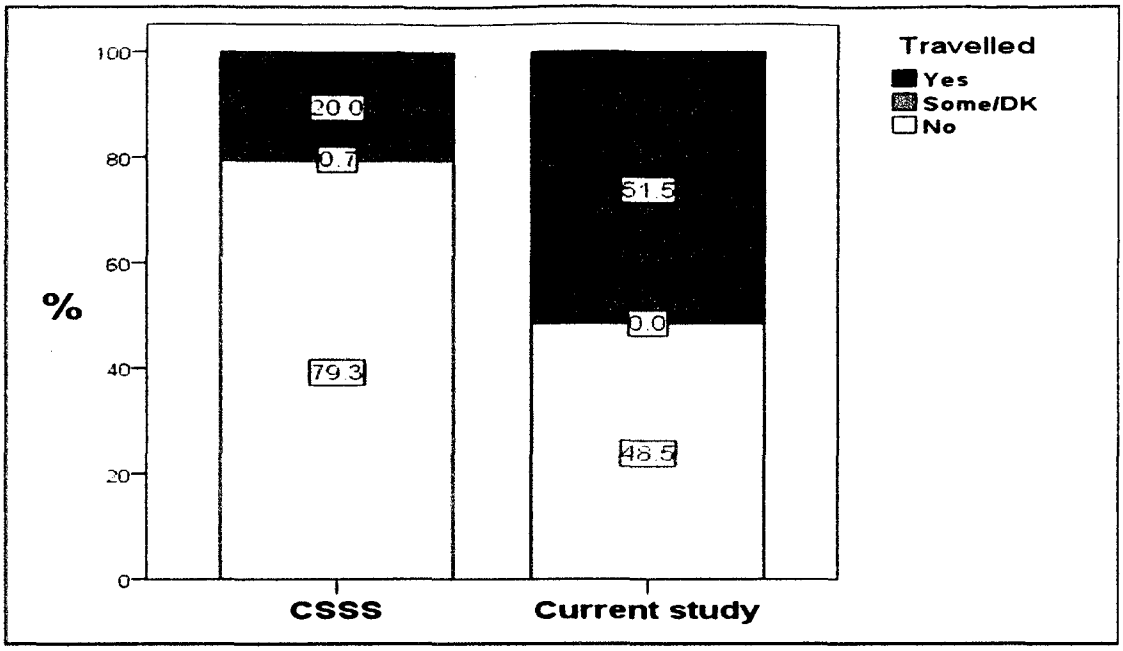


Table 12 shows the comparison for the primary motive for travelling west. Percentages were significantly higher for the current sample on five different categories: family doctor, referral, operation, English services and reputation of the hospital.

Table 12. Comparison with CSSS study: Primary Motives for Travelling.

	CSSS	Current study	
Question #	%	*n*	%
8. What is your primary motive for going west?			
Family doctor[1]	**27.1**	**135**	**71.1**
My Specialist Practices there	18.5	44	23.0
I was referred there[2]	**6.2**	**26**	**13.7**
My operation was scheduled there[3]	**0.9**	**15**	**7.9**
English services are better there[4]	**12.9**	**66**	**34.6**
Recommendaton from family/friend	2.2	5	2.6
Reputation of the hospital[5]	**3.8**	**37**	**19.4**
Service is not avaialble near home	4.1	11	5.8
Service is near my work/school	1.0	3	1.6

[1] $X^2(1, n = 190) = 185.79 = p < .001$ [2] $X^2(1, n = 191) = 18.04$, $p < .001$

[3] $X^2(1, n = 191) = 103.54$, $p < .001$ [4] $X^2(1, n = 191) = 79.71$, $p < .001$

[5] $X^2(1, n = 191) = 126.69$, $p < .01$

Note: Only 'Yes' answers are recorded for this question

3.5 Responses to open-ended question

Table 13 summarizes responses to the open-ended question about suggestions to improve English-language healthcare services. By far the most common comment was a need for more English and/or bilingual workers and services (*N*=59, or 50% of the total sample).

Table 13. Comments about Access to English Heath Care Services.

	Female		Male		Total	
Question # 19	*N*	%	*N*	%	*N*	%
Want more English workers and services	29	51.8	5	27.8	34	45.9
Want Bilingual Workers and services	17	30.4	8	44.4	25	33.8
There is no alternative/we need choice	3	5.4	1	5.6	4	5.4
Don't go to CLSC because of language	2	3.6	1	5.6	3	4.1
I translate for my colleagues/elderly should learn both languages	1	1.8	1	5.6	2	2.7
Have no problem with available services	1	1.8	1	5.6	2	2.7
No comment/we can not change/Language issue is confusing	3	5.4	1	5.6	4	5.4

4. DISCUSSION

4.1 Key findings

The findings generally answered the study question, showing that English-speaking seniors in East-End Montreal experience difficulties when trying to access healthcare services.

4.1.1 Current sample

This study was based on a convenience sample of 199 elderly people served by an Anglophone agency in East-End Montreal. Subjects were mainly females (73%), of English or other European background (90%). A majority (89%) were Catholic, and born in Canada. Approximately half lived alone. A substantial majority of subjects reported that they travelled outside Montreal East for healthcare services, most (68%) using services downtown or in Montreal West. Subjects with a poorer knowledge of French were significantly more likely to travel west for healthcare services, and they reported significantly longer average travel times. Home-based subjects, who were more likely to receive family or agency help in accessing services, were less likely to travel west for services and experienced significantly shorter waiting times.

A number of subjects (28%) reported that they would prefer to have an interpreter when they were dealing with health care providers, but only 8% said they were actually able to get an interpreter. Of the responses to the open-ended question on possible improvements, 50% mentioned the need for more English-speaking or bilingual workers.

4.1.2 Comparison with CSSS sample

Compared with the earlier study, respondents in the current sample were older, had less knowledge of the French language, reported more travel outside Montreal East for healthcare services, and were more likely to do so to see a family doctor or because English services were better there. All these differences were highly statistically significant.

4.2 Limitations

The study had several limitations. Foremost, the language ability and coping strategies are self-reported; therefore, the study may not fully capture French-language effectiveness in navigating the healthcare system or communicating with healthcare providers. Other limitations were as follows:

1. This was a convenience sample, limited to elderly Anglophones and Allophones who were members of the Almage Seniors' Centre. Results cannot be generalized to the entire English-speaking population of Montreal East.
2. The questionnaire used was designed for this study. Though it was pre-tested with a sample of seniors, some of the wording may not have been completely clear.
3. Though the same instrument was used, different methods were followed for agency and home-based subjects. The interviewers had an opportunity to observe home-care subjects and explain the questionnaire, which may have introduced some bias into the responses.

4.3 Implications for Policy and Practice

The results of the current study provide empirical support for the relationship between language communication capability and ease of access to healthcare services. Use of community organizations' services in accompaniment and transport was associated with a low level of reaching and waiting times. Linguistic barriers experienced by the elderly in agency settings contribute to long-distance travel in the search for healthcare services in their language of choice. This study did not indicate a high preference for interpreters, probably because many respondents simply chose to go west for healthcare services.

Policy:

One policy suggestion would be to renew funding and mandate of the human resource training project at McGill University so that it could produce and retain more bilingual healthcare providers in East-End Montreal who could provide better Anglophone client-centered bilingual healthcare services there.

Agency visiting elderly appear to have an increased risk of difficulty in accessing health care as compared with those in the Almage homecare program. Therefore, home-help programs for the elderly could prove to be more effective when they are community based and all services are readily accessible when needed.

The availability of community programs, such as the Almage Senior Centre, bilingual and culturally sensitive trained staff and volunteers to facilitate the regularity of access to health care, ought to be prioritized and ensured. This is necessary to help minimize reaching and waiting times for healthcare services and will thus contribute to seniors' quality time. The findings confirm Andersen's conceptualization that system enablers in healthcare services could address the barriers faced by elderly people (Andersen, 1995).

Practice:

Therefore, building community capacity to create and delivery programs and services at the community level is key to improving elderly persons' access to healthcare services. It is recommended that more programs like that of the Almage Seniors' Centre be established throughout Montreal, especially where minority seniors are concentrated, and that these programs be supplemented with additional specialty services with seamless linkages at different levels. Such services could include, but not be limited to transportation, accompaniment and language interpretation.

Since social workers and policy makers work hand in hand to effect change. Professional training programs should be developed to provide the necessary skills for social workers and community support personnel to engage collaboratively with healthcare professionals. Bilingual/multilingual language training and inculcation of cultural sensitivity should be encouraged in both schools and the community to facilitate communication for healthcare providers and receivers. Community organizations could also promote a helping spirit towards the elderly among the community's members through good neighborhood initiative programs and/or educational workshops.

Therefore, it is recommended that:

- Emphasis be placed on and application be made of the People in the Environment (PE) model, and that client-centered theory for elderly healthcare service provision be fostered as an alternative to minimize alienation, with its socio-economic implications, and to improve access for seniors to healthcare services of their choice and to improve their quality of life:
- Support for and usage of community services to ensure for elderly people programs of sustainability and community survival be advocated and mobilized.

The value and benefit of this study is to contribute knowledge in our community discourse on issues of linguistic barriers in relation to access to healthcare service provision, and the implications for the health, social integration and quality of life of our elderly fellow citizens.

4.4 Suggestions for further Research

- A larger sample could be used, tapping more data sources and possibly involving different ethnic groups (there were twelve ethnic and cultural groups reported in East-End Montreal).
- The questionnaire could be translated into other relevant languages.
- For greater generalization, the study could be extended to other Anglophone elderly people (from other east-island social service centers) not included in this study to find out what their experiences are, what other challenges they face, and how they are coping with them.
- The study looked at access and healthcare services in general terms; different results might be yielded if information for specific services were sought.
- The methodology could be improved by using a client-centered approach to assess the satisfaction of frail older adults concerning their access to health care experiences and to measure the level of their feelings and to observe their reactions.
- Use of different research design and sampling procedure.

- A comparison study could be pursued between the Almage Centre and similar community centers in the western part of the island. A sample from the Almage Centre might be compared with samples from an organization such as the Teapot 50 Plus Centre of Lachine, Quebec.
- The actual health profile of these people and their use of healthcare services could be checked, health statistics for East-End Francophones and West-End Montreal Anglophones could be compared.
- A test could be constructed to find out how the same respondents would react if English-language healthcare services were provided in their neighbourhood by English-speaking Francophones (e.g. bilingual workers trained by the McGill project).

4.5. Conclusion

In conclusion, it can be noted that studies on the experiences among the elderly of linguistic minorities in accessing healthcare services have been limited by methodological concerns. Interpretations of the identified geographical differences, demographic factors and the importance of culture practice in the healthcare community suggest that elderly healthcare service providers and policy makers should recognize the variety of values and preferences found among people of divergent ages, racial and ethnic groups in order to facilitate easier accessibility.

Findings demonstrate that the Anglophone/Allophone elderly in East-End Montreal experience undue hardship in accessing healthcare services primarily because of their inability to speak French fluently enough to communicate effectively with healthcare providers. Although this study did not specify the range of healthcare services to which the elderly seek access, it is evident that both lack of language competence on the part of these elderly people and the lack of availability of interpreters play a key role in limiting access to healthcare services.

Language barriers can have an adverse effect on choices and initial access to healthcare facilities regardless of where they are located. The example on elderly people

having to travel out of East-End Montreal for health care services reflects the stress that is experienced by those who cannot access services closer to their homes.

Furthermore, results show that aside from language barriers, there are related issues, such as choice and proximity, which point to motivation as an issue affecting elderly people's ability to use healthcare services near their homes. Although the findings suggest that there are insufficient numbers of bilingual healthcare providers to meet the needs of the Anglo and Allophone elderly, there is a reservation about the use of interpreters, as has been pointed out by other studies. This is because translation is not the same as direct communication between the healthcare provider and the recipient; and this, in turn, suggests that with the use of interpreters care given and received may be to some extent compromised.

Hence, the limited number of community organizations that advocate for elderly people's access to health care by provision of home-care programs contributes to an increase in frustration among seniors and the demand for bilingual workers and services. Only a few of these seniors are able to be accompanied by the Almage staff and volunteers in order to reduce their travelling and waiting time.

It is clear that future research priorities ought to better inform clinicians and policy makers about ways to allow for more linguistic and culturally sensitive approaches to the elderly people's access to health care in their communities. The situation could be ameliorated by increasing the number of healthcare providers who are bilingual and by adding to the number of highly skilled interpreters who can better communicate with seniors about their health problems.

APPENDICES

APPENDIX 1
Questionnaire

McGill

Please do not write your name on this questionnaire

LANGUAGE AND HEALTH CARE ACCESSIBILITY QUESTIONS

The information you provide will be used as part of my Master of Social Work thesis, at McGill University and not for any other purpose. All questionnaires will be in the researcher's safe possession and will be treated as confidential and not revealed to any person not involved in this study. The questionnaire will take you about 15-20 minutes to complete.
Remember: You have the right to withdraw from this study anytime you may wish to do so.

Please circle the answer which best suits your situation and experience.

Here we would like to find out where you live and the kind of health care services available near your home.

1. Where do you live?
    1. Point aux Trembles/Rivière des Praires
    2. Mercier Est
    3. Anjou
    4. Rosemont
    5. St. Leonard
    6. Maisonneuve/Hochelaga
    7. Other: Mention: .....

2. Is there a community/CLSC near your home?
    1. Yes
    2. No

3. Does it provide healthcare services in English?
    1. Yes
    2. No

Here we would like to know your choice for healthcare services and reason behind it.

4. Where do you go when you have health problems? (Circle all appropriate) 1.
    Government/hospitals
    2. Community/CLSC
    3. Private clinic
    4. Family doctor
    5. Other: Mention:. . . . . .

5. Have you ever been to a CLSC for healthcare services? 1
    Yes
    2. No

6. If you decide to go to a CLSC. Where do you go?
    1. D' Ahuntisic et Montréal-Nord territory
    2. Saint-Léonard et Saint-Michel
    3. Lucille- Teasdale territory
    4. Pointe de l'Ille territory
    5. Other: Mention:.....

Appendix 1 - continued.....

McGill

Please do not write your name on this questionnaire

7. If you decide to go further to get English-language services. Where do you go?
   1. At your borough
   2. East-end
   3. Downtown
   4. Notre-dame
   5. Other. Mention .....

8. What is your primary motive for travelling to receive healthcare services:
   1. My family doctor practices there
   2. My specialist practices there
   3. I was referred there
   4. My operation was scheduled
   5. English services are better there
   6. Recommendation from family/friend
   7. Reputation of hospital
   8. Service is not available near home
   9. Service is near my work/school

Here we would like to know how you go, time spent and language of communication while there.

9. Who takes you to the hospital/clinic/doctor?
   1. No one, I go alone
   2. Family member
   3. Friend
   4. Other, Mention: .....

10. What transport do you use when going for English-language healthcare services?
    1. Public (bus/metro)
    2. Private (drive/taxi)
    3. Community centre transport
    4. Other, Mention .....:.....

11. In the past twelve months have you traveled to receive healthcare services in English outside your CLSC territory/west of Saint-Laurence blvd?
    1. Yes
    2. No

12. How long does it take you to reach English-healthcare services? .....hrs .....min

13. Are there English signs to help you find your way around CLSC clinics?
    1. Yes
    2. No

14. Do you know French well enough to consult a healthcare professional in French?
    1. Yes
    2. No
    3. Sometimes

15. Do you prefer an interpreter in your encounter with healthcare providers?
    1. Yes
    2. No

Appendix 1 - continued.....

McGill

Please do not write your name on this questionnaire

16. Do you actually get an interpreter to help you communicate with healthcare workers?
    1. Yes
    2. No

17. Have you gone without medical care because English services were far from your home?
    1. Yes
    2. No

18. How long does it take you to get English-language services at CLSC?.....hrs. .....min

19. Any other comments or concern to improve English-healthcare services:
.....
.....
.....

Here we would like to know few things about you: (Circle the appropriate condition)

20. Sex: 1. Female
    2. Male

21. Marital status:
    1. Married
    2. Single
    3. Divorced/Separated
    4. Widow

23. What do you consider to be your ethnic or cultural origin?
    1. Italian
    2. Chinese
    3. Polish
    4. Hindu-Pakistan
    5. Spanish
    6. Greek
    7. Irish
    8. British
    9. Ukrainian
    10. First Nations

24. Age: 1. Under 65 years
    2.65 -75 years
    3. 75 - 85 years
    4. More than 85 years

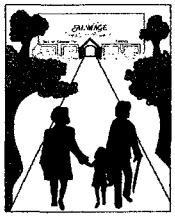
25. Living arrangement:
    1. I live alone
    2. With family member
    3. With friend
    4. Other (Mention):.....

26. Religion:
    1. Catholic
    2. Protestant! Anglican
    3. Jewish
    4. Muslim
    5. Other, Mention:.....

27. Were you born in Canada?
    1. Yes
    2. No

28. If you answered 'no' in question 27. How long have you lived in Canada?
    1. 1-15 years
    2. 15-30 years
    3. More than 30 years

APPENDIX 3
Almage Centre Authorization



ALMAGE

Serving the English Speaking Senior Community of East End Montreal
Since 1982

September 6th 2006

Ms. Lynda McNeil
Research Ethics Officer
James Administration Building, Room 429
McGill University

Dear Ms. McNeil,

This is to confirm that Ms. Rosemary Thomas, MSW student, will be working on the Cultivating Roots Project—Access to English-Language Healthcare Services for Elderly in East-End Montreal.

We authorize Ms. Thomas to meet with Almage Center members, clients, and volunteers in order to conduct her study. In addition, Ms. Thomas will have access to and permission to use the center members' files and any other information needed to facilitate the study.

During the data collection there will be one student intern (BSW—U2), a volunteer (former intern) and a staff member (Home Support Program) who will assist Ms. Thomas as research assistants. They will be available to help on Tuesdays and Wednesdays.

There is a mutual understanding that all data collected via the questionnaire will be kept confidential and is intended as part of Ms. Thomas' "Master's in Social Work Program" thesis at McGill University. The information will also be used by the Almage Center for program planning.

Please feel free to contact me should you require additional information.

Sincerely,
Filomena Manno

Filomena Manno
Center Director

CCS 8680 Hochelaga, Montreal, Quebec, H1L 2M6 Tel: (514) 355-1712 Fax: (514) 355-0806
E-mail: almage@ccs-Montreal.org Website : www.almage.org

APPENDIX 5
Questionnaire Cover Letter

Montréal, Sept 2006

Dear Participant,

RE: Questionnaire on access to English language healthcare services for elderly in East-end Montreal

Information you provide on attached questionnaire is an important part of Ms. *Rosemary H. Thomas* Master's of Social Work thesis requirement at McGill University, her research supervisor is *Prof. Sydney Duder* at School of Social Work.

This questionnaire is anonymous; your participation is voluntary and confidential. Though, study result will be shared by the researcher, her supervisor, and may be used by CCS and Almage Center in program planning.

You have the right to withdraw from the study anytime you wish to do so, however, that will have no immediate or future effect/relationship on services provided to you by the Centre. The questionnaire may take you about 15-20 minutes to complete.

For more information and/or if you have interested on the findings, you may contact me at rosemary.thomas@mcgill.ca .

Thank you for your participation.

Rosemary Hellen Thomas

APPENDIX 6
Recoded questions

Question #	Original Categories	Recoded Categories
1	1. Point aux Trembles/Rivière des Praires 2. Mercier Est. 3. Anjou 4. De Rosemont 5. St. Leonard 6. Maisonneuve/Hochelaga 7. Other	1. Ahuntsic et Montreal Nord 2. Saint-Léonard/St. Michel 3. LucilleTeasdale (4,6) 4. Pointe-de-l'ile (1,2,3)
7	1. At Your Borough 2. East End 3. Downtown 4. Notre-Dame 5. Other	1. Montreal East (1,2) 2. CDN/NDG (4,5) 3. Downtown/Montreal west (CDN= Cote Des Neiges)
9	1. No one, I go alone 2. Family member 3. Friend 4. other	1. Alone 2. Family/Friend (2,3) 3. Almage Centre Volunteer
21	1. Married 2. Single 3. Divorced/Separated 4. Widow	1. Married 2. Divorced/Separated (2,3) 3. Widow
22	1. I live alone 2. With family member 3. With friend 4. Other	1. Alone 2. With someone (2,3,4)
23	1. Italian 2. Chinese 3. Polish 4. Hindu-Pakistan 5. Spanish 6. Greek 7. Irish 8. British 9. Ukrainian 10. First Nation 11. Other	1. British & Irish (7,8) 2. Other European (1,3,5,6,9) 3. American (10,11) 4. Asian & M. East (2,4,11))

Appendix 6 continued.....

26	1. Catholic 2. Protestant/Anglican 3. Jewish 4. Muslim 5. other	1. Catholic 2. Protestant/Anglican 3. Muslim/Orthodox (3,4,5)
28	1. 1 – 15 years 2. 16 – 30 years 3. More than 30 years	1. 1-30 years (1,2) 2. More than 30 years

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