OVERCOMING BARRIERS TO ACCESS TO HEALTHCARE IN ENGLISH-SPEAKING ETHNOCULTURAL AND IMMIGRANT COMMUNITIES

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ABSTRACT

Drawing on knowledge of the historical evolution of health and social services in Quebec and Canadian studies on accessibility to healthcare for immigrants, this paper provides some reflections for initiating dialogue on this subject in relation to English-speaking ethnocultural and immigrant communities. A training tool designed to sensitize health and social service practitioners to barriers of access within a multiethnic context is also outlined as means of improving accessibility as well as the quality of care.

INTRODUCTION

The vitality of any community is necessarily linked to the capacity of its institutions to serve and address the needs of its members. This is particularly the case of the health and social services. Present in all stages of life, this sectors plays a key role in community development. In a survey of 3,100 English-speaking Quebecers, conducted for the Community Health and Social Services Network (CHSSN), health care is identified as one of the top three priority issues for the community, 48.9% declaring it as 'Extremely Important' and 44.6% as 'Important' (Jedwab, 2006). Health and social services also constitute a front-line actor in the redefinition and renewal of community boundaries to include new forms of membership. Over the past few years increased attention has been given to the heterogeneity of the English-speaking community in Quebec, particularly in relation to the aging demographic structure of the community, significant socio-economic disparities and its multiethnic character. While recent initiatives have begun to document the accessibility of health and social services for aging English-language speakers and those with low socio-economic status (CHSSN, 2003; Pocock, 2006)[1], little is known about the

accessibility of services to English-speaking ethnocultural and immigrant communities. Drawing on knowledge of the historical evolution of health and social services in Quebec and Canadian studies on accessibility to health care for immigrants, this paper provides some reflections for initiating dialogue on this subject. In the final part of the paper we discuss a training tool designed to sensitize health and social service practitioners to barriers of access in a multiethnic context.

AN HISTORICAL OVERVIEW OF THE ADAPTATION OF QUEBEC HEALTH AND SOCIAL SERVICES TO DIVERSITY

Multiethnic diversity is a defining characteristic of contemporary Quebec society, both in the English and French speaking communities. In 2006, for instance, 11.5% of Quebec's population (20.6% in Montreal) was born outside of the country. Of this number, 50.3% speak both English and French, 17.5% English only and 5% neither English nor French (MICC, 2009). Diversity within the English-speaking community is not only a recent phenomenon, but rather has strong roots in the past. In addition to immigrants of English, Irish and Scottish origins who arrived throughout the settlement period, other English-speaking communities also have a long history in Quebec. The Black Anglophone community, for instance, has been present since the 1700s, the first waves arriving initially as slaves and later as free migrants from the United States and the Caribbean (Williams, 1998). Chinese, Russian, Polish, Rumanian and German nationals formed other important immigration waves in the latter half of the 19th century as a result of political and economic repression in their homelands. Throughout the 20th century, Greek, Italian and Portuguese immigrants also joined the ranks of the English-speaking community, followed in the 1970s by numerous other immigrant groups from non-European countries (MAIIC, 1995; Roy & Montgomery, 2003; Legault & Rachédi, 2008).

Despite this early history of diversity, issues relating to multiethnicity have been largely occulted in the organisation of Quebec health and social services until recent years. Like all societal institutions, these services do not develop in a vacuum. Rather, they mirror the organisation and prevailing beliefs of society at any given point in time. Like Quebec society itself, the mainstream health and social service institutions have tended to be organised along ethno-linguistic lines, serving principally the majority English and French-speaking communities. Throughout the 19th century and early 20th centuries, few institutions specifically addressed the needs of new immigrant populations, with the exception of some private companies providing medical care to their immigrant workers and charitable and philanthropic organisations within the Protestant, Jewish and Catholic communities (Jacob, 1992). Generally speaking, however, these organisations operated on the margins of mainstream public health and social service institutions (Jacob, 1992; Fiorino, 1996; Christensen, 2003; Roy & Montgomery, 2003). It is not until the 1980s and 1990s that diversity became a preoccupation for the Quebec government. Within the space of a decade, two major policy papers addressed the issue of accessibility in all public sectors of activity: *Autant de façons d'être Québecois (1981)* and *Au Québec pour bâtir ensemble (1990).* With respect to the health sector more specifically, this period was also marked by the establishment, in 1984, of an umbrella association promoting accessibility to health and social services for immigrant populations *(Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux,* 2006) and the publication of two governmental reports on the same subject.[2] Today, equality of access to the health and social services for persons of all origins is clearly written in the *Act respecting health and social services* which states that resources must be designed "to take account of the distinctive geographical, linguistic, sociocultural, ethnocultural and socioeconomic characteristics of each region (art. 2.5)" and "to foster, to the extent allowed by the resources, access to health services and social services in their own languages for members of the various cultural communities of Québec (art. 2.7)".[3]

BARRIERS OF ACCESS TO HEALTH AND SOCIAL SERVICES FOR ETHNOCULTURAL AND IMMIGRANT COMMUNITIES

Despite the official acknowledgement of equal access to services, significant barriers still exist. As far as we know, there have been no systematic studies of access to English-speaking health and social services for ethnocultural and immigrant populations in Quebec. Other Quebec and Canadian studies, however, have documented the difficulties facing these populations in general. A series of analyses based on the National Population Health Study have proposed what is known as the 'Healthy Immigrant Effect' (Chen et al., 1996; Pérez, 2002; Ng et al., 2005). These studies suggest that the health status of recently arrived immigrants tends to be better than that of the Canadian-born population, a situation explained in part by the immigration selection process and healthy lifestyle habits of several immigrant communities. This health advantage, however, decreases over

time and their health status converges with that of the overall population. Between 1994 and 2003, for instance, immigrants were more likely to report a change from good, very good or excellent health to fair or poor health than the general population (Ng et al., 2005). Some subgroups also have higher risk factors than others for perceived low health status, particularly those living in low-income situations or poor housing conditions, groups who have faced significant traumatic situations during the migratory process, such as refugees, and groups historically confronted by discrimination or other forms of exclusion (Ng et al., 2005; Health Canada, 1999).

According to the Quebec health survey, persons of immigrant origin tend to use health and social services to a lesser degree than the general population (Chevalier & Gravel, 2002), a finding which has been corroborated in other Canadian studies (Health Canada, 1999). The under-utilization of services has been attributed to a number of factors. Formal immigration statuses may constitute a barrier for some, particularly for asylum seekers and persons with non-permanent statuses (temporary workers, foreign students, clandestine migrants), who are not covered by Quebec public health insurance and must rely on temporary health programmes, private insurance regimes or pay outright for care (Oxman & Hanley, 2007). The immigration experience itself may also contribute to the under-use of services. In the early stages following migration, insufficient knowledge of existing resources and of the way in which the health system is organised may limit contact with health care services. Also, the initial period following migration is often referred to as the 'survival phase', in which individuals may be more preoccupied with ensuring basic living conditions (housing, employment, feeding their families) and set health preoccupations aside. In a Quebec study of immigrant men and access to health and social services, these types of preoccupations constitute an important factor limiting consultations regarding their health and well-being (LeGall et al., in press). Practitioners may also lack sufficient knowledge about migratory statuses and the migration experience, leading to misunderstandings and misconceptions between practitioners and clients (Roy & Montgomery, 2003; McAll et al., 1997).

Language, of course, is another significant barrier of access to care. From the point of view of the patient, poor knowledge of English or French may mean that they are not able to adequately express their symptoms, talk about past health history or understand diagnoses and treatment options. Bowen (2001) describes several ways in which language barriers may effect the use of health and social services: diminished participation in health prevention and promotion programmes (cancer screening, prenatal and first aid courses); lower use of mental health services; increased use of emergency services and diminished use of telephone help services; higher risk of diagnostic errors; lesser understanding of health condition and treatment; poorer management of chronic illnesses, such as diabetes and asthma and lesser satisfaction with regards to services. Language barriers can also be examined from an organisational point of view. Where translation services are required, institutions must juggle between the costs of additional resources and the health risks stemming from potential miscommunication. Over and above the question of translation per se, (Battaglini et al., 2005; Battaglini, 2008) has suggested that interventions are generally 2.9% longer with newly arrived immigrant clients. The increased length of interventions is not strictly related to language barriers per se, but also includes other types of miscommunication stemming from divergent understandings of intervention objectives or differing cultural conceptions of health and ways of managing care (Battaglini et al., 2005; Battaglini, 2008). As some have suggested, the language barrier itself cannot be isolated from other factors and must be situated in a broader comprehension of social relations between the host community and ethno cultural or immigrant communities. Stereotypes, preconceptions and prejudice may play into the way in which practitioners and clients interact with one another, creating potential conflicts and undermining the establishment an effective clinical relationship (McAll et al., 1997; Roy & Montgomery, 2003). These barriers and others constitute the substratum of intervention practices in a multicultural context. They often operate unconsciously, thus contributing to the reproduction of exclusionary practices with respect to ethno cultural and immigrant communities. One means of addressing such barriers is through training programmes directed at sensitizing health and social service care professionals to intervention-related issues in working with a multiethnic clientele.

INTERCULTURAL MODEL FOR TRAINING HEALTH AND SOCIAL SERVICE PROFESSIONALS

The Research and Training Centre (RTC) of the CSSS (Centre de santé et de services sociaux) de la Montagne and its interdisciplinary research team METISS[4] offers a series of intercultural training seminars[5] to healthcare establishments and to community organisations working with a diverse population. These seminars were developed in order to provide practitioners with a tool for clinical problem solving within a context of diversity using a framework which places importance on social factors and barriers

to access to care while adopting a reflexive and critical approach to culture as an explanatory factor.

The initial intercultural training sessions (Kanouté et al., 2002) were co-developed by a group of RTC researchers and practitioners between 1998 and 2000, following a series of monthly, interdisciplinary 'research-training' workshops which brought together nurses, social workers, dental hygienists, psychosocial educators etc.[6] More precisely, the workshops consisted of group discussions aimed at clarifying the various elements involved in challenging clinical cases with highly diverse and mostly immigrant populations. Some dominant themes raised include the following: "tensions or misunderstandings due to diversity, social class differences, gender differences and different understanding of masculine and feminine roles, confusion or misunderstanding on the part of clients with regard to bureaucratic norms inherent in interventions within public services, identity questions tied to the migration process, interdisciplinary tensions between practitioners working with the same clients, etc."(Kanouté et al., 2002) At the end of the process, participants expressed the need for a continuation of such training sessions since they allow practitioners to take time to reflect within a framework which is in proximity to their practice but also removed from it. This experience also revealed the tremendous reflexive and creative capacities present when a team of practitioners engages in a problem solving activity where the focus is placed on mobilising and rendering explicit individual knowledge and practice, within a non-judgemental context. The ensuing training seminars sought to capitalise on the existing reflexivity and problem-solving capacity of professionals. A series of two day training seminars have been developed and thus far offered to more than five hundred health and social care practitioners.

A fundamental principle underlying the theoretical approach of the intercultural training seminars is a rejection of culturalist or essentialist positions in explaining intervention issues as a means of avoiding the creation of stereotypes which are often generated by such approaches.[7] In their day to day interventions, practitioners are not in contact with *cultures* or with *ethnics*. Rather they encounter individual bearers of multiple identities, with culture being one component. The same applies to practitioners. The way an individual identifies with their culture may vary within a given group, since the possibility of choosing certain customs, values and ideas over others exists. This process may evolve over a person's lifetime and be modified by a number of social factors including social class, gender, years of education and the migration process. A practitioner cannot presume to know the client's cultural values, beliefs or a practice simply based on the latter's ethnic origin or cultural belonging. The contrary also applies to clients in their intervention encounters with practitioners (Kanouté et al., 2007).

A rejection of the culturalist approach does not signify the evacuation of culture as a factor in understanding intervention issues. Rather it cautions practitioners against a systematic reliance of culture as the sole explanatory factor in understanding clinical cases, and this as a means of preventing the propagation of stereotypes and prejudices. As Cognet (et al., 2007) mentions, the ethnicization of health risks or problems, whether based on a cultural or racial bias, not only deforms the understanding of the situation but contributes to existing negative social perceptions in society. As in other studies (Cognet et al., 2007; Fortin & Laudy, 2007), the presumed neutrality of the clinical encounter is called into question and a methodology based on an intersectional model (Yuval-Davis, 2006) for the analysis of clinical cases is proposed. In other words, culture is juxtaposed with other explanatory factors such as the country of origin, the migration trajectory, religions, social class, gender, years of education, degree of familiarity with bureaucratic, organisational, and deontological norms of the healthcare system, as well as knowledge of professional roles and mandates. Similarly, the identity, gender, migration trajectory (if applicable), and the professional status of practitioners is considered (Kanouté et al. 2007). Such an approach not only helps practitioners in gaining a better understanding of beliefs, practices, and at times resistance on the part of clients during the intervention process but it also provokes the former in questioning their own framework.

CONCLUSION

This short reflection on barriers of access to healthcare is based on literature on immigrants in general as well as a training model for practitioners intervening in a context of diversity, rather than specifically on English-speaking ethnocultural and immigrant communities. This being said, the issue raised concerning the tendency of recent immigrants to under utilize services also holds relevance for members of English-speaking ethnocultural and immigrant communities. This tendency to under utilize services is attributed to numerous factors including migration status and the insertion process within Quebec society as well as language, diverging conceptions of health and illness, lack of knowledge of the healthcare system, and negative social preconceptions and prejudices. Also proposed is an intercultural training model which sensitizes practitioners to existing barriers to healthcare affecting persons of immigrant and diverse ethnocultural origin as a means of improving frontline

interventions. Taking into account existing barriers of access to healthcare and developing tools to improve quality and access of services for English-speaking immigrants, represents a few of the possible measures aimed at contributing to the vitality of the English-speaking community as a whole. This discussion also provides fertile ground for further research. More specifically, little is known about the specific challenges facing English-speaking immigrants in gaining access to healthcare and social services institutions. Little is known either about the way in which practitioners belonging to ethno linguistic minorities live and perceive their professional experience within the healthcare system, nor of the types of strategies, skills and tools they develop in working with a diverse clientele. The same applies to professionals working in community organisations that provide services and resources to diverse populations within a context of recent immigration and diversity. How does the community sector interface with mainstream healthcare and how are existing and emerging challenges identified and dealt with? Finally, on a management level, how do healthcare organisations manage diversity within the context of barriers to access of care? How are specific needs, be it in terms of language, poverty, or other factors, addressed while respecting the principles of equity and quality?

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NOTES

[1] In 2009, the Canadian Institutes for Health Research, in collaboration with the Community Health and Social Services Network, organised a symposium on official language minorities, the objective being to stimulate research interest on this theme. Also, the Quebec English-Speaking Communities Research Network (QUESCREN) is currently undertaking a project on poverty in the English-speaking community which also addresses the question of access to health care.

[2] Bibeau, G. et al. 1987. *À la fois d'ici et d'ailleurs. Les communautés culturelles et leurs rapports aux services sociaux et aux services de santé*, Québec, Les Publications du Québec. Sirros, E. 1987. Rapport du consultatif sur l'accessibilité des services des établissements du réseau aux communautés culturelles, Québec, Publications officielles.

[3] *Act respecting health and social services*, Government of Quebec: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2_A.html , consulted January 5, 2010)

[4] Migration et Ethnicité dans les Interventions de Santé et de Service social, Équipe FQRSC en partenariat centre affilié universitaire. www.csssdelamontagne.qc.ca

[5] Current training seminars for practitioners and support staff : « Interculturel I : Les mots pour dire et pour intervenir »; « Interculturel II : Connaître ses clients, statuts, trajectoires et vécus migratoires »; « Séminaire de formation en interculturel : Intervenir par téléphone en contexte de diversité »; For managers and supervisors : « Gérer dans la diversité ».

[6] The 2005 Quebec Health Reform as stipulated by Bill 25 led to the creation of the present day 95 CSSS (Centre des services santé et services sociaux) in the province of Quebec and the reorientation of services around local networks. The CLSC Côte-des-Neiges merged with the CLSC Métro and the CLSC Parc Extension to become the CSSS de la Montagne. Its territories of CLSC Parc-Extension and CLSC Côte-des-Neiges are characterized by a high percentage of recent immigration (62% and 43% respectively) compared to only 28% for the island of Montreal. (Direction de la santé publique. 2006. « Le portrait socio-sanitaire de la population au 31 octobre 2006 » www.csssdelamontagne.qc.ca).

[7] According to this position culture is seen as the totality of shared behaviour among members of society and that cultural groups are fixed entities. Culture is comprised as an ensemble of natural, fixed traits which are transmitted from generation to generation.