Needs Assessment for English-Speaking Seniors: Maintaining Health and Well-Being

Final report based on the multiple perspectives and experiences of Quebec's English-speaking seniors living in the community

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Executive summary

This research report addresses three main themes related to the challenges and needs of Quebec's English-speaking seniors. First, it outlines the obstacles they face, particularly language barriers that limit access to healthcare and increase isolation, especially in rural and remote areas where support from caregivers and the community is essential. Second, it identifies their priorities for improving health services, emphasizing the need for respectful and accessible care, particularly end-of-life services, and addressing digital exclusion, which heightens their vulnerability. Finally, it assesses the CHSSN model (2019) " Promoting the health and well-being of English-speaking seniors in Quebec: a community model" to validate its relevance and adapt it to the realities of English-speaking seniors, confirming its suitability for the diverse experiences of aging.

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INTRODUCTION

Like most countries in the world, Canada is rapidly aging. In 2023, nearly 19% of all Canadians were aged 65 or over. Although Canadians reaching age 65 can expect to live another 20 years rating their health as satisfactory, they can also expect increasing physical, mental, and social health challenges necessitating frequent interactions with health care systems (ASP, 2020). Currently, 2/3s of Canadians aged 65 and older live with at least one chronic condition, making access to care and services of critical importance. In Quebec specifically, English-speaking adults aged 65 years + comprise 15.4% (193,685 people) of the total English-speaking population and up to 30.5% of the older adults in rural and remote areas. Research has established links between language barriers, reduced access to preventive services and increased risk of medication errors across age groups.

English-speaking seniors in Quebec face several challenges in accessing health and social services. According to a Health Canada study (Gouvernement du Canada, 2022), 73% of Quebec anglophones aged 55 and over reported difficulties in obtaining healthcare services in their preferred official language. These challenges include language barriers, a lack of awareness of available services, and an insufficient supply of services in English. Additionally, English-speaking seniors often experience socio-economic vulnerabilities, including higher rates of low income compared to their francophone counterparts, which can further limit their access to necessary services (Éthier & Carrier, 2022).

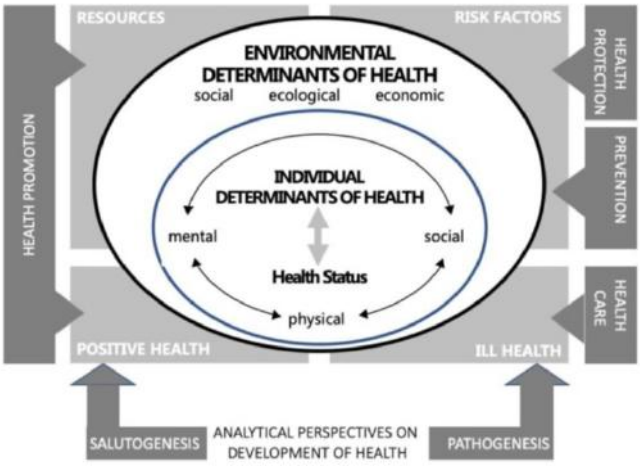
However, studies did not shed much light on the perspective of English-speaking seniors themselves regarding their needs and issues in terms of access to healthcare services that enable them to maintain their well-being. Also, studies have yet to yield deep and important insight into, in addition to language, which various intersections and social determinants (e.g., rural versus urban location, age, disability status, sex, gender and social identities, living arrangements, presence or absence of family, access to health care technology) affect access and in what specific ways.

AGING: A HETEROGENEOUS PHENOMENON

Aging is a universal biological process, but it **manifests itself in profoundly heterogeneous** ways for different individuals. This variability is explained by multiple factors, including genetics, life trajectories, social, economic and cultural environments, as well as lifestyle habits (Henard, 2002). Biologically, some people experience more marked aging, with a rapid accumulation of physical and cognitive frailties, while others retain exceptional functional capacities well into old age. Socially, access to care, support networks and living conditions also influence this diversity. Finally, perceptions of aging vary according to culture and context, which can modulate the expectations and needs of older people.

One model that takes this heterogeneity into account in understanding health is The Health Development Model by Bauer et al (2006). This is a conceptual framework that aims to explain how health develops throughout life, taking into account biological, social and behavioral factors. The model is based on a dynamic approach, in which health is seen not as a static state, but as an evolving process influenced by complex interactions between the individual and his or her environment, as seen in Figure 1. Here are the model's key points: 1) Health as a developmental process. Health is conceptualized as a cumulative result of transitions and interactions over the life course. This includes prenatal developmental experiences, childhood events, behavioral choices in adulthood, and living conditions later in life; 2) The role of windows of vulnerability and opportunity. Certain periods of life, such as childhood or the transition to old age, are identified as critical windows where environmental influences, lifestyle habits and healthcare have a disproportionate impact on the health trajectory; 3) Ecological and systemic approach. The model integrates factors at several levels (Individual: genetics, biology, behaviors) such as **social** (e.g. family interactions, social networks, socio-economic status) and **environmental** (e.g. cultural and political context, access to healthcare services).

Figure 1. Health Development Model



Understanding the needs of the elderly should take this heterogeneity into account, enabling a response that is tailored to the different realities and constraints of aging citizens. A multi-dimensional approach is therefore necessary and this heterogeneity calls for a personalized approach in public policies and support practices. This means analyzing needs from different angles, including culture, gender and socio-economic status.

For example, the ageing process differs significantly **between urban and rural areas**, mainly due to disparities in access to resources and services, as well as social and environmental particularities specific to each context (Kinsella, 2001; LISA, 2022). Rural, semi-urban and urban contexts are

distinguished by their demographic, geographic, economic and social characteristics. An urban context refers to an environment characterized by intensive human development, high population density and the presence of complex infrastructures and facilities (Coop Carbone, 2018). In the portrait of Quebec's regions, four categories of rural communities were identified: 1) outlying rural communities; 2) intermediate rural communities; 3) remote rural communities; and 4) isolated rural communities (Coop Carbone, 2018). It is already recognized that living in a rural, semi-urban or urban environment has a significant impact on access to community services, their availability and their nature (Ticala, 2020). The differences between these environments are notably influenced by population density, geographical accessibility, community culture and the specific needs of each region.

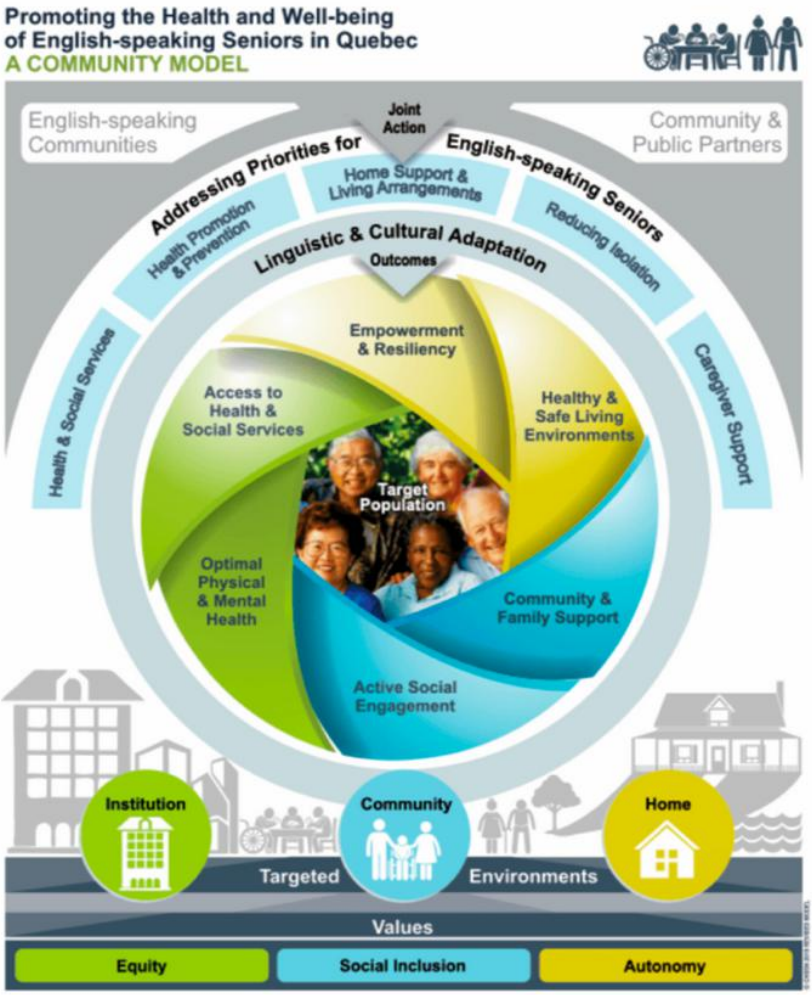
In rural areas, older people face significant challenges, such as limited access to healthcare due to geographical distances, lack of healthcare professionals, and often inadequate transport infrastructure. These obstacles contribute to a higher prevalence of chronic diseases, such as cardiovascular disorders and diabetes, due to insufficient prevention. In contrast, urban areas offer better access to specialized care and adapted infrastructures, although pollution, noise and urban stress can be detrimental to seniors' mental and physical health.

Socially, isolation is a central issue in both contexts, but it manifests itself differently. In rural areas, low population density can limit social interaction, although community ties are often stronger (Cohen, & Greaney, 2023). Conversely, urban areas, despite a greater number of opportunities for social interaction and diversified community services, can reinforce isolation due to anonymity or social fragmentation. Finally, the physical environment plays a key role: urban infrastructures such as public transport and sidewalks encourage the mobility of the elderly, while rural environments, although quieter and more natural, often lack facilities adapted to the needs of this population. These disparities underline the importance of adopting a contextualized approach to promote healthy aging in a variety of environments.

Another factor that can influence the aging process is **belonging to a minority group**. Among other things, speaking a minority language can have an impact on health (Angel & Angel, 2006). For example, some data tend to highlight the fact that English-speaking seniors, who are therefore in a minority group in Quebec which is a French-speaking swine, face unique challenges due to language barriers, socioeconomic inequalities, increased social isolation, high caregiving demands on the few family caregivers, as well as lack of awareness of their needs and lack of representation associated

with their community's minority status. To help them meet these multiple challenges, the Community Health and Social Services Network (CHSSN) is a provincial non-profit organization whose mission is to support Quebec's English-speaking communities by promoting equitable access to health and social services in English. It does this by developing programs and cross-sector partnerships that address the social determinants of health and foster community vitality. CHSSN is a fiduciary organization that receives funds from the provincial and federal governments and distributes them to community organizations in all regions of Quebec, in addition to responding to specific mandates to better understand the needs and issues experienced by English-speaking seniors in Canada. From research of the scientific literature, they created a model in 2019 to support community actions that promote the health and well- being of English-speaking seniors. This model puts forward 5 priority needs of English-speaking seniors in Quebec are as follows: 1) Health and social services; 2) Health promotion and prevention; 3) Home support and living arrangements; 4) Reducing isolation and 5) Caregiver support, as seen in Figure 2.

Figure 2. Promoting the health and well-being of English-speaking seniors in Quebec: a community model



BACKGROUND AND OBJECTIVES OF THE STUDY

As part of the CHSSN mission, Health Canada has made funds available to better understand the needs of Quebec's English-speaking seniors living in the community.

Based on the multiple perspectives and experiences of Quebec's English-speaking seniors living in the community, a research project was achieved in 2024, aimed at 1) drawing up a portrait of their **needs** with a view to maintaining a meaningful life and well-being, 2) identifying with them their **priorities** about possible improvements in the health sector to enhance their well-being, and 3) **review the model** developed by CHSSN in 2019 in order to validate and adjust it from the perspective of the seniors concerned.

Improving access to, and the quality of, healthcare necessarily involves questioning the people directly affected by these improvements. This understanding is crucial at a time when the needs of seniors are growing, and when several reports point out that the current healthcare system will not be able to meet these needs efficiently and satisfactorily in the medium term if the status quo is maintained. Considering the needs of seniors from linguistic minorities could make it possible to, among other things, improve quality of care for this population, including recognizing cultural differences in perceptions of health, illness and treatment. Reducing health inequalities for this population, improve engagement and satisfaction in care and develop effective policies and programs are other possible effects of taking the specific needs of English-speaking seniors into account in thinking about healthcare reform and innovation.

METHODOLOGY

A mixed methodology has been employed in this project. The aim of using a mixed-method approach was to question many seniors about issues of interest, and to refine this information by giving voice to individuals to gain a more detailed understanding of their experiences and the particularities linked to their backgrounds.

More specifically, an **online questionnaire** was distributed through the communication channels of CHSSN-affiliated groups and centers and was open for completion by participants from February 2024 to March 2024. The questionnaire consisted of 10 questions, including sociodemographic questions, questions about the use of community and health services, questions on the challenges experienced, and questions about the participants' perceived priorities.

In March 2024, **three focused groups** were conducted, in three regions of Québec; 1) Gaspésie (remote), Lanaudière (rural), and Montreal (urban). A reasoned choice method was used to select focus groups in regions with varying demographics and territorial realities. The focus groups were held in community centers, providing a familiar and accessible environment for participants. Each session was facilitated by two researchers who guided the discussions and took detailed notes to capture the insights shared. Each focus groups lasted approximately 1.5 hours and were structured into two main parts. The first part addressed the challenges and needs of English-speaking seniors, while the second part explored the model proposed by the CHSSN, with the goal of gathering feedback to improve it.

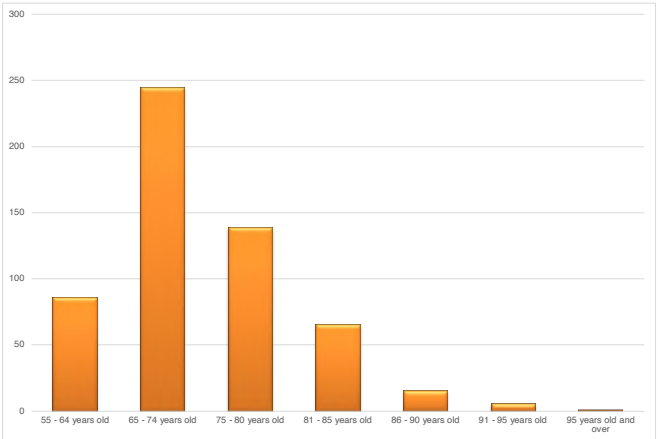
Data from the questionnaires were analyzed using simple inferential statistical analysis. Data from focus group verbatim transcripts were analyzed using thematic content analysis. The analysis of sequences using coding and categories was carried out according to the techniques described by Sundler et al. (2019). These techniques are appropriate because they are specifically designed for thematic analysis of interview data using a phenomenological approach to health. Consistent with the literature presented earlier on the heterogeneity of aging, the analysis we carried out took into account several variables, including the living environment (remote, rural, urban) of the participants.

PARTICIPANT DESCRIPTION

Online questionnaire

A total of **565** people responded to the online questionnaire. Although participants varied in age, as shown in Figure 3, most respondents were between 65 and 85 years old, with an average age between 65 and 74 years old.

Figure 3. Participants pyramid of ages



Based on the density of population, types of activities and distance from developed infrastructure (especially health infrastructure), it is possible to categorize regions where participants live into three different groups: urban, rural and remote (Wakerman, & al., 2017). The urban category considers the people who lives in a densely populated areas with developed infrastructure and predominance of non-agricultural activities. The rural category considers the people who lives in a sparsely populated areas, primarily focused on agriculture or natural resources, with limited infrastructure. The remote area considers the people who live in an isolated areas far from cities, with minimal infrastructure and services, and low population density. Most of the participants came from **urban** (43%) and **rural** regions (56%). Table 1 shows all the regions identified by respondents.

Table 3. Distribution of participants by region

Region	Percentage
Bas-Saint-Laurent (rural)	0.5
Mauricie (rural)	1.1
Estrie (rural)	2.9
Montreal (urban)	31.7
Outaouais (rural)	6.6
Abitibi-Temiscamingue (remote)	0.7
Laval (urban)	9.1
Laurentides (rural)	2.9
Lanaudiere (rural)	1.4
Monteregie (rural)	37.4
Centre-du-Quebec (rural)	1.4
Total	100.0

Focused group

A total of **34 seniors** took part in the focus groups, 26 women and 8 men. More specifically, 13 seniors took part in the remote region focus group (Gaspésie), 6 seniors took part in the rural region focus group (Lanaudiere), while 13 took part in the urban focus group (Montreal).

RESULTS

SERVICES USED BY SENIORS TO MAINTAIN THEIR HEALTH AND WELL-BEING

During the focus groups, English-speaking seniors were asked to discuss the various services they use in their communities to support their well-being. Across all participants, certain services were consistently highlighted as essential. These included visits to family doctors, consultations with specialized nurse practitioners, and access to community and self-help services, which are often provided by dedicated volunteers and various organizations. These services collectively form the backbone of health and well-being support for English-speaking seniors met.

For English-speaking seniors living in **rural** areas, **pharmacists** play a pivotal role as first-line healthcare providers. Many participants emphasized that they often consult their pharmacist before seeking other health services. This preference is driven by the accessibility and familiarity of local pharmacies. As one participant remarked

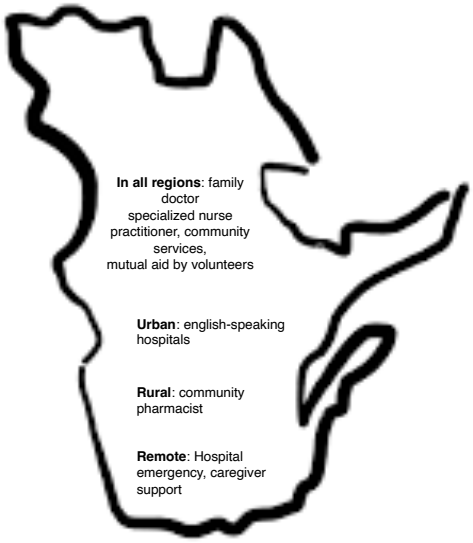
"The pharmacy is a central part of our community. We go there regularly to ask questions."[1]

Pharmacists are seen not only as medication experts but also as trusted advisors for general health concerns. Additionally, **rural** seniors frequently turn to their **caregivers**—family members or close friends—for day-to-day support, particularly when navigating health and well-being challenges. The reliance on caregivers reflects the strong interpersonal bonds within these communities and the limited availability of immediate professional healthcare services.

In **urban** areas, English-speaking seniors also report consulting their **caregivers** for health-related concerns. However, they benefit from a wider range of healthcare options compared to their rural counterparts. Participants noted that they readily access English-speaking hospitals in their region without hesitation, ensuring that language barriers do not hinder their care. Urban seniors appreciate the **availability of specialized services**, such as outpatient clinics and advanced diagnostic tools, which are more accessible in urban settings. This accessibility fosters a sense of confidence in seeking timely and appropriate care.

[1] In this report, the excerpts in quotation marks and italics are extracts from the participants' own words, taken from the focused discussion groups.

For English-speaking seniors in **remote** regions, the reliance on **close-knit support systems** is even more pronounced. These seniors often depend heavily on family and friends to meet their health and well-being needs. When professional services are required, they typically turn to the emergency departments of their local hospitals. The scarcity of readily available healthcare options in these areas highlights the importance of emergency services as a critical safety net. Participants shared stories of relying on their immediate community to fill the gaps left by limited healthcare infrastructure, underlining the resilience and resourcefulness of remote seniors.



The **survey** revealed both commonalities and distinctions in how English-speaking seniors navigate their healthcare and support services across rural, urban, and remote settings. While family doctors, specialized nurses, and community services are universally important, the role of pharmacists, caregivers, and hospitals varies significantly depending on geographic context. These findings underscore the need for tailored healthcare policies and support systems that consider the unique challenges and resources of each community type, ensuring that all English-speaking seniors have equitable access to the services they rely on most.

CHALLENGES FOR MAINTAINING HEALTH AND WELL-BEING

The Table 2 highlights the key challenges indicated by respondents to the online questionnaire concerning challenges experience when accessing health care services, categorized by rural, urban, and remote areas. It presents the percentage of seniors facing difficulties such as obtaining services in their language, feeling misunderstood by healthcare providers, accessing services close to home, and feeling excluded from care processes. The table also includes other concerns, such as difficulty finding a family doctor.

Notably, **rural** seniors report the **highest difficulty accessing services near home** and in their language, while remote seniors experience significant challenges in feeling understood by caregivers. It's worth noting the **high percentage** of respondents (50%) in **remote** areas who say they feel that the people they meet to discuss their health problems don't understand the situation or their needs.

Table 4. Challenge faced by seniors by types of regions

Challenge	Rural	Urban	Remote
Difficulty obtaining services in my language	44.7	35.8	25
Feeling that the person I meet doesn't understand my needs	19.4	18.8	50
Difficulty accessing services close to home	37.5	21.8	0
Feeling excluded	20.4	16.2	0
Others (especially getting a family doctor)	9.9	10.5	0

The focus groups also provided an opportunity to discuss with English-speaking seniors about their experience of accessing services in the community to support their well-being, and the various issues and difficulties they encounter.

Accessible care

The quest of the family doctor

Many focus group participants reported significant difficulties in accessing a family doctor, leaving them feeling unsupported and uncertain about their healthcare. This issue was particularly pronounced in **remote** areas, where the scarcity of healthcare providers adds to the challenge. As one participant expressed:

"When my family doctor left, I became an orphan. It was four years ago. Here, doctors don't arrive, they leave or retire and are not replaced. They don't come and we don't have any follow-up."

In **urban** areas, participants noted long wait times and overburdened systems, forcing them to rely on walk-in clinics or emergency services for routine care. The situation is even more critical in rural and remote regions, where seniors often face prolonged waiting periods for appointments. These challenges highlight the need for systemic improvements to ensure timely and reliable access to family doctors for all seniors.

A long-distance quest

Many seniors reported that accessing healthcare and community services often requires **traveling long distances**, a challenge that is both physically demanding and emotionally taxing. Transportation, when needed, is frequently difficult to arrange, further amplifying feelings of isolation and helplessness.

"Transportation isn't easy. There are buses, but not enough. I always have to ask for help, be creative or sometimes cancel an appointment that was hard to get."

In addition to the scarcity of personnel, seniors in **remote** areas report that, faced with local French-language services that don't meet their needs, they prefer to travel several hours to see English-speaking doctors, for example in a neighboring English-speaking province.

"I prefer to do a one-hour drive and have access to a doctor who takes time with me and understand me."

"Many of us would rather drive to New Brunswick than to a hospital near us, to be better understood and welcomed."

These challenges underline the critical need for improved local services and accessible transportation options to support seniors' health and well-being.

Building a therapeutic relationship

High turnover of specialist in rural and remote area

Seniors frequently face extended wait times for appointments, particularly with specialists, due to high turnover in the healthcare system. This constant change disrupts continuity of care, making it challenging for seniors to receive consistent and reliable treatment. The lack of stability in specialist availability further complicates their health management, increasing frustration and uncertainty in accessing necessary care.

Access services in the primary language

Many seniors expressed frustration with the lack of consistent access to services in English, particularly in community service centers (CLSCs) and healthcare environments. The issue is compounded by **unilingual French signage**, creating barriers for English-speaking individuals to navigate care facilities and understand instructions. This sentiment was echoed by participants, with one urban senior sharing:

"At the hospital in Montreal, the guard refused to speak in English with me, and all the signage is in French. I didn't even know how to get to my surgery room and had to wander around the huge hospital to find the place."

The inconsistent availability of English-language resources, such as translated website sections or automated telephone tools, further complicates English-seniors' experiences. For instance, while some parts of a telephonic system may be translated, others are not, leading to confusion and a sense of exclusion.

The lack of linguistic accommodation also extends to interactions with healthcare professionals. Many participants reported difficulty communicating their needs effectively, with some professionals either unwilling or unable to provide services in English. This reality was reflected in survey responses, where 45.33% of participants highlighted challenges in receiving services in their preferred language (see Table 3). One senior recounted being dismissed by a healthcare professional, stating:

"It happened that some professional told me he doesn't have the time to deal with that. Imagine, a doctor who doesn't have the time to take the time to understand me."

These linguistic barriers create **feelings of alienation and diminish trust** in the healthcare system. Participants stressed the importance of improving **bilingual signage**, enhancing **translation quality on digital platforms**, and ensuring healthcare staff are equipped to address the needs of English-speaking seniors effectively.

Table 3. Ease of access to obtaining health care and social services in English in Quebec

		Percentage
Rural	It's always difficult to access services	33.6
	Some services are difficult to access	42.8
	Most services are easily accessible	21.7
	Total	98.0
Urbain	It's always difficult to access services	30.6
	Some services are difficult to access	39.3
	Most services are easily accessible	27.1

	Total	96.9
Remote	It's always difficult to access services	25.0
	Some services are difficult to access	75.0
	Most services are easily accessible	0
	Total	100

Issues related to the intersectionality

As we seen previously, many participants shared that **they felt excluded** from specific programs and services due to the lack of English-language accessibility. This language barrier posed significant challenges in accessing necessary care and contributed to feelings of **frustration and exclusion**. The lack of linguistic accommodation often left participants feeling disrespected and **powerless**. Access to services in one's own language was consistently identified as essential for **preserving dignity** and ensuring respectful treatment.

Experiences of **dehumanization** were a recurring theme, with participants frequently describing condescending and infantilizing attitudes from service providers in rural, urban and remote areas.

"They treat us as children. Even more so when I try to express myself in French to make myself understood, but it's as if with my accent, they believe even more that I'm not capable of understanding things."

"They make you feel diminishing. I'm old and I have trouble expressing myself, imagine that!"

"I was unspeakable. I felt like it wasn't easy to talk to me and that I wasn't worth the effort to explain things to me and understand me."

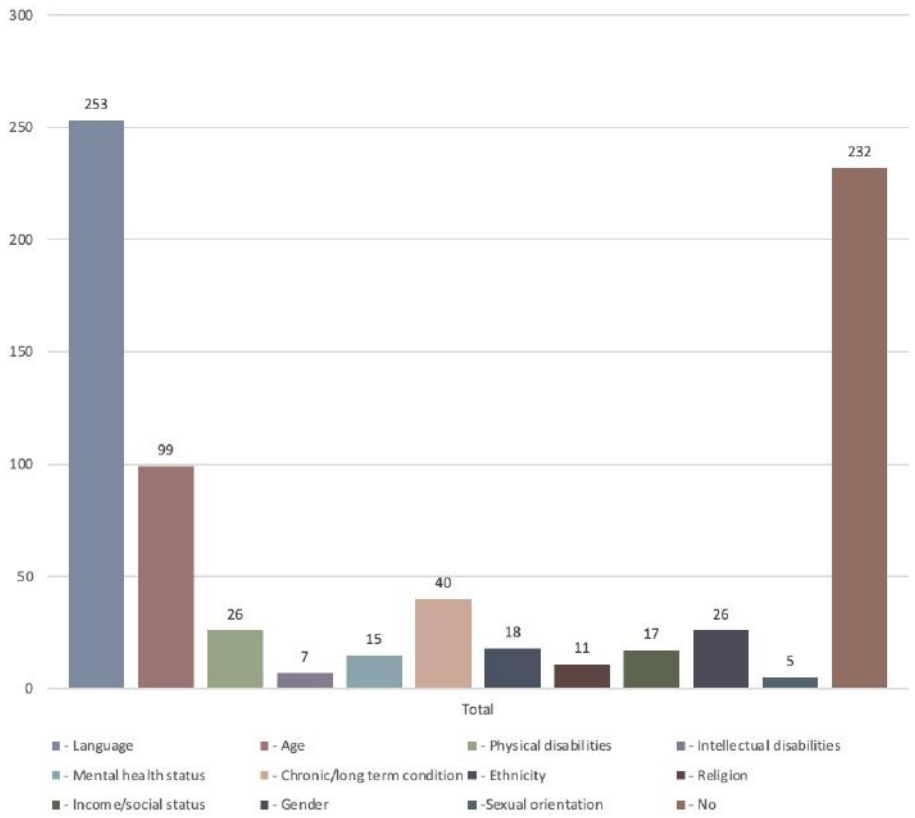
The time constraints in medical consultations further compounded these issues. Seniors in rural areas, for instance, highlighted the **unrealistic expectations** placed on patients, with one participant stating:

"When you see the doctor, you only have 20 minutes, and you can only have one issue. That is not realistic. Sometimes it takes me half that time just to gather my thoughts and start the conversation, especially when I have to express myself in French"

Intersectionality issues, particularly related to ageism, language, and sexual orientation, exacerbated these challenges. The Figure 4 illustrates the key reasons reported by participants

for feeling stigmatized within healthcare settings, along with the corresponding percentages of individuals who identified each reason.

Figure 4. Reasons reported for feeling stigmatized within healthcare settings



The data highlights the prevalence of stigmatization based on factors such as **language barriers, ageism**, and other intersectional issues (e.g. the presence of a chronic illness or gender), emphasizing the challenges faced by English-speaking seniors in accessing equitable and respectful care. Some participants noted that efforts to include English-speaking seniors are **deemed superficial**, often limited to token gestures such as the widely used "Bonjour-Hi" greeting, without meaningful follow-through. Participants in focus groups echoed these concerns, pointing out that they **often felt stigmatized** due to their age or language when accessing healthcare services.

These experiences underscore the need for systemic changes to create a more inclusive and respectful care environment. This includes improving access to English-language services, addressing biases related to age and language, and ensuring that healthcare providers engage with seniors in ways that affirm their dignity and individuality.

MISMATCH BETWEEN TECHNOLOGICAL REQUIREMENTS AND CAPICITIES

Increased use of technology

Many seniors reported significant difficulties in adapting to the increasing reliance on technology for accessing services. Technologies such as websites, voicemail systems, and automated messages are often designed with speed and efficiency in mind, which can conflict with the pace at which many seniors are comfortable navigating these tools. These technological demands, such as rapidly clicking to refresh an online appointment page or quickly pressing phone buttons to select options, create accessibility barriers that **disproportionately affect** seniors. Participants shared the frustration and stress caused by these systems.

"There is discrimination in technology, the automatic call, for example, with a limiting time to respond."

"It takes me maybe two minutes longer than a younger person to press the appointment button, and since the time slots fill up quickly, I've lost the chance of getting an appointment with my doctor."

Others highlighted the endless waiting times and lack of human interaction, with one stating:

"You can stay in the waiting until you die. No one answers, and after pressing several options that are not always translated, sometimes the line goes dead."

These automated processes often lack the flexibility and patience required to accommodate seniors' needs, making them feel excluded and undervalued.

In addition to speed-related challenges, seniors also expressed difficulty navigating the complexities of online systems. For some, even basic tasks like logging in or navigating websites can feel overwhelming. One urban participant candidly shared:

"I feel old on the internet; it is difficult to navigate. It takes a lot of time."

This frustration is compounded by a lack of user-friendly designs and inadequate support for seniors who may be less familiar with digital tools. With the advent of online modules and operations supported by artificial intelligence, some see this as a solution to making it easier to obtain information in English, but most fear that it will only exacerbate the unwillingness of authorities to fund bilingual operators to answer the phone and speak to understand, for example, the services available.

These barriers not only hinder seniors' access to essential services but also exacerbate feelings of alienation and disempowerment. Many participants emphasized the need for more accessible and inclusive technological solutions. Suggestions included simplifying online platforms, providing clearer instructions, and ensuring the availability of alternative, non-digital options such as live operators or in-person assistance. By addressing these challenges, service providers can create systems that better serve the needs of seniors, fostering inclusivity and ensuring equitable access to vital resources.

Untranslated technology

Seniors reported frustrations with **inconsistent English accessibility** in websites and automated telephone systems, where some parts are translated while others are not. This creates confusion, particularly in urgent situations. As one urban participant noted:

> *"Will I be able to speak in French on the phone if it's an emergency? I can often manage, but if it's urgent and I have to understand instructions in French, I'm afraid I won't be able to do it."*

These challenges highlight the need for consistent, high-quality English support across all technological platforms to ensure equitable access for English-speaking seniors.

Terror of long-term care

Seniors across all regions express significant concerns about long-term care, driven by fears regarding the quality, accessibility, and personalization of services. Many worries about losing their independence and being placed in facilities where compassionate and tailored care might not be guaranteed. In rural and remote areas, these fears are heightened by inconsistent availability of medical personnel and limited access to specialized services. Seniors are particularly apprehensive about whether their physical, emotional, and social needs will be met and whether they will have a voice in decisions impacting their care.

> *"We worry about how we will be treated. We need to be included in the process."*

For English-speaking seniors, especially those in predominantly French-speaking or bilingual regions, long-term care presents additional challenges. Language barriers can hinder effective communication with caregivers, fostering fears of being misunderstood or receiving inadequate care. In remote areas, retaining English-speaking healthcare professionals is particularly difficult, further limiting access to essential long-term care services. These seniors are especially concerned about receiving **dignified end-of-life care in their preferred language**, which they view as essential for maintaining comfort and respect.

"Will I be able to have enhanced support for end-of-life care in English?"

"At such an important stage, I hear that it's sometimes difficult to dictate our last wishes in English. Imagine not being able to understand end-of-life care instructions - it's impossible!"

NEEDS AND PRIORITIES

Focus group participants were asked to identify their needs and priorities for the coming years to improve the care and services they need to maintain their health. Some needs and priorities were named by all the groups, while others were highlighted more specifically in certain focus groups. The following Table 4 summarizes the elements discussed.

Table 4. Expressed needs and priorities by seniors

Needs	Priorities
Improve access to - training and support in the use of technologies related to health services; - bilingual signage in care settings - a family doctor Obtain **legal services** in English - related to end-of-life care without additional costs **Increase the financial and human resources** - of community organizations involved with English-speaking seniors - for English translator in long-term care	Improve and enhance **long-term and end-of-life care** Increase recognition of **family caregivers** - time and money - enhance the role of family caregiver through training. Be able to explain and be understood when explaining health problems in English Sensitize professionals to **destigmatization** Improve the user experience of technology and **reduce the use** of voice mail, recorded messages, in favour of a human presence.

Needs

To address the challenges faced by English-speaking seniors, several key improvements have been identified by this population. First, providing **access to training and support in the use of technologies** related to health services would help seniors navigate increasingly digital healthcare systems more effectively. Many seniors find it difficult to manage online appointments and automated systems, which often require quick responses or specific actions. In addition to training (which is individually dependent), it would be essential for software not to favour the accessibility of young people or those without disabilities in favour of those who require more time to use the functionalities.

Additionally, obtaining **legal services related to end-of-life care** in English without additional costs is identify as crucial. Seniors need to feel confident that their wishes will be respected and understood in their preferred language, without having to bear extra financial burdens.

Another important improvement would be **ensuring bilingual signage** in care settings, which would allow English-speaking seniors to navigate healthcare facilities more comfortably. Unilingual French signage often creates confusion and exacerbates feelings of isolation for these seniors.

There is also a need to **increase the financial and human resources of community organizations** that work with English-speaking seniors. These organizations often serve as a lifeline, providing critical support in navigating health services and addressing language barriers.

Finally, **improving access to family doctors** is essential for all seniors, but particularly for those in rural or remote areas, where the shortage of healthcare professionals is more acute. Having consistent access to a family doctor ensures that seniors receive continuous and personalized care.

Priorities

In terms of the priorities identified by English-speaking seniors to support their well-being, participants identified global priorities, and other priorities were specific to certain regions. Among the global priorities, participants suggested improving and valuing long-term and end-of-life care and **increasing recognition of caregivers** (give more resources; ex. time and money). One way of doing this, they suggested, would be to enhance the role of caregivers through training and financial recognition.

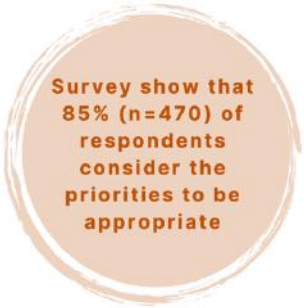
Participants also identified the **humanization of services** as a priority, in terms of both people and technology. On the human front, this involves raising awareness among professionals about destigmatization (age, language, sexual orientation). On the technological front, the aim is to improve the user experience by reducing the use of voicemail, recorded messages, etc., in favour of a human presence.

Another priority identified by all participants is **to receive care and services in English**, so that they can explain their health problems and be understood, as well as understand the professionals involved. Participants pointed out that their ability to express themselves in their second language (e.g. French) diminishes with advancing age. However, it is imperative to make ourselves understood when it comes to our health and to name our needs in terms of medical follow-up. It is therefore imperative, especially in long-term care settings, to be able to call on the services of translators or assistants.

Among the priorities specific to seniors in certain regions, those from rural and remote regions stressed that priority should be given to **improving the quality of homecare services**. More specifically, English- speaking seniors in remote region identified access to homecare services as a priority.

Promoting health and well-being model

Focus group participants and survey respondents were asked to comment on the priorities identified in the Community model for Promoting the health and well-being of English-speaking seniors in Quebec; do they accurately reflect the current priorities of English-speaking seniors? Do any categories need to be added?



The online survey showed that **85% (n=470) of respondents consider the priorities to be appropriate**. Among respondents, 23% suggested **adding long-term and end-of-life care** to the priorities, with a view to improving the quality of home care, access to legal support in English, and a compassionate and dignified approach. Among respondents, 13% suggested **adding the prevention of elder abuse** in all its forms, including organizational abuse in long-term care.

In the focus groups, participants judged the priorities to be appropriate. They suggested **adding/integrating mental health and well-being, and highlight the importance of a meaningful life while avoiding normalizing depression among seniors.** Several participants also stressed the importance of emphasizing prevention and health promotion, and of **focusing on the inclusion** of seniors rather than on reducing isolation.

DISCUSSION

Based on the multiple perspectives and experiences of Quebec's English-speaking seniors living in the community, this research project had three main objectives.

Firstly, the approach taken was designed to draw a portrait of Quebec's English-speaking seniors challenges and needs with a view to maintaining health and well-being. While many challenges in healthcare are shared by all seniors, English-speaking seniors face additional burdens tied to language barriers. These include difficulty accessing services, exclusion from decision-making processes, and the emotional toll of feeling dehumanized or ignored. The growing reliance on technology compounds these challenges, as many seniors struggle to navigate complex systems that often lack adequate language support. The health services used, in addition to visits to family

doctors and use of community services, vary according to the type of region inhabited. In rural areas, help from caregivers is considered essential, while in remote areas, people report that mutual aid from community members is valuable and their primary safety net. In October 2020, the Quebec government adopted the Act to Recognize and Support Caregivers, affirming the importance of their contribution to society. This policy served as the foundation for the National Policy for Caregivers, which aims to improve the quality of life, health and well-being of these individuals, regardless of the age, living environment or nature of the disability of the people they support. The policy is built around four core values: dignity, solidarity, caring and equity. It proposes concrete actions, such as improving respite services, developing day centres, strengthening psychosocial services and increasing support for community organizations dedicated to caregivers. This comprehensive approach aims to recognize the diversity of realities experienced by caregivers, and to offer them support tailored to their specific needs. We believe it's essential to better understand **how this policy ties in with local services offered in rural and remote areas**, where caregivers are crucial.

The second objective of this project was to identify with Quebec's English-speaking seniors their priorities about possible improvements in the health sector to enhance their well-being. These priorities are mainly linked to **access to quality care**, marked by respect and humanism. The quality of home support services and end-of-life care were widely emphasized by participants. Quebec's Act Respecting End-of-Life Care, adopted in 2014, establishes a legal framework for access to palliative care and medical aid in dying, emphasizing respect for patients' dignity, autonomy and wishes. However, this law does not explicitly mention linguistic minorities, such as English-speaking or allophone communities, with regard to access to end-of-life care. In remote areas, the importance of finding strategies to attract and retain specialists was central to several discussions. In addition, the importance of **not relying solely on technology** as a key element in providing services and information in English was emphasized. The digital divide and technological exclusion of the elderly has already been the subject of a number of studies (e.g. Charmarkeh, & al., 2017; Mubarak, & Suomi, 2022; Paul, & Stegbauer, 2005), generating multidimensional issues affecting their autonomy, health and social participation. The inability to use digital tools limits access to essential services, such as healthcare or administrative procedures, and reinforces social isolation in an increasingly connected world. This exclusion increases socio-economic inequalities, particularly for seniors living in rural areas or in financially precarious situations. It can also affect their mental health, generating feelings of incompetence and social exclusion. In the face of these challenges, solutions such as adapted digital training, simplified interfaces and intergenerational support are essential to promote inclusive, connected ageing. For English-speaking seniors, ensuring that all digital processes are properly translated and that they don't fall into incomprehensible and confusing processes is important.

Finally, the third objective of this project was to review the model developed by CHSSN in 2019 in order to validate and adjust it from the perspective of the seniors concerned. This model was widely supported by participants. Its multidimensional nature, consistent with the heterogeneity of aging, seems to have made its categories suitable for representing the needs of English-speaking seniors.

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