ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

Impact of language barriers on access to healthcare for official language minority Francophones in Canada

Healthcare Management Forum
2017, Vol. 30(4) 207-212

DOI: 10.1177/0840470417706378
journals.sagepub.com/home/hmf
SAGE

Danielle de Moissac, PhD[1] and Sarah Bowen, PhD[2]

Abstract

While there is strong international evidence that language barriers present obstacles to healthcare access, quality and safety, little research has been conducted on the experience of official language minorities in Canada. This multiple method research used online and paper-based surveys, combined with semi-structured individual interviews to explore the experience with access to care of Francophone minorities living in four Canadian provinces. The majority of Francophones surveyed reported limited access to French language services and described an environment where low importance is given to addressing language barriers within the health system. Even when services are available, the lack of services in French sometimes results in avoidance of care. Results confirm that many Francophones face similar barriers to care as other language minorities in Canada. Strategies to improve access for official language minorities are discussed.

Introduction

Several international research reviews provide consistent evidence of the impact of language barriers on accessibility, safety and quality of healthcare services.[1-5] A recent review of the literature explored evidence of patient and organizational risks from failing to address language barriers on the dimensions of care outlined by Accreditation Canada.[5] One of these dimensions is accessibility, which refers to availability and ease of use of direct services, as well as awareness of health conditions and available services.[5] The review found that language barriers negatively affect access to most services: health promotion/education resources,[6] prevention activities,[7] cancer screening,[8] mental health services[4] and referral to specialised services.[9] They result in lower rates of recommended preventive care[10] and having a regular healthcare provider.[11] To date, however, little Canadian research has explored the specific situation of official language minorities in Canada (eg, Francophones living outside Quebec),[12] and it is sometimes assumed that these language minorities do not face the same barriers to care as other language minorities.

Health systems are increasingly recognizing the importance of Language access services (LAS) in providing appropriate care for vulnerable populations[4] and managing organizational risk.[13] Language access services include provision of service by bilingual providers, trained interpretation services, signage, and translated health information. In Canada, efforts to promote recruitment, training, and retention of professionals fluent in French have been promoted as the primary strategy to increase provision of French language services (FLS).[14,15] Shortage of bilingual health professionals,[16,17] however, means that language concordant services are not consistently available. To facilitate access to FLS, providers are encouraged to practice active offer (note 1). This includes being asked in what language services should be provided, documentation in French, bilingual name tags, health-related telephone services, and advertisement of available FLS.

When language concordance is not feasible, service provided by trained health interpreters is the next best option.[19,20] Such services are available in some Canadian health jurisdictions.[21,22] Although models of health interpretation services differ based on contextual needs, minimum standards of practice have been identified. These include coordinated organizational policy and procedures, use of only trained interpreters, interpreter screening and testing, availability of information on interpretation services for patients and health providers, and systems for record keeping and evaluation.[23,24] The interpreter role has sometimes been combined with other roles (such as patient navigator)[25] to provide individualized assistance in overcoming barriers and facilitating timely access to care.[26]

This article reports on one component of a study of Francophone patients' experience with LAS in healthcare and the impact of language barriers on access, quality, and safety of care. The research questions focused primarily on active offer and interpreter, navigator, or companion services. This article focuses on healthcare access.

Methods

Francophones living in Newfoundland and Labrador, Saskatchewan, Alberta and two sites in Ontario (North Simcoe/Muskoka and Thunder Bay) were eligible to participate.

[1] Université de Saint-Boniface, Winnipeg, Manitoba, Canada.
[2] Applied Research and Evaluation Consultant, Centreville, Nova Scotia, Canada.

Corresponding author:
Danielle de Moissac, Université de Saint-Boniface, Winnipeg, Manitoba, Canada.
E-mail: ddemoissac@ustboniface.ca

Table 1. Demographics of survey participants by province

	NL	ON[a]	SK	AB	Total
	N (%)	N (%)	N (%)	N (%)	N (%)
Characteristics	N = 16 (5.3%)	N = 24(8%)	N = 108 (36.4%)	N = 53 (17.8%)	N = 297 (100%)
Female	12 (75)	23 (95.8)	78 (75)	38 (71.7)	194 (78.9)
Married or common-law	8 (50)	19 (79.2)	79 (75.2)	40 (75.5)	181 (73)
Education					
Elementary or secondary school	0 (0)	1 (4.2)	8 (7.6)	7 (13.7)	17 (6.9)
College	7 (43.8)	6 (25)	23 (21.9)	18 (35.3)	74 (30.1)
University	9 (56.3)	17 (70.8)	74 (70.5)	26 (51)	155 (63)
Income					
Less than $25,000	2 (13.3)	1 (4.2)	14 (13.8)	11 (21.6)	34 (14.2)
$25,000 to $49,000	6 (40)	10 (41.7)	28 (27.7)	11 (21.6)	69 (29)
$50,000 or more	7 (46.7)	13 (54.2)	58 (57.4)	28 (54.9)	133 (55.9)
Origin					
Born in Canada	14 (87.5)	18 (75)	66 (62.3)	35 (66)	169 (68.4)
In Canada less than 5 years	1 (6.2)	3 (12.5)	13 (12.3)	8 (15.1)	29 (11.7)
In Canada more than 5 years	1 (6.2)	3 (12.5)	27 (25.5)	10 (18.9)	48 (19.4)
Language most often used in the household					
French	10 (66.7)	21 (87.5)	80 (79.2)	40 (78.4)	188 (78)
English	1 (6.7)	0 (0)	3 (3)	1 (2)	8 (3.3)
French and English	4 (26.7)	3 (12.5)	18 (17.8)	10 (19.6)	45 (18.7)
English proficiency during a medical consultation					
Very good to excellent	7 (43.8)	11 (47.8)	59 (56.2)	33 (62.3)	139 (56)
Good	6 (37.5)	7 (30.4)	30 (28.6)	13 (24.5)	68 (27.4)
Weak	3 (18.8)	5 (21.7)	16 (15.2)	7 (13.2)	41 (16.5)

[a]Data collection in Ontario was limited to North Simcoe Muskoka and Thunder Bay areas

While Francophone density is similar in these areas, availability of and support for additional LAS differs significantly (note 2). A subsample of survey participants who had experienced in person or distance interpreter or navigator services were invited to participate in an individual telephone interview.

Details of data collection and analysis methods are described in detail elsewhere.[32] Briefly, Francophones living in selected provinces were invited to participate in an on-line or paper-based survey, distributed via advertisements in regional healthcare settings, Francophone organization e-mail lists and at local events. The 21-question survey, using both closed and open-ended questions, focused on personal experiences with healthcare and LAS. Semi-structured interviews explored the impact of language barriers on individual health behaviour and health system experience, as well as adequacy of interpreter, navigator, or companion services.

Frequencies and percentages were used to describe survey and interview participants. Two-sided significance testing was used for the χ^2 test and Kruskal-Wallis test with post hoc Mann-Whitney *U* tests using SPSS v.21 (IBM Corporation). Interviews were audio-recorded and partially transcribed. Qualitative analysis was conducted using a general inductive approach.[33,34] Codes were identified and combined into categories and themes using NVivo v.10 (QRS International, 2012).

Results

Participant demographics

A total of 297 Francophones (average age 42.5) participated in the survey. As illustrated in Table 1, a larger proportion of participants were female, married or common-law, of higher than average income, born in Canada, and identified French as language most often used at home. Approximately half the participants felt they could communicate well in English during a medical consultation. A larger proportion of participants reported Saskatchewan residence, although 32.3% of participants did not specify province of residence. No statistical differences in participant demographics were noted between provinces, however, participants with weak English proficiency (EP) were more likely to be of lower income and born outside of Canada.

Twenty interviews were conducted; 70% were from Saskatchewan. Demographics of interview participants were similar to those of survey respondents.

Access to LAS in health and social services

Reported experience of survey participants with access to LAS are presented in Table 2. Access to health and social services was perceived as good to excellent by the majority, whereas most described access to such services in French as weak or non-existent. Eighty five percent felt that the health system was

Table 2. Survey participant perceptions of LAS by province

	NL	ON	SK	AB	Total
	N (%)	N (%)	N (%)	N (%)	N (%)
Perception of access to LAS and health system's response to the need for LAS					
1. Access to overall health and social services					
Very good to excellent	9 (56.2)	14 (60.9)	62 (57.4)	31 (59.6)	160 (54.8)
Good	5 (31.2)	6 (26.1)	34 (31.5)	8 (15.4)	84 (28.8)
Weak or inexistent	2 (12.5)	3 (13)	12 (11.1)	13 (25)	48 (16.4)
2. Access to health and social services in French					
Very good to excellent	0	1 (4.2)	6 (5.6)	7 (13.5)	20 (6.8)
Good	0	4 (16.7)	11 (10.3)	10 (19.2)	48 (16.4)
Weak or inexistent	16 (100)	19 (79.2)	90 (84.1)	35 (67.3)	225 (76.8)
3. Health system's awareness of need for and issues surrounding LAS for Francophones					
Aware to very aware	1 (6.2)	5 (20.8)	11 (10.8)	7 (14.6)	43 (15.7)
Somewhat aware	12 (75)	15 (62.5)	51 (50)	27 (56.2)	146 (53.3)
Not aware	3 (18.8)	4 (16.7)	40 (39.2)	14 (29.2)	85 (31)
4. Health system's response to current issues related to LAS for Francophones					
Very good to excellent	0	1 (4.2)	5 (4.7)	2 (3.8)	13 (4.6)
Good	0	4 (16.7)	8 (7.5)	13 (25)	45 (15.8)
Weak	12 (75)	16 (66.7)	75 (70.1)	32 (61.5)	185 (64.9)
Non-existent	4 (25)	3 (12.5)	19 (17.8)	5 (9.6)	42 (14.7)
Steps taken to access FLS					
1. Do the best I can without assistance	10 (62.5)	11 (45.8)	62 (57.4)	34 (64.2)	153 (51.5)
2. Do not seek service	5 (31.2)	2 (8.3)	26 (24.1)	11 (20.8)	63 (21.2)
3. Search for services available in French[a]	3 (18.8)	19 (79.2)	37 (34.3)	26 (49.1)	117 (39.4)
4. Speak in French, either in person or by phone[a]	0	12 (50)	16 (14.8)	6 (11.3)	47 (15.8)
5. Bring a family member or friend as interpreter	2 (12.5)	7 (29.2)	17 (15.7)	8 (15.1)	45 (15.2)
6. Request bilingual healthcare provider	1 (6.2)	6 (25)	15 (13.9)	7 (13.21)	35 (11.8)
7. Request interpreter, navigator or companion services	0	1 (4.2)	1 (0.9)	4 (7.5)	9 (3)
8. Complain when services are not available in French	0	1 (4.2)	3 (2.8)	1 (1.9)	6 (2)
9. Report incidents when care provided was inadequate because of language issues[a]	0	3 (12.5)	0	1 (1.9)	5 (1.7)

Abbreviations: LAS, Language access service; FLS, French language services
[a]Statistical differences between provinces

not aware of the need for, and issues surrounding, LAS for minority Francophones. As an interview participant from Ontario explained: "I've been told by staff working in bilingually designated regions: '*We know there is a FLS law, but we don't take it seriously because [we believe that] all Francophones speak English*.' That is ignorance." Others described healthcare personnel's lack of understanding of challenges minority Francophones face. In general, participants felt that all responsibility for accessing FLS was placed on the patient.

When questioned about actions taken to access FLS, 51.5% stated that they did their best without linguistic assistance; this percentage increased to 68.3% for participants with weak EP. Overall, 20% did not seek health services when these were not available in French for fear of not understanding or being understood: "The language barrier prevents me from going to my appointments [. . .], if they were in French, I would willingly consult my physician". Some reported avoiding care because of difficulties finding an interpreter.

Others were more proactive. Approximately 40% of participants stated that they actively searched for health services in French. Most interviewees described using the Internet to identify and locate services or to translate medical terms. Several interviewees reported that previous unsuccessful searches discouraged them from requesting or seeking services in French: "There is none, there is none, therefore I stop looking." A small proportion of participants reported initiating the conversation in French when requesting an appointment or consulting a healthcare provider. A total of 58.5% of participants with weak EP reported being accompanied by a family member or a friend acting as an interpreter. Few participants requested interpretation (3%), complained when services were not available in French (2%), or reported incidents when care provided was inadequate because of language issues (1.7%).

Almost half of participants reported having access to a bilingual family physician; this proportion increased to 67% for Ontario and Alberta participants and 73% for participants with weak EP. Interviewees, however, qualified this observation ("I rejoice in having a Francophone doctor, but it is not sufficient"), as referral specialists or allied healthcare professionals may not be able to provide services in French. However, 48.5% also reported access to other bilingual healthcare providers.

Table 3. Facilitators and barriers to LAS by province

	NL	ON	SK	AB	Total
	N (%)	N (%)	N (%)	N (%)	N (%)
Facilitators					
1. Directory of health-related FLS	7 (43.8)	14 (58.3)	58 (53.7)	28 (52.8)	133 (44.8)
2. Brochures or documents in French	4 (25)	12 (50)	35 (32.4)	17 (32.1)	94 (31.6)
3. Health-related telephone services in French	3 (18.8)	10 (41.7)	35 (32.4)	17 (32.1)	85 (28.6)
4. Written health-related forms in French	3 (18.8)	10 (41.7)	28 (25.9)	19 (35.8)	81 (27.3)
5. Direct enquiry as to language service is required	5 (31.2)	9 (37.5)	24 (22.2)	19 (35.8)	77 (25.9)
6. Health interpretation	8 (50)	7 (29.2)	25 (23.1)	14 (26.4)	70 (23.6)
7. Bilingual name tags	4 (25)	7 (29.2)	24 (22.2)	10 (18.9)	69 (23.2)
8. Advertisements for FLS	3 (18.8)	8 (33.3)	24 (22.2)	14 (26.4)	64 (21.5)
9. Health-related companion services	1 (6.2)	4 (16.7)	16 (14.8)	13 (24.5)	41 (13.8)
10. Health-related navigator services	2 (12.5)	5 (20.8)	12 (11.1)	10 (18.9)	40 (13.5)
Barriers					
1. Shortage of bilingual healthcare providers	11 (68.8)	21 (87.5)	82 (75.9)	38 (71.7)	198 (66.7)
2. Low patient awareness of LAS	11 (68.8)	13 (54.2)	62 (57.4)	33 (62.3)	159 (53.5)
3. Limited availability of interpretation	8 (50.0)	13 (54.2)	46 (42.6)	17 (32.1)	110 (37.0)
4. Distance to access FLS[a]	4 (25.0)	14 (58.3)	24 (22.2)	21 (39.6)	85 (28.6)
5. Negative attitude from staff regarding language issues	4 (25.0)	13 (54.2)	29 (26.9)	14 (26.4)	79 (26.6)
6. Prolonged wait time for appointments with FLS	1 (6.2)	6 (25.0)	18 (16.7)	14 (26.4)	60 (20.2)
7. Poorer quality of service[a]	0	4 (16.7)	18 (16.7)	2 (3.8)	31 (10.4)

Abbreviations: LAS, Language access service; FLS, French language services
[a]Statistically significant difference between provinces

Facilitators and barriers to LAS

Survey participants were asked to identify available options they found useful in accessing LAS and barriers to this access (Table 3). A health service directory identifying FLS, often available on-line, was the support most often noted (44.8%). Translated brochures (31.6%), health-related forms (27.3%), and bilingual health information and navigation helplines (28.6%) were also reported. The phone helpline was most helpful to participants with weak EP (48.8%).

Approximately one quarter of participants reported receiving active offer of services in French. One interviewee stated that her non-Francophone physician understands the importance of language concordance and asks to be accompanied by a bilingual nurse. However, most interviewees reported that "too often, we are not given the choice. Service is provided spontaneously in English". In general, interviewees stated that to access FLS, one must seek and request them.

Interpretation services were identified as a facilitator by less than 24% of participants. Lack of interpreter services was a barrier for 37%; this proportion almost doubled for participants with weak EP. Four interviewees had used telephone interpretation services: three were not satisfied with them, reporting slow response and poor interpretation.

Participants reported that shortage of bilingual healthcare providers and wait times for appointments with them remained the most important barriers to LAS. Interviewees stated that most providers were non-French speakers and language concordant encounters, particularly in hospital settings, were rare. The few bilingual staff members were not always present or readily identifiable. Comments suggested that this invisibility contributes to perceived shortage. Furthermore, 26.6% of participants reported negative attitudes from staff regarding their linguistic needs.

Discussion

This study is one of few focusing on the impact of language barriers on minority official language speakers in Canada. Results are consistent with international research on other minority language populations and demonstrate that Francophones living outside Quebec face similar barriers to healthcare access. Findings challenge the common assumption that needs of Francophones, many of whom, in contrast to other minority groups, speak English well, are adequately met: a significant minority of participants reported avoiding seeking care when FLS was not available. The literature indicates that preventive and primary care is most likely to be neglected, suggesting the potential of increased healthcare costs as well as poorer patient health in the long term.[2,35,36]

Ratings for general healthcare access were good, in contrast to ratings of access to FLS or LAS. Almost half the participants reported access to bilingual family physicians. Participants with weak EP appear to have better access, suggesting that there are efforts to direct more vulnerable populations towards bilingual providers.

Shortage of bilingual healthcare professionals continues to create challenges: improved recruitment and retention strategies[37] are needed. Appropriate interpreter services should be developed in contexts where providing bilingual staff is not feasible, a reality in many rural and remote communities.[38] The risks of using ad hoc, untrained interpreters have been well

established[39,40]: interpreter service models, whether inperson or distance, should reflect research on best practice.[38]

Findings also suggest that simple actions at the institutional or health region level may optimize access to FLS currently available. It is recommended that health leaders support on-line directories of FLS, translation of key documents, and greater promotion of active offer. That over a quarter of participants reported negative attitudes of healthcare staff to language needs is of concern. While active offer is being promoted in French-language professional training programs,[14] greater efforts are required to increase general awareness of risks of language barriers and use of untrained interpreters,[5,41] as well as the importance of active offer in the health system.[17] Systematic identification of patients needing linguistic assistance and improving patient awareness of LAS is also important.[17]

Preliminary results also suggest that greater exploration of impact of provincial French language law is needed. Participants from Ontario, the only province with such a law, were more likely to actively search for FLS and complain when services were not available. Legal support for official language minorities may have health-related implications.

This research has a number of limitations. Sample size was relatively small and reflects selection bias: those most interested in the issue would be expected to have a higher response rate. In addition, active recruitment by language advocates may have varied between regions (eg, over-representation of Saskatchewan participants in interviews). However, only minor differences are noted between provinces, suggesting that findings may be generalized to minority Francophones across Canada. This preliminary study suggests avenues for further exploration, including analysis of similarities and differences in experience between Francophone and Anglophone minorities in Canada, and variation in barriers experienced by level of English language proficiency. In addition, evaluation of the feasibility and effectiveness of various interventions designed to increase language access is needed if quality care is to be ensured.

Conclusion

Many minority official language speakers experience barriers to healthcare access. While improved recruitment and retention of bilingual health providers should continue to be prioritized, enhanced visibility of FLS currently available, education of health professionals of the risks of language barriers, and promotion of active offer of services in French should be addressed, as they have potential to increase access in minority language contexts.

Acknowledgments

The authors would also like to thank Yves Couturier and Anne Leis for support with research proposal and revision of research report.

Funding

This research was supported through funding provided to the Société Santé en français (SSF) by the Official Language Community Development Bureau. The support of SSF and its regional coordinators is gratefully acknowledged.

Notes

1. Active offer refers to measures intended to ensure that FLS are readily available, easily accessible and evident, and that the quality of these services is comparable to that of services in English.[18]
2. Only Ontario has a French language law,[27] although Saskatchewan has an FLS policy.[28] Franco-Albertans rely on the University of Alberta Hospital Multicultural program[29] or Canadian Volunteers United in Action for navigation or interpretation.[30] In Newfoundland, the Eastern Health Authority provides interpretation on a part-time basis in St. John's.[31]

References

1. Jacobs E, Chen AH, Karliner LS, Agger-Gupta N, Mutha S. The need for more research on language barriers in healthcare: a proposed research agenda. *Milbank Q*. 2006;84(1):111-133.
2. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res*. 2007;42(2):727-754.
3. Ohtani A, Suzuki T, Takeuchi H, Uchida H. Language barriers and access to psychiatric care: a systematic review. *Psychiatr Serv*. 2015;66(8):798-805.
4. Schwei RJ, Del Pozo S, Agger-Gupta N, et al. Changes in research on language barriers in healthcare since 2003: a cross-sectional review study. *Int J Nurs Stud*. 2016;54:36-44.
5. Bowen S. *The Impact of Language Barriers on Patient Safety and Quality of Care*. Ottawa, Ontario: Société Santé en français; 2015.
6. Brar S, Tang S, Drummond N, et al. Perinatal Care for South Asian Immigrant Women and Women Born in Canada: telephone Survey of Users. *J Obstet Gynaecol*. 2009;31(8):708-716.
7. Cohen AL, Christakis DA. Primary language of parent is associated with disparities in pediatric preventive care. *J Pediatr*. 2006; 148(2):254-258.
8. McDonald JT, Kennedy S. Cervical cancer screening by immigrant and minority women in Canada. *J Immigr Minor Health*. 2007;9(4):323-334.
9. Fryer C, Mackintosh S, Batchlor F, Hill K, Said C. The effect of limited English proficiency on falls risk and falls prevention after stroke. *Age Ageing*. 2012;41(1):104-107.
10. Shi L, Lebrun LA, Tsai J. The influence of English proficiency on access to care. *Ethn Health*. 2009;14(6):625-642.
11. Ngwakongnwi E, Hemmelgarn BR, Musto R, Quan H, King-Shier KM. Experiences of French speaking immigrants and non-immigrants accessing healthcare services in a large Canadian city. *Int J Environ Res Public Health*. 2012;9(10): 3755-3768.
12. Fédération canadienne des francophones et acadiens. *Profils des communautés francophones et acadiennes du Canada*. Ottawa, Ontario: Canadian Federation of Francophones and Acadians; 2011. Available at: http://profils.fcfa.ca/fr/Vitalite-Demographique_200. Accessed May 18, 2017.
13. Ramisetty-Mikler S, Mikler A, O'Neill M, Komatz J. Conceptual framework and quantification of population vulnerability for effective emergency response planning. *J Emerg Manag*. 2015; 13(3):227-238.

14. Consortium national de formation en santé. *Étudier en français en santé, des carrières qui font du bien!*. Ottawa, Ontario: Association des collèges et universités de la francophonie canadienne (ACUFC); 2015. Available at: http://cnfs.net/. Accessed May 18, 2017.
15. Médecins francophones du Canada. *Formation Continue*. Montréal, Québec: Médecins francophones du Canada; 2010. Available at: http://www.medecinsfrancophones.ca/formation-continue/en-quelques-mots/association-agreee.fr.html. Accessed May 18, 2017.
16. de Moissac D, Giasson F, Roch-Gagné M. Accès aux services sociaux et de santé en français: l'expérience des Franco-Manitobains. *Min Ling Soc*. 2015;6:42-65.
17. Drolet M, Savard J, Benot J, et al. Health services for linguistic minorities in a bilingual setting: challenges for bilingual professionals. *Qual Health Res*. 2014;24(3):295-305.
18. RIFSSSO. *Trousse d'appui RH: Vers un Service Bilingue*. Toronto, Ontario: RIFSSSO; 2012. Available at: http://www.rifssso.ca/wp-content/uploads/2008/05/Trousse-francais-pages-qui-se-suivent1.pdf. Accessed May 18, 2017.
19. Juckett G, Unger K. Appropriate use of medical interpreters. *Am Fam Physician*. 2014;90(7):476-480.
20. VanderWielen L, Enurah A, Rho H, et al. Medical interpreters: improvements to address access, equity, and quality of care for limited-English-proficient patients. *Acad Med*. 2014;89(10):1324-1327.
21. Silversides A, Laupacis A. Interpretation services in healthcare. Healthy Debate. 2013. Available at: http://healthydebate.ca/2013/04/topic/quality/interpretation-services-in-hospitals. Accessed May 18, 2017.
22. Winnipeg Regional Health Authority. *Language Access Interpreter Services*. Winnipeg, Manitoba: Government of Manitoba. Available at: http://www.wrha.mb.ca/Professionals/language/index.php. Accessed May 18, 2017.
23. Healthcare Interpretation Network. *National Standard Guide for Community Interpreting Services*. Toronto, Ontario: Healthcare Interpretation Network; 2010. Available at: http://healthcareinterpretationnetwork.ca/publications/standards/. Accessed August 18, 2016.
24. Winnipeg Regional Health Authority. *Language Access: Code of Ethics and Standards of Practice for Interpreters*. Winnipeg, Manitoba: Winnipeg Regional Health Authority; 2013. Available at: http://www.wrha.mb.ca/professionals/language/files/EthicsCode.pdf. Accessed May 18, 2017.
25. Sarfaty M, Turner C, Damotta E. Use of a patient assistant to facilitate medical visits for Latino patients with low health literacy. *J Community Health*. 2005;30(4):299-307.
26. Hedlund N, Risendal B, Pauls H, et al. Dissemination of patient navigation programs across the United States. *J Public Health Manag Pract*. 2014;20(4): E15-E24.
27. Government of Ontario. *French Language Services Act, R.S.O. 1990, c. F.32*. Toronto, Ontario: Government of Ontario; 2015. Available at: https://www.ontario.ca/laws/statute/90f32. Accessed May 18, 2017.
28. Government of Saskatchewan. *French-Language Services Policy*. Regina, Saskatchewan: Government of Saskatchewan; 2009. Available at: https://www.saskatchewan.ca/~/media/files/executive%20council/bonjour/french%20language%20services%20policy.pdf. Accessed May 18, 2017.
29. Government of Alberta. *Multicultural Program*. Edmonton, Alberta: Government of Alberta; 2017. Available at: https://myhealth.alberta.ca/find-healthcare/services/Pages/profile.aspx?SERVICEID=1051957. Accessed August 18, 2016.
30. Canadian Volunteers United in Action. *Nos Services*. Edmonton, Alberta: Canadian Volunteers United in Action; 2016. Available at: http://www.canavua.org/nos_services.html. Accessed May 18, 2017.
31. Eastern Health Authority. *Bilingual Services*. St. John's, Newfoundland: Government of Newfoundland and Labrador; 2013. Available at: http://www.easternhealth.ca/OurServices.aspx?d=2&id=1736&p=202. Accessed May 18, 2017.
32. de Moissac D. Accès aux services de santé et d'interprète-accompagnateur: l'expérience des communautés minoritaires à faible densité de francophones au Canada. Ottawa, Ontario: Société Santé en français; 2016.
33. Patton MQ. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, CA: Sage Publications; 2002.
34. Thomas DR. A general inductive approach for evaluating qualitative evaluation data. *Am J Eval*. 2006;27(2):237-246.
35. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient access to professional interpreters in the hospital decreases readmission rates and estimated hospital expenditures for patients with limited English proficiency. *Med Care*. 2017;55(3):199-206.
36. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. *J Gen Intern Med*. 2012;27(10):1294-1299.
37. Savard S, de Moissac D, Benoît J, et al. Le recrutement et la rétention d'intervenants en santé et services sociaux bilingues en situation francophone minoritaire. In: Drolet M, Bouchard P, Savard J, eds. *L'offre active de services sociaux et de santé pour les communautés de la francophonie canadienne en situation minoritaire: Les acteurs, le système et les leviers d'action*. Ottawa, Ontario: Presses de l'Université d'Ottawa; 2016.
38. Bowen S. *Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications*. Winnipeg, Manitoba: Winnipeg Regional Health Authority; 2004.
39. Flores G, Abreu M, Barone CP, Bachur R, Lin H. Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters. *Ann Emerg Med*. 2012;60(5):545-553.
40. Kilian S, Swartz L, Dowling T, Dlali M, Chiliza B. The potential consequences of informal interpreting practices for assessment of patients in a South African psychiatric hospital. *Soc Sci Med*. 2014;106:159-167.
41. Bischoff A, Hudelson P. Access to healthcare interpreter services: where are we and where do we need to go? *Int J Environ Res Public Health*. 2010;7(7):2838-2844.