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Facing the Challenges of Social Participation for Seniors with Disabilities

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Résumé de l'article

La population francophone au Manitoba est vieillissante et davantage vulnérable en ce qui a trait à sa santé et l'accès limité aux services de santé dans la langue officielle minoritaire. La prévalence de maladies chroniques et de problèmes de mobilité exigent un appui supplémentaire pour éviter l'isolement. Cette étude vise à mieux connaître l'état de santé actuel des aînés francophones vivant en milieu minoritaire linguistique au Manitoba et leur accès aux services de santé en français. Des données démographiques et de santé physique, émotionnelle et sociale ont permis de dresser un profil des francophones ayant recours aux soins à domicile auprès de l'Office régional de la santé de Winnipeg. Bien qu'ayant un diagnostic médical similaire aux non-Francophones, les aînés francophones sont moins souvent évalués avec une capacité cognitive réduite et une condition d'humeur ou de comportement instable, tel qu'associé à la démence autre que l'Alzheimer's. Des lacunes ont été identifiées au niveau des services de santé bilingues en pharmacie, audiologie et ergothérapie, en services de repas et de transport, ainsi qu'en soutien aux aidants naturels. Plusieurs logements avec services offrent du soutien en français aux aînés et, de surcroît, favorisent les interactions sociales entre Francophones. Pour les personnes âgées vivant toujours à domicile et leurs aidants naturels, les services d'appui dans la langue officielle minoritaire sont requis.

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Health Status of Minority Francophone Seniors in Manitoba and Access to Services in French : Potential for Social Isolation

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Abstract

Francophone seniors in Manitoba represent a growing and vulnerable population, with poorer health outcomes and limited access to health and social services in the official minority language. To avoid isolation, support services are required, as chronic diseases and reduced mobility have a direct impact on both physical and social needs. The purpose of this study is to examine the current health status of seniors in the Francophone minority population of Manitoba and their access to health and social services in French. Demographic, social and health profiles were obtained for Francophone and non-Francophone Home Care clients in Winnipeg. Although diagnosed with similar health conditions as non-Francophones, Francophone seniors are less likely to be assessed with reduced cognitive performance and conditions making mood and behaviour unstable, such as dementia other than Alzheimer's. Gaps in bilingual health services were identified for pharmacy, audiology and occupational therapy services, meal and transportation systems as well as support services for informal caregivers. Housing options with in-house support services provided in French are available and additionally provide opportunities for seniors to socialize with other Francophones. For the elderly living in single-home units and their caregivers, support services provided in the official minority language are needed.

Keywords : seniors, health, Francophone minority, home care

Résumé

La population francophone au Manitoba est vieillissante et davantage vulnérable en ce qui a trait à sa santé et l'accès limité aux services de santé dans la langue officielle minoritaire. La prévalence de maladies chroniques et de problèmes de mobilité exigent un appui supplémentaire pour éviter l'isolement. Cette étude vise à mieux connaître l'état de santé actuel des aînés francophones vivant en milieu minoritaire linguistique au Manitoba et leur accès aux services de santé en français. Des données démographiques et de santé physique, émotionnelle et sociale ont permis de dresser un profil des francophones ayant recours aux soins à domicile auprès de l'Office régional de la santé de Winnipeg. Bien qu'ayant un diagnostic médical similaire aux non-Francophones, les aînés francophones sont moins souvent évalués avec une capacité cognitive réduite et une condition d'humeur ou de comportement instable, tel qu'associé à la démence autre que l'Alzheimer's. Des lacunes ont été identifiées au niveau des services de santé bilingues en pharmacie, audiologie et ergothérapie, en services de repas et de transport, ainsi qu'en soutien aux aidants naturels. Plusieurs logements avec services offrent du soutien en français aux aînés et, de surcroît, favorisent les interactions sociales entre Francophones. Pour les personnes âgées vivant toujours à domicile et leurs aidants naturels, les services d'appui dans la langue officielle minoritaire sont requis.

Mots-clés : aînés, santé, minorité francophone, soins à domicile

In Manitoba, as across Canada, population trends predict a significant increase in the number of seniors due to the aging of the baby boomer generation (Centre on Aging, 2010; Statistics Canada, 2010). It is estimated that by 2026, the percentage of Manitobans 65 years and older will increase from 13.9% to 19.9% (Doupe & al., 2011). Such an increase has direct implications on health and social services, as seniors are more susceptible to chronic disease and co-morbid conditions, requiring frequent, diverse and complex care (Canadian Institute for Health Information [CIHI], 2011). Seniors are also at risk of social isolation, as normal aging processes influencing physical abilities and social roles may hinder inclusion in social activities (Betts Adams, Leibrandt & Moon, 2011). Community support and opportunities for social participation are essential, as they are closely associated to the health and well-being of seniors (Gilmour, 2012; Cattan & al, 2005).

To remain healthy and prevent illness, hospitalization and long-term care, seniors are encouraged to be active and engaged in their community (Public Health Agency of Canada, 2011; Brasset-Latulippe, 2011). In Canada, as in other countries, age friendly community initiatives have been strategically developed and supported by policy action at the municipal, provincial and federal levels (Plouffe and Kalache, 2011). In Manitoba, government programs focusing on seniors' health promote community-based services and accessible environments, thereby expanding the healthcare continuum beyond hospitals and personal care homes (PCH) (Doupe & al., 2011). One such program, Aging in Place, was initiated in 2004 and focuses primarily on seniors living alone (Government of Manitoba, n.d.), as these individuals are at increased risk of isolation, depression and malnutrition (Stone, Evandrou & Falkingham, 2013; Kiesswetter & al., 2013). In 2008, the province-wide Age-Friendly Manitoba Initiative was launched, focusing on providing assistance relative to housing, transportation, health care services and community support and allowing seniors to maintain their independence and live in their homes for as long as possible (Menec et al., 2014). To ensure safe and adequate care for these seniors, a newly developed assessment tool helps determine seniors' needs and the best housing and care options, whether it be in their home with Home Care assistance, in housing with support services or in a personal care facility (Doupe & al., 2011). These strategies are expected to decrease the number of seniors requiring institutionalized long-term care, as formal and informal supports in the community are made available (CIHI, 2011).

For Francophones, the official language minority group of Manitoba, the issues surrounding adequate healthcare services and community support in French for the aging population are of great concern. The primary concern is that access to health and social services in French is relatively recent in this province and therefore less well developed than for the English-speaking majority population. Although Manitoba was initially declared bilingual in 1870 (Jourdain, 2002), French was soon abolished as an official language, and it would take almost a century before it would again be recognized, with health, social and education services provided in this language (Francophone Affairs Secretariat, 2009). Although the Francophone minority group represents only four percent of the total population of Manitoba, the *French Language Service Policy* adopted in 1989 and revised in 1999 states that services provided by the Government of Manitoba are to be offered, whenever possible, in both official languages in regions where the French-speaking population is concentrated (Francophone Affairs Secretariat, 1999). Overall, forty health and social service agencies in Winnipeg are designated bilingual, with internal policies and resources to actively offer services in the minority language (Conseil communauté en santé du Manitoba, 2009). To further promote health and social services in French, an official agency representing the Francophone community was put in place in 2004 (CCS, 2009). In the last ten years, professional training in the health field has been provided in French at Université de Saint-Boniface in partnership with the Consortium national de formation en santé (CNFS), a coalition of post-secondary institutions created to promote health-related training

in French across Canada. This collaboration increases the number of healthcare professionals trained locally and facilitates their recruitment and retention in bilingual positions in Manitoba (CNFS, 2012).

Despite these policies, services and local training opportunities, access to health and social services in French is currently limited in Manitoba. For example, only 28% of the Francophone population has access to a family physician able to provide services in French (Chartier et al., 2012), and on average, only one quarter of the Francophone population claims receiving services from other healthcare professionals in this language (de Moissac et al., 2011). Health, social and community services are generally more readily available in French in Winnipeg, the provincial capital, as generally, a greater number of French-speaking professionals work in larger centres (Lesage, Bouchard-Coulombe & Chavez, 2012; Marmen & Delisle, 2003). However, the current shortage of French-speaking professionals remains a great barrier to the availability of these services (de Moissac & al., 2012; Forgues, Doucet & Noël, 2011). For Francophone seniors, who are reported to consult healthcare professionals more often than Anglophone seniors (Forgues, Doucet & Noël, 2011), current services in French may not be adequate.

A second concern for Francophones is that seniors comprise a larger proportion of their population as compared to non-Francophones. Fifty-five percent of Francophones are 45 years and older and almost twenty-one percent are 65 years and older, as compared to forty and thirteen percent respectively for all Manitobans (Lesage, Bouchard-Coulombe & Chavez, 2012). The proportion of Francophones 65 years and over is almost twice as high as that of individuals under 15 years of age, whereas this ratio is reversed among non-Francophones. This trend is also observed in other Francophone minority communities in other parts of Canada (Forgue, Doucet & Noël, 2011). This demographic reality puts greater pressure on the younger generations within the Francophone populations with respect to caring for their elderly family members.

Lastly, minority Francophones in Canada are considered a vulnerable population in terms of their health, as they are at greater risk of being undereducated, having lower income and living in rural areas as compared to the linguistic majority (Allaire et al., 2010; Bouchard, Gaboury & Chomienne, 2009). It has been reported that Francophone minorities are more prone to chronic disease, stress, alcohol consumption, tobacco and medication use, and have a weaker support network (Bouchard & al., 2009; Gaboury, Noël & Forgues, 2009). In Manitoba, Francophones born before 1958 are at greater risk of poor health outcomes as compared to non-Francophones of the same age and of similar socioeconomic status, as well as compared to Francophones born after 1958 (Chartier et al., 2012). Older Francophones have a higher rate of diabetes and hospitalization as well as a greater use of prescription medications compared to other Manitobans of the same age (Chartier & al., 2012). Community-dwelling older adults in the Francophone neighbourhoods are more commonly subjected to potentially inappropriate prescribing of benzodiazepine than are non-Francophones (Chartier & al., 2012). In one particular francophone neighbourhood (St. Boniface) where dementia is more prevalent, Francophones aged 75 years and older are more likely to be admitted to PCHs than non-Francophones (Chartier & al., 2012). However, the median wait time for admission to a bilingually designated PCH is twice the length of time (average of 16 weeks) as it is for a non-Francophone PCH (average of 8 weeks) (Chartier & al., 2012). As suggested by the authors of this study, health disparities between generations in the Francophone population may be linked to the lack of availability of education, health and social services in French before 1958 (Chartier & al., 2012). Greater access to services in the minority language in the past few decades may have contributed to the well-being and health of younger Francophones in Manitoba (Chartier & al., 2012).

The main purpose of this article is to describe the current health status of community-dwelling Francophone seniors receiving support services from the home care program run by the Winnipeg Regional Health Authority (WRHA).

Of particular interest are demographic, health and social indicators which may lead to isolation. These measures include but are not limited to, living alone, being unmarried, perceiving lack of social support and feeling lonely (Cornwell, 2009). The WRHA Home Care Minimum Data Set has been identified as a fitting source of information, reporting not only demographic data, but also physical, social and mental health status as well as support service utilization of clients requiring home care. This data set allows for a comparison between non-Francophone home care clients and a Francophone cohort within the region. In addition, availability of and access to health, social and community services in French will be described, focusing primarily on the Francophone neighbourhoods of Winnipeg. These communities have been a target area for the development of such services (Commissioner of Official Languages, 2007). Hence, the greatest number of bilingual health professionals and health-related government and community services available in French are located in these neighbourhoods. Finally, gaps between the health needs of the Francophone senior population and services currently available in French will be identified.

Methods

- Health and Needs of Home Care Clients

To describe the current health and social status as well as services required by community-dwelling seniors receiving support services, administrative data collected by the Winnipeg Regional Health Authority (WRHA) Home Care program were used. The Resident Assessment Instrument Minimum Data Set [RAI-MDS, 2002 version, WRHA] is a standardized assessment tool which records information on individuals based on their ability to function in the home environment. The most recent assessment (MRA), whether it be an initial, follow-up, routine, review prior to discharge, review at return from hospital or change in status evaluation, provides the most current state of affairs pertaining to demographics, general health and service utilization of home care clients. This data was used to describe the non-Francophone home care clientele as well as a Francophone cohort composed of clients with a French-language indicator. In the absence of reported primary language use in these data sets, the French-language indicator allows identification of clients having a preference for provision of services in French.

Access to the WRHA records was obtained via the funding agency for this study. The data profile was selected by the research team and the funding agency in consultation with a WRHA Home Care data analyst. Specific measures, including demographics such as sex, age, marital status, education, informal support and social isolation, as well as health characteristics such as predominant diagnosis, conditions that make cognition, mood, activities of daily living and behaviour unstable, cognitive performance scale, depression rating scale and physical function, were examined. Furthermore, average days on service at time of assessment, special treatments or therapies and use of medication were selected to best describe the needs of this population. Due to time constraints, provisions were made that the WRHA would provide a descriptive report presenting data in an aggregated form.

Records for active home care clients born on or prior to December 31, 1946, for whom the most recent full assessment was between January 1, 2009, and December 31, 2011, were selected. Of these 8302 records, 131 had a French-language indicator. This subgroup constitutes the Francophone cohort. The data were de-identified, zipped with encryption and password protected by a WRHA data analyst. Data were sent to a contracted School of Public Health and Health Systems (University of Waterloo) associated analyst, who has expertise in MDS data analysis and who provided the requested report. Further assessments for data quality and completeness were performed prior to analysis. Descriptive variables, such as informal support, were taken directly from recorded items. Outcome scales such as the Cognitive Performance Scale and activities of daily living were computed as previously described (Canadian Institute of Health Research, 2010). Demographic characteristics, health character-

istics and health-related services provided for Francophone and Non-Francophone cohorts were reported as percentages. These were then compared using Chi Square or Fisher's exact test. Analysis was carried out using the IBM SPSS Statistics (version 20; SPSS Inc., Chicago, IL). Ethics approval was obtained from Université de Saint-Boniface and the Winnipeg Regional Health Authority Research Ethics Boards prior to data processing and analysis.

- *Availability of and Access to Healthcare in French*

An inventory of health and social services provided in French in Winnipeg was collected. Two data collection methods were used. First, a search of government, private for-profit, private not-for-profit and community health and social services available in French was conducted within various existing documents at the local, municipal and provincial levels. Secondly, a systematic site survey of the Francophone neighbourhoods identified other French-language health and social services not currently listed in the directories.

To assess the utilization of health and social services in French by seniors living in the Francophone neighbourhoods of Winnipeg, a secondary analysis was conducted on prior data obtained from a community-based survey (de Moissac & al., 2011). Survey questions related to the importance of accessing health-related services in French and ways to identify such services. Respondents also reported the type of health professional which offered a service in French. Data quality and completeness were assessed prior to performing statistical analysis. Variables referring to services offered in French were assessed by Chi square and univariate logistic regression analysis. Analysis were performed with SPSS version 13.0 (SPSS Inc, Chicago, Ill) and SAS version 9.1 (SAS Institute, Inc, Cary, NC) by a Université de Saint-Boniface statistical analyst. Ethics approval was obtained from the Université de Saint-Boniface Research Ethics Boards prior to data collection and analysis.

Results

- *Home Care Clients' Health Status and Service Utilization*

Within the Winnipeg Regional Health Authority, 8302 seniors received Home Care services, of which 131 have identified French as their preferred language of service. Francophones therefore comprise less than 1.6% of Home Care clients in Winnipeg.

Table 1 describes the demographic characteristics of the Francophone and non-Francophone home care cohorts. Statistically significant differences between Francophone and non-Francophone clients are indicated by an asterisk beside the p value. Francophone home care clients are more often women. Half of the Francophone clients are widowed and a greater percentage (12.2%) has never been married as compared to non-Francophone clients (5.8%). Although not statistically significant, more than 55% of Francophone clients have not graduated from high school, and 11.5% have only a high school diploma, as compared to 46.5% and 15% for the non-Francophone cohort, respectively.

Table 2 presents indicators of social support and social isolation. Approximately 36% of Francophone clients live with their caregiver as compared to 41.1% for non-Francophone clients, and most often the caregiver is a child or child-in-law. Secondary caregivers are also often children for both cohorts. It should be noted that more than 21% of home care clients in both cohorts do not have a secondary caregiver. Although very few Francophone clients are left alone all the time during the day (7.6%) as compared to non-Francophone clients (14.9%), more Francophone clients are left alone for long periods (45.8% vs 41.2%) or report feeling lonely (17.6% vs 12.1%) than clients of the non-Francophone cohort.

TABLE 1
Demographic characteristics of Francophone (FR) and Non-Francophone (NFR) Home Care cohorts

Demographic characteristics	FR (n = 131)	NFR (n = 8171)	*P* value
Sex			
Male	22.1	30.8	0.032*
Female	77.9	69.2	
Age (yrs)			
Average	85	83.0	
Lowest	66	65.0	
Highest	99	107.1	
Marital status			
Never married	12.2	5.8	0.017*
Married	30.5	32.3	
Widowed	49.6	51.9	
Separated	0.8	2.0	
Divorced	3.8	6.4	
Other	3.1	1.5	
Education			
No schooling	1.5	1.1	0.248
Up to Grade 12	55.0	45.4	
High school diploma	11.5	15.0	
Post-secondary education	19.1	24.0	
Unknown	13.0	14.5	

Note: *Unless otherwise stated, results are reported as percentages. *Variables with statistical significance of 5%.*

TABLE 2
Indicators of social support and social isolation of Francophone (FR) and Non-Francophone (NFR) Home Care cohorts

Demographic characteristics	FR (n = 131)	NFR (n = 8171)	*P* value
Informal support			
Lives with a caregiver	35.9	41.1	0.229
Primary caregiver is child or child-in-law	60.3	58.5	0.673
Secondary caregiver is			
Child or child-in-law	67.2	56.3	0.013*
Other relative	8.4	13.8	0.075
No secondary caregiver	21.4	21.5	0.972
Social isolation			
Time left alone during the day			
Never/hardly ever	29.8	31.8	0.049*
About 1 hour	16.8	12.0	
Long periods – e.g. all morning	45.8	41.2	
All the time	7.6	14.9	
Client says he/she feels lonely	17.6	12.1	0.059

Note: *Unless otherwise stated, results are reported as percentages. *Variables with statistical significance of 5%.*

Table 3 describes the health status of Francophone and non-Francophone home care clients. The predominant diagnoses reported for Francophone clients are hypertension and arthritis, with osteoporosis, cataracts, thyroid disease, diabetes and stroke reported to a lesser degree. These conditions are similarly reported for clients of the non-Francophone cohort. Cataracts are reported more often for Francophones, but the difference is not statistically significant. Francophone clients (22.9%) suffer less from medical conditions that make cognition, mood, activities of daily living or behaviour unstable as compared to non-Francophone clients (36.1%). For example, dementia other than that associated with Alzheimer's disease is reported significantly less often for Francophone clients than for non-Francophones.

Significant differences are, however, noted between the Francophone and non-Francophone cohorts pertaining to Cognitive Performance Scale. Francophone clients are more likely to suffer mild impairment in daily decision-making, short-term memory recall, making oneself understood and eating, whereas a greater proportion of non-Francophone clients score with moderate to severe impairment. The Depression rating scale confirms that less than 12% of Francophone clients have symptoms suggestive of depression, comparable to rates for non-Francophones.

Physical function scores for activities of daily living (ADL), which include personal hygiene, toilet use, locomotion and eating, suggest that the majority of Francophone home care clients are independent (71.8%), with 17.6% having limited impairment (1 or more ADLs requiring limited assistance). Furthermore, Francophone clients are fewer to decline in their ADL score in the last 90 days prior to current assessment as compared to non-Francophone clients. Scores for instrumental activities of daily living, which include meal preparation, general maintenance of the house and household chores, management of personal finances, transportation, shopping, and using the telephone, suggest that a greater percentage of Francophone clients have difficulties with these tasks than the non-Francophone clients and are therefore more dependent. More than 53% of Francophone clients use nine or more different medications, which is statistically comparable to 45.7% for non-Francophone clients. In general, health characteristics are similar between the Francophone and the non-Francophone cohorts, with statistical differences reported for fewer conditions making cognition, mood, ADL and behaviour unstable, cognitive impairment and dependence with elaborate activities of daily living for the Francophone cohort.

Table 4 describes health-related services provided to home care clients. In general, clients in the Francophone cohort had fewer average days on service at the time of assessment than non-Francophone clients. The home care services most often requested by Francophones are home health aides to provide hygiene and basic healthcare and homemaking services. Statistically significant differences between cohorts pertain to the treatments or specialized therapy most utilized: medical alert bracelets and electronic alert systems are significantly higher for Francophone clients and accompaniment for visits to a physician or clinic are higher for non-Francophones. Moreover, fewer Francophone clients had hospital visits requiring an overnight stay in the previous 90 days than non-Francophone clients.

TABLE 3
Health characteristics of Francophone (FR) and Non-Francophone (NFR) Home Care clients

Health characteristics	FR (n = 131)	NFR (n = 8171)	*P* value
Predominant diagnoses			
Hypertension	64.1	64.7	0.890
Arthritis	57.3	57.7	0.917
Osteoporosis	22.9	17.5	0.108
Cataracts	20.6	14.7	0.059
Thyroid disease	19.8	19.2	0.850
Diabetes	17.6	22.9	0.149
Stroke	17.6	17.2	0.913
Conditions/diseases making cognition, mood, activities of daily living and behaviour unstable	22.9	36.1	0.002*
Alzheimer's	7.6	5.7	0.335
Dementia other than Alzheimer's	6.9	17.1	0.002*
Cognitive Performance Scale			
Intact	48.1	47.5	
Borderline intact	12.2	14.5	0.017*
Mild impairment	35.9	27.1	
Moderate to very severe impairment	3.8	10.9	
Depression Rating Scale			
No symptoms (0)	65.6	68.6	
Few symptoms (1-2)	22.9	21.0	0.624
Mild to moderate symptoms (3-5)	6.9	7.5	
High number of symptoms (6-14)	4.6	2.9	
Physical function			
Activities of daily living (ADL)			
Independent	71.8	66.5	
Supervision required	3.8	8.8	0.115
Limited impairment	17.6	14.9	
Extensive assistance required to total dependence	6.9	9.8	
ADL decline, compared to 90 days ago	25.2	36.6	0.007*
Instrumental activities of daily living			
0-5 (independent)	16.8	24.1	
6-10	21.4	26.9	0.024*
11-15	32.1	23.3	
16-21 (dependent)	29.8	25.7	
Medication use in last 7 days			
1-4	12.4	17.7	
5-8	33.3	36.6	0.108
9 or more	53.4	45.7	

Note: *Unless otherwise stated, results are reported as percentages. *Variables with statistical significance of 5%.*

TABLE 4
Health-related services provided to Francophone (FR) and Non-Francophone (NFR) Home Care clients

Health-related services	FR (n = 131)	NFR (n = 8171)	*P* value
Average days on service at time of assessment (days)	912	1319.4	NA
Service utilization in last 7 days			
Home health aide	56.5	54.2	0.597
Homemaking services	48.1	42.8	0.227
Visiting nurse	13.0	11.7	0.646
Meals	10.7	13.2	0.391
Special treatment/therapy in last year			
Medical alert bracelet/ electronic security alert system	25.2	16.8	0.011*
Special diet	16.0	21.7	0.119
Physician or clinic visit	15.3	24.1	0.018*
Hospital visit (with overnight stay) in last 90 days	17.6	25.8	0.031*

*Note: Unless otherwise stated, results are reported as percentages. *Variables with statistical significance of 5%.*

NA: not available, as a standard deviation was not collected by WRHA.

Availability of and Access to Health Services in French

- Inventory

Health and social services available in French in the francophone neighbourhoods of Winnipeg (St. Boniface and St. Vital) are categorized and listed in **Table 5**. The five categories are further divided into types of services, with the corresponding number of establishments offering the service. These categories include housing, mental health and social well-being, primary and tertiary health care, specialized services and services for community-dwelling seniors and their informal caregivers.

Although all types of services are provided in French by at least one establishment in Winnipeg, some services are more likely to be available as they are more numerous. For example, housing options for residents aged 55 years and over are plentiful in the Francophone neighbourhoods, with two personal care homes and 18 other types of accommodation that offer varying degrees of assistance to residents. Of these eighteen housing facilities, five offer assisted living options and five are subsidized supportive housing; both provide meals, social activities and physical fitness classes. Six other facilities are independent living options, but a high concentration of residents are Francophones. Sixteen of the eighteen housing units are centrally located in proximity to primary and tertiary health services.

Mental health and social well-being services are also numerous, in particular counselling and psychotherapy services. Half of these services are provided by the Winnipeg Regional Health Authority and half are provided by community organisations. Only one psychologist able to provide services in French was identified. Many information and referral call lines are also available in French, not only for Winnipeg residents but for seniors across the province.

TABLE 5
Health services available in French

Category of service	Type of service	Number of Establishments Offering the Service
Housing	Long-term personal care homes	2
	Supportive housing	5
	Assisted living	5
	Independent living	8
Mental health and social well-being	Counselling/psychotherapy	14
	Literacy training	1
	Basic needs	1
	Women's shelter	1
	Information and referral	26
Primary and tertiary care	Community health clinic	3
	Medical clinic	5
	Hospital care	1
	Laboratory and diagnostic services	1
	Palliative care	2
	Pharmacy	1
		2
Specialized services	Nutrition (dietitian)	4
	Audiology	1
	Chiropractic	6
	Fitness training / Athletic therapy	5
	Dentistry	10
	Occupational therapy	1
	Massage therapy	4
	Oncology	2
	Speech therapy	2
	Physiotherapy	3
	Reflexology	3
Services for community-dwelling seniors and their informal caregivers	Day program	2
	Meals and transportation program	1
	Respite care	3
	Home care	2
	Foot care	4
	Informal caregiver support	2

Services in primary and tertiary care in French are limited. In primary care, three community health clinics and five privately owned medical clinics are able to provide service in French, but only a small proportion of family physicians in the latter are proficient in the official minority language. The regional hospital provides services not only to Francophones but also to Manitobans from the entire Winnipeg health region and surrounding rural areas. This hospital is not designated bilingual, but has a mandate to provide service in French. In general, bilingual staff members are those most often in contact with the public in key units such as the

patient admission and registration unit, emergency, geriatrics and rehabilitation departments (D. Mohr, Regional Director of French-language Services, personal communication). Other types of services not readily available in French in this category include laboratory and diagnostic services and pharmacy services, for which service in French is available only occasionally at two sites, when bilingual staff are on duty.

Specialized services readily available in French are varied, including dentistry, chiropractic, athletic therapy, nutrition and massage therapy. A shortage of audiologists and occupational therapists is observed; these services are provided only through the hospital rehabilitation program. Home-care services provided by the Winnipeg Regional Health Authority are made readily available for community-dwelling seniors. The Home Care Program provides personal care, nursing, counselling and problem solving, household assistance, respite, occupation therapy and physiotherapy assessments as well as referrals to other agencies and coordination of internal and external services in the community to seniors with increasing dependence (WRHA, n.d.). In the WRHA Home Care services, all administration, case management, human resource management and administrative staff are bilingual, whereas 26.67% of the targeted bilingual positions for direct service, including home care attendants and home support workers, are held by bilingual employees. Other services for community-dwelling Francophone seniors are limited, such as meals and transportation, day programs and support services for informal caregivers.

- *Community-dwelling Francophone Seniors' Access to Healthcare Services in French*

Sixty-nine urban seniors participated in a provincial survey investigating access to healthcare services in French. Most participants were from the Francophone neighbourhoods, as recruitment strategies targeted these areas. Of these respondents, 64.7% were women. A greater percentage of participants had education and income levels higher than the average senior population of Winnipeg (Allaire & al., 2010), with 61.5% of participants having pursued post-secondary education and fewer than one third (31.1%) with an annual income lower than $24 000.

The majority of Francophone senior respondents (94.2%) considered receiving services in French to be important or very important, as was the case for Francophones of all age groups (de Moissac & al., 2011). The majority of Francophone seniors (63.2%) reported understanding health information better when it is made available in writing in French. Similarly, treatment options and instructions are better understood by seniors (72.0%) when provided by healthcare professionals orally in French.

Senior respondents were asked to identify health professionals that they consulted and from whom they had received services in French. **Table 6** lists these health professionals in decreasing order of frequency of consultation. For health professionals who were consulted by more than 60% of Francophone seniors, such as family physicians and medical specialists, dentists and dental hygienists, pharmacists, optometrists and nurses, access to services in French ranges from 65.22% to 3.77%. Services in French were especially limited from pharmacists (9.43%), medical specialists (3.77%) and optometrists (10.42%). For health professionals consulted by approximately 42% of Francophone senior respondents, service in French was offered on average to 45.85% of respondents. This group includes chiropractors, nurse practitioners and physiotherapists. Among the health professionals who were consulted by less than a third of Francophone seniors, such as audiologists, dietitians, psychologists, social workers and speech therapists, data shows that services offered in French from audiologists (14.29%) and speech therapists (10.0%) were limited.

TABLE 6
Professional healthcare services offered in French to Francophone seniors

	Services offered in French	
Health Professionals	% of senior respondents who have consulted	% of seniors who were offered services in French
Family physician	85.51	62.70
Dentist	81.16	53.57
Pharmacist	76.81	9.43
Medical specialist	76.81	3.77
Optometrist	69.57	10.42
Nurse	66.67	65.22
Dental hygienist	62.32	48.84
Chiropractor	43.48	46.67
Nurse practitioner	42.03	55.17
Physiotherapist	40.58	35.71
Audiologist	30.43	14.29
Dietitian	24.64	64.71
Psychologist	23.19	68.75
Social worker	15.94	63.64
Speech therapist	14.49	10.0

Discussion

The present study provides an overview of the current health status of Francophone seniors and availability of bilingual health and social services for this official language minority population in Manitoba. With an increasing number of seniors living in their homes, community-based support systems must be developed not only to ensure safe environments and adequate care, but also to reduce social isolation and loneliness. For Francophones, use of the minority language adds a level of complexity, as services in French are not as readily available as those provided in the majority language. It is thus useful to gain insight into the health and social needs of Francophone seniors as well as their utilization of services provided by the Home care program and other support systems available in their community, as unmet needs and inadequate resources may put them at greater risk of social isolation and poor health.

Findings obtained in this study reveal that Francophone seniors may indeed be at risk for several reasons. Although a greater proportion of the Francophone population in Manitoba are seniors as compared to the Anglophone population, a disproportionate few receive Home care services, with fewer days on service than their non-Francophone counterpart. Francophones represent 4% of the population in Manitoba; however, less than 1.6% of Home care clients indicate a preference for provision of services in French. It is possible that a greater proportion of Home care clients are indeed Francophone, but as the primary language is not collected in the data set, this is difficult to estimate. Francophone seniors capable of communicating in both official languages may not have requested services in French. Studies have shown that bilingual individuals, particu-

larly those living in a minority context, will not ask for services in French because of linguistic insecurity (Landry, Allard and Deveau, 2008; Landry, Deveau and Allard, 2006) or for fear of not receiving services as rapidly or of similar quality as those provided in the majority language (Drolet & al., 2014; de Moissac & al., 2012). Furthermore, having had no healthcare services provided in French for several decades, some members of the minority population believe they are not available (Société Santé en français, 2007). Hence, in the absence of active offer, where providers identify the client's predominant official language and actively assist them in receiving language-appropriate services, access to healthcare in the minority language is limited (Savard & al., 2015).

The language issue in health and social services is fundamental, as ineffective communication in a second language negatively impacts the quality of care and on patient safety (Ohtani & al., 2015; Schwei & al., 2015; Lesage, Bouchard-Coulombe & Chavez, 2012; Johnstone & Kanitsaki, 2006). Francophone seniors participating in the community survey admit preferring services in French, as health information is better understood when provided in their mother tongue. Studies have demonstrated potential consequences of poor communication, such as the misunderstanding of symptoms, improper diagnosis and treatment plan development, as well as poor adherence to prescribed treatment and follow-up care (Health Canada, 2007; Drouin & Rivet, 2003; Bowen, 2001). For seniors with hearing deficiencies or dementia, communication in a second language is even more problematic (Madoc-Jones, 2004). This in turn may increase complexity of the care and lead to inefficient use of services (Dubuc & al., 2011; Allen & Mor, 1997).

Language issues may also arise during the assessment of health status. Our findings demonstrate significant differences between cohorts for health characteristics, with Francophone clients less often evaluated with conditions altering their ability to live on their own. Francophones are less likely to be diagnosed with a condition or disease making cognition, mood, activities of daily living and behaviour unstable, particularly dementias other that Alzheimer's. Francophones are also less likely to suffer from moderate to very severe cognitive impairment and exhibit a decline in physical function associated with activities of daily living. Furthermore, home care services have provided less assistance to Francophone clients for physician or clinic visits. If predominant diagnoses are similar for both cohorts, why would Francophone seniors be assessed for cognitive performance and ability to do activities of daily living differently than non-Francophones? One has to question why they appear to receive less home care service hours, as well as assistance to access other healthcare services such as primary care, especially if they have been identified as being at greater risk of poor health outcomes than non-Francophones of the same age and of similar socioeconomic status (Chartier & al., 2012). Recent studies suggest that language access may be the key, as communication barriers may directly impact on accessing health services generally (Ohtani & al., 2015; Lai & Surood, 2013) and on diagnostic evaluation (Garra & al., 2010; Waxman & Levitt, 2000), such as under-diagnosis of dementia in elderly minority patients (Nielsen & al., 2011). Linguistically adapted assessment tools are necessary to adequately evaluate the health status of Francophone seniors, as being elderly and members of a minority group may put them at greater risk of misdiagnosis (Lamont, Swift and Abrams, 2015; Haslam & al, 2012). Misdiagnosis may then lead to poor housing or care choices, putting Francophone seniors at greater risk as their condition may require increased supervision than currently provided.

Other findings are suggestive that Francophone home care clients may be at greater risk of social isolation, but Francophone seniors have opportunities to be socially active. Although Francophone and non-Francophone Home care clients have similar demographic and social support profiles, a greater percentage of Francophone clients are women and have never been married compared to non-Francophone clients. Less than half the clients from either cohort live with a caregiver, but the

prevalence of requests for medical alert bracelets or electronic alert systems suggests the need for easy access to assistance from outside the home for Francophone clients. Francophone clients are also more dependent on instrumental activities of daily living such as meal preparation, house maintenance, telephone use and transportation. Fortunately, many housing options providing additional support services for seniors are located in the Francophone neighbourhoods of Winnipeg. These residences provide not only basic services such as meals and housekeeping, but also transportation and activities focusing on physical fitness, recreation and spiritual needs. Furthermore, seniors are given the opportunity to socialize with other residents and community members during meals and other activities. Hence, social isolation is not as likely in these residences as for Francophone seniors living in single unit homes in the community. With few transportation and respite services, day programs and support programs for informal caregivers available in French, these seniors have less support. Even within the Home care program, bilingual direct service staff is limited, as only one quarter of targeted bilingual positions are actually held by bilingual employees. Although our data collection did not allow us to distinguish between seniors residing in community housing or in single-family homes, we believe services for seniors in the latter category should be prioritized. Further studies focusing on seniors living in single-unit homes in this community would be necessary.

Several healthcare services in French are not readily available and accessible to Francophones in our community. Among these services are optometry, audiology and speech therapy. Our inventory of available services also demonstrates few services relating to audiology and occupational therapy in French. Sensory deficits are common among the elderly, and may negatively impact on mental health (Bernabei, 2011) and patient safety (Kulmala & al, 2009). Furthermore, limited availability of and poor access to bilingual pharmacists is of particular concern, as local studies have shown a prevalence for multiple medication use in home care clients and community-dwelling Francophone seniors (Chartier & al., 2012). Polypharmacy has been shown to increase the incidence of adverse drug events, confusion, compliance issues and errors in management (Ballentine, 2008). Understanding of prescription labels may also be more difficult for seniors with limited English-proficiency (Masland, Kang, & Ma, 2011). Hence, it would be recommended that bilingual pharmacy services, as well as specialized sensory related therapists be put in place for Francophone seniors in this community.

Currently, strategies to provide safe and adequate services in French for Francophone minorities in Manitoba include the implementation of government policies and the bilingual designation of healthcare institutions. Our study demonstrates, however, that this approach, although beneficial, does not suffice to ensure access to health and social services in French, even in urban neighbourhoods where bilingual health professionals and services are more common. Previous studies have suggested that the challenge in a minority setting lies in identifying Francophone clients and matching them with bilingual professionals (Drolet & al., 2014; de Moissac & al., 2012). What is needed is a mechanism to facilitate this matching. Perhaps the integration of health and social services (Lafortune, Béland & Bergman, 2011) and the coordination of care for Francophone patients by harmonizing the services provided in French by multidisciplinary primary care teams, community services and institutional services, would be useful. The model of integrated services has been used for seniors in other provinces (Béland, 2012; Hébert, Tourigny & Gagnon, 2004). This model has proven to be efficient and cost-effective, as reduction of use and cost of institutional services occurs without reducing the quality of care or increasing the burden on seniors and their informal caregivers (Hebert & al., 2010; Hebert & al., 2008). These authors also report a reduction of functional decline and a lesser proportion of participants with unmet needs, as well as an increase in satisfaction and a feeling of empowerment by the participants (Dubuc & al., 2011; Hebert & al., 2010). Such a model would allow linguistic matching between clients and healthcare pro-

viders and facilitate the long-term provision of care to seniors in the community. Implementation of this model of care for Francophone seniors is currently under investigation.

In conclusion, Francophone seniors receiving home care services may be at greater risk of social isolation because of limited access to language-appropriate health and social services in their predominant language. Linguistically adapted care is important to senior Francophones and should be provided to ensure client safety. However, many housing options with support services are available, providing basic services as well as opportunities to be socially active. Further studies focusing on support systems for seniors living in single-unit homes, for whom support services in the official minority language are limited, are necessary.

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