INSPQ INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC

Health Profile of Linguistic Communities in Québec

LANGUAGE AS DETERMINANT OF HEALTH AND QUALITY OF SERVICES

Québec

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Symbols and abbreviations

CHSSN	Community Health and Social Services Network
CI	Confidence intervals
CV	Coefficient of variation
INSPQ	Institut national de santé publique du Québec
ISQ	Institut de la statistique du Québec
MSD	Musculoskeletal disorders
MSSS	Ministère de la Santé et des Services sociaux
N/A	Not available
PNR	Partial non-response
QPHS	Québec Population Health Study
STI	Sexually transmitted infection

Highlights

This health profile of linguistic communities is based on data from the 2014-2015 Québec Population Health Survey (QPHS). It addresses a number of topics broken down into 16 indicators covering certain behaviors associated with prevention and health promotion, certain aspects of physical and mental health status, as well as occupational health. Topics addressed in the report cannot be covered with medical or government databases or with census data. The data has been analyzed from a linguistic minority standpoint and according to immigrant status.

The highlights shown here only apply to indicators for which statistically significant differences were observed between the anglophone and allophone linguistic minority communities and the francophone linguistic community.

Linguistic minority status

Compared to francophones, anglophones:

- scored favorably for three indicators: consistent condom use, psychological distress, and non-traumatic work-related musculoskeletal disorders (MSDs);
- scored unfavorably for four indicators: lower contraception use among men and women, cannabis use, and work/life balance;
- did not differ from francophones for the other nine indicators studied.

Compared to francophones, allophones:

- scored favorably for one indicator: unintentional injuries;
- scored unfavorably for four indicators: Pap test, perception of oral health, psychological distress, and work/life balance;
- did not differ from francophones for five of the other indicators studied.
- Data cannot be presented for the other six indicators due to statistical bias.

Minority linguistic status and immigrant status[1]

Compared to francophones, anglophones born in Canada:

- scored favorably for three indicators: consistent condom use, Pap test, and non-traumatic work-related musculoskeletal disorders (MSDs);
- scored unfavorably for four indicators: lower contraception use among women, cannabis use, unintentional injuries as well as work/life balance issues;
- did not differ from francophones on the other nine indicators.

Compared to francophones, immigrant anglophones:

- scored favorably on two indicators: perceived oral health and psychological distress;
- did not differ from francophones on eight indicators; statistical biases prevent comparison for the other six.

Compared to francophones, allophone immigrants:

- scored unfavorably for one indicator: Pap test;
- did not differ from francophones for eight of the other indicators studied; statistical biases prevented comparison for the other seven indicators.

[1] Data for allophones born in Canada is not presented in this report due to low numbers.

1 Introduction

In 2016 about 10% of the Québec population preferred to use English at home, while 7% spoke neither French nor English (Statistics Canada, 2017a). Accordingly, 1.4 million people are part of a linguistic minority. This linguistic difference is associated with numerous challenges in daily life, and is an obstacle to obtaining care and public services, which are usually provided in French, the official language of Québec.

In recent years a number of studies have suggested that more attention should be paid to language in health and social planning (Bouchard and Desmeules, 2013). For example, disparities between English-speaking (anglophone) and French-speaking (francophone) people in Québec have been reported for perinatal health (Auger, Park, and Harper, 2012), as well as avoidable mortality (Trempe et al., 2013) and mortality associated with unintentional injuries (Burrows, Auger, and Lo, 2016), but not necessarily always to the disadvantage of English speakers. However, it is possible that some of these disparities may lessen over time (Tu, Bilodeau-Ber trand, and Auger, 2018).

Aside from language, immigrant status may also affect health status and well-being. In Québec, recent immigrants are often found to be in better health (Gushulak at al., 2011). Statistics from the 2016 census by language spoken most often at home show that in Québec, 22% of English-speaking people (or anglophones) and 72% of people who speak neither English nor French at home (allophones) are immigrants (born outside Canada), compared to only 7% of francophones (Statistics Canada, 2017a).

It is therefore important to consider language in conjunction with immigrant status when possible, in order to identify the health gaps associated with one or the other of these determinants. As far as we know, few published health studies have looked at both characteristics simultaneously. One that does reported significant differences in mortality between Québec's linguistic communities when immigrant status was taken into account (Lo et al., 2018): Mortality rates for immigrant anglophones and francophones born in Québec were comparable, whereas rates observed among anglophones were generally lower than those observed among francophones when immigrant status was not taken into account.

The main objective of this health profile of linguistic communities is to provide a recent portrait of certain key health indicators that users outside the health network don't have access to. Improving knowledge about the health of minority and majority communities will help decision makers and stakeholders identify current concerns, anticipate future trends, and adjust existing measures in order to reduce the health gaps between these communities.

2 Methodology

2.1 Data

The data used for this health profile is taken from the 2014-2015 Québec Population Health Survey (QPHS), available from the Infocentre de santé publique du Québec. The data is for Québec as a whole. The details of the survey can be found in "L'Enquête québécoise sur la santé de la population, 2014-2015 : pour en savoir plus sur la santé des Québécois" (Camirand, Traoré, and Baulne, 2016).

2.2 Characteristics and topics covered

Data was extracted for each linguistic community defined according to three categories of languages spoken at home:

- Francophones are those who speak "at least French";
- Anglophones are those who speak "at least English but not French";
- Allophones are those who speak "neither French nor English."

Data about language spoken at home was also cross-referenced by immigrant status (defined by place of birth: Canada or outside Canada).

Sixteen indicators were chosen and grouped according to the following topics:

Behaviors related to prevention and health promotion

- Oral hygiene
- Contraception
- Sexual behavior
- Cannabis use
- Pap test

Physical and mental health status

- Perceived health
- Perceived oral health
- Dissatisfaction with social life
- Psychological distress
- Unintentional injuries

Occupational health

- Work/life balance
- Recognition at work
- Psychological harassment at work
- Non-traumatic work-related musculoskeletal disorders (MSDs)

Other key indicators (e.g., drug use by injection) were not included because the small sample size made it impossible to assess differences between linguistic communities.

The potentially most vulnerable populations can be identified when pairing these indicators with other factors such as socio-economic or demographic. Tables highlighting these factors are available in an ISQ report (Camirand, Traoré and Baulne, 2016) for most of the indicators highlighted in this report.

2.3 Statistical analyses

Data from linguistic minority communities (anglophone and allophone) was compared with data from the linguistic majority community (francophone). The statistically significant differences between the proportions of each linguistic community were determined by Chi-square tests and the construction of the Wald statistic from the difference in the logit transformations of the proportions to a value of $p < 0.05$. Differences between language groups according to their immigrant status were established by examining the overlap of confidence intervals (CIs).

For readability, the differences shown between linguistic groups are implicitly statistically significant. Similarly, when it was not possible to conclude that there was a statistically significant difference between two language groups, the term “is comparable” is used.

The graphs represent the non-standardized proportions for each indicator, according to linguistic community. The error bars represent 95% CIs.

Data with coefficients of variation (CVs) considered too high (between 15% and 25%) to allow reliable conclusions to be drawn are not presented or discussed in the text, but are available in Table 4 in the Appendix. We did the same for data with a high partial non-response (PNR) rate (greater than 10%) because of the high risk of bias. Allophone data is often affected by one or the other of these situations (CV between 15% and 25% or PNR > 10%), which explains, among other things, the complete exclusion of Canadian-born allophones. Results for all allophones with high variability or risk of bias are identified by “N/A” (not available) in the bar graphs.

However, all data is available in Table 4 of the Appendix, with the exception of data with a CV greater than 25% or a PNR greater than 15%.

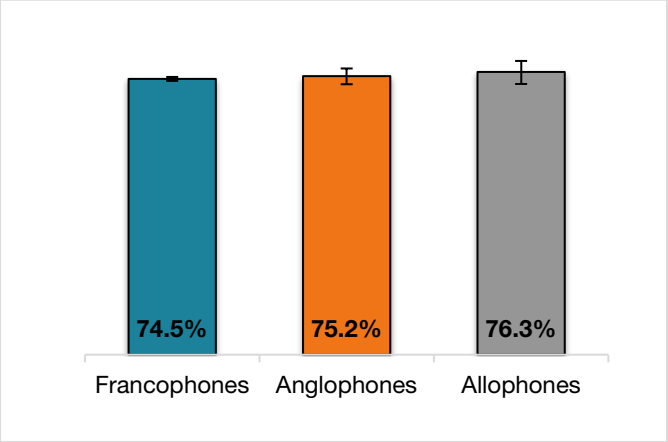
3 Behaviors related to prevention and health promotion

3.1 Oral hygiene

Certain good oral hygiene habits, such as tooth brushing at least twice a day, are thought to be sufficient to prevent gum disease and tooth decay.

In Québec, in 2014-2015, comparable proportions of francophones (75%), anglophones (75%), and allophones (76%) brushed their teeth (or dentures) at least twice a day (Figure 1).

Figure 1 Tooth brushing (or dentures) at least twice a day, 2014-2015



Language spoken at home and immigrant status

- Among individuals born in Canada, the proportion of people who brush their teeth (or dentures) at least twice a day was 74% for both francophones and anglophones.
- Among immigrants, the proportions of francophones (80%), anglophones (78%), and allophones (77%) who brush their teeth at least twice a day were also comparable.

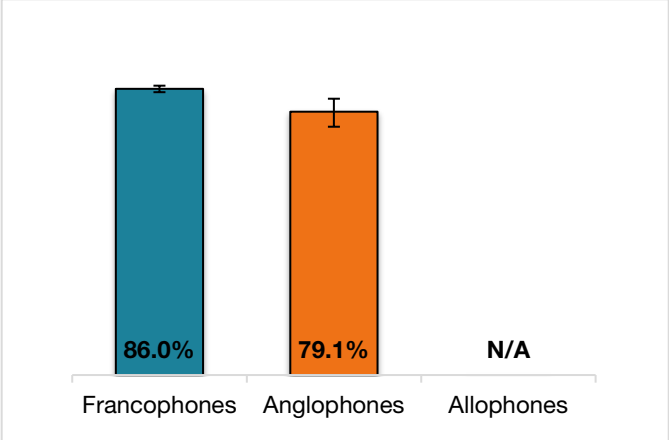
3.2 Contraception use

The use of contraceptives is a current priority in reproductive health and an important strategy for preventing unwanted pregnancies (Institut national de santé publique du Québec).

Women

In Québec, in 2014-2015, among sexually active women aged 15 to 49, fewer anglophones (79%) than francophones (86%) were found to have used contraception in the previous 12 months (Figure 2).[2]

Figure 2 Use of contraception by sexually active women in the previous 12 months, 2014-2015



Note : Allophone women had a partial non-response rate of over 10%. Data not shown.

Language spoken at home and immigrant status

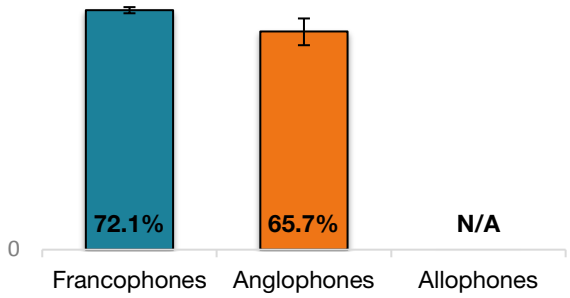
- Among women born in Canada, the proportion of francophone women (87%) who had used contraception in the previous 12 months was higher than that of anglophones (79%).
- Among immigrant women, contraceptive use was comparable among francophones (78%) and anglophones (80%).

[2] As suggested in the report by Camirand et al. (2016), a comparison between the sexes is not desirable because the two established population groups differ.

Men

Among sexually active men in 2014–2015, fewer anglophones (66%) than francophones (72%) had used contraception in the previous 12 months (Figure 3).

Figure 3 **Use of contraception by sexually active men in the previous 12 months, 2014–2015**



Note: Allophone men had a partial non-response rate of over 10%. Data not shown.

Language spoken at home and immigrant status

- Among individuals born in Canada, the proportion of anglophone men (69%) who had used contraception in the previous 12 months was comparable to that of francophones (73%).
- Among English-speaking and allophone immigrants, the partial non-response was too high to present the results.

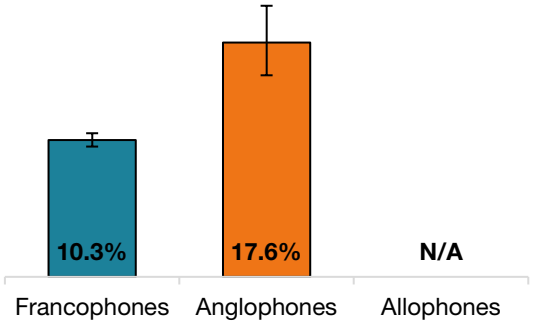
3.3 Sexual behavior

Condoms are the best way to prevent sexually transmitted infections (STIs) (Centers for Disease Control and Prevention). Certain sexual behaviors may be associated with an increased risk of contracting STIs, such as the number of partners (Institut national de santé publique du Québec). This information on sexual behavior also helps determine the sexual health of individuals (Joubert and Du Mays, 2014).

Condom use

In Québec, in 2014-2015, among sexually active people, more anglophones (18%) than francophones (10%) had always used condoms in the previous 12 months (Figure 4).

Figure 4 **Sexually active people who had always used a condom in the previous 12 months, 2014-2015**



Note: Allophones had a partial non-response rate of over 10%. Data not shown.

Language spoken at home and immigrant status

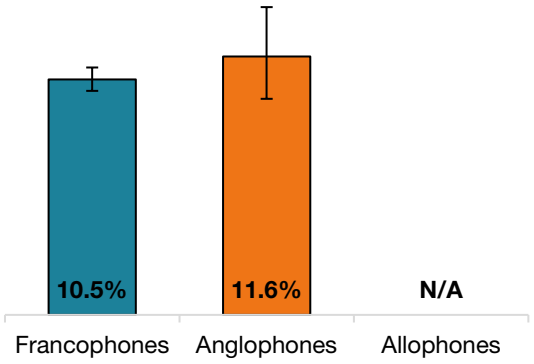
- In 2014–2015, among sexually active people born in Canada, more anglophones (18%) than francophones (10%) were found to have always used condoms over the previous 12 months.
- Among immigrants, the proportions of francophones (12%) and anglophones (17%) who always used a condom were comparable.

Number of partners

In Québec in 2014-2015, among sexually active people, the proportion of anglophones who had had only one partner in the previous 12 months was slightly lower than that of francophones (84% and 87% respectively) (data not shown).

However, there was no statistically significant difference by language spoken at home for the proportion of sexually active people who had had two to four partners in the previous 12 months (Figure 5).

Figure 5 **Sexually active people who had two to four partners in the previous 12 months, 2014-2015**



Note: Allophones had a partial non-response rate of over 10%. Data not shown.

Language spoken at home and immigrant status

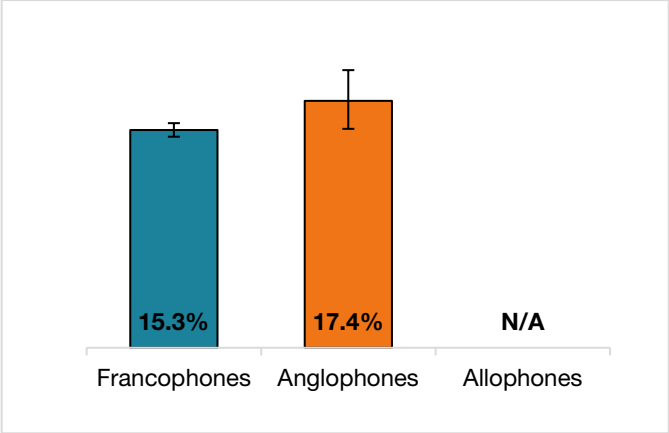
- In 2014–2015, among Canadian-born sexually active individuals who had 2 to 4 partners in the previous 12 months, anglophones (13%) and francophones (11%) were comparable in proportion.
- Among immigrants, due to the small numbers of anglophones and allophones, it is impossible to comment on the differences in the number of sexual partners between linguistic communities.

3.4 Cannabis use

Drugs and psychoactive substances can have harmful effects on health and well-being. The risk of cannabis users developing an addiction is reported to be about 9%. Cannabis was the most widely used illegal substance among the Québec population[3] (Chapados et al., 2016).

In Québec, in 2014-2015, the proportion of the population that had used cannabis in the previous 12 months was higher among anglophones (17%) than francophones (15%) (Figure 6).

Figure 6 **Cannabis use over the previous 12 months, 2014-2015**



Note: Allophones had a partial non-response rate of over 10%. Data not shown.

Language spoken at home and immigrant status

- In 2014-2015, among Canadian-born individuals age 15 and older, the proportion of cannabis users was higher among anglophones (22%) than francophones (16%).
- Among immigrants, statistical biases among anglophones and allophones are too significant to comment on potential differences in cannabis use between linguistic communities.

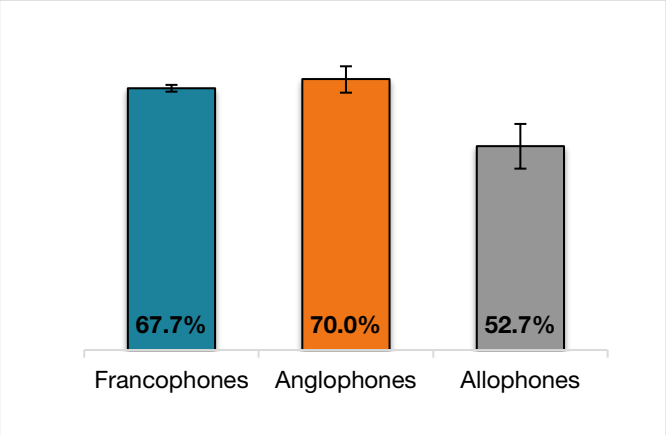
[3] Cannabis was legalized in Canada in October 2018, between the time of the French publication and the English publication of this report.

3.5 Pap test

The Pap test detects abnormal changes in cervical cells that can lead to cancer. A Pap test is recommended every two to three years (Portail Santé mieux-être, Government of Québec, 2017; Camirand, Traoré, and Baulne, 2016).

In Québec, in 2014-2015, among women age 18 to 69, allophones (53%) were less likely than anglophones (70%) and francophones (68%) to have had a Pap test within the previous three years (Figure 7).

Figure 7 Women who had a Pap test within the previous three years, 2014-2015



Language spoken at home and immigrant status

- Among Canadian-born women age 18 to 69, anglophones (74%) were more likely to have had a Pap test in the previous three years than francophones (68%).
- The situation for women born outside Canada was similar to that of all women: The proportions of women who had had a Pap test in the previous three years were comparable among francophones (63%) and anglophones (61%) but lower among allophones (53%).

3.6 At a glance – Behaviors related to prevention and health promotion

Table 1 Behaviors related to prevention and health promotion

ANGLOPHONES			
	Total	**Bord in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones	Condom use	Condom use Pap tests	
Are comparable to francophones	Oral hygiene Sexual behaviors Pap tests	Oral hygiene Contraception (men) Sexual behaviors	Oral hygiene Contraception (women) Condom use Pap test
Compare **UNFAVORABLY** to francophones	Contraception (men and women) Cannabis use	Contraception (women) Cannabis use	
Not presented for methodological considerations			Contraception (men) Sexual behavior Cannabis use

ALLOPHONES			
	Total	**Born in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones			
Are comparable to francophones	Oral hygiene		Oral hygiene
Compare **UNFAVORABLY** to francophones	Pap test		Pap test
Not presented for methodological considerations	Contraception (men and women) Condom use Sexual behavior Cannabis use	Oral hygiene Contraception (men and women) Condom use Sexual behavior Cannabis use Pap test	Contraception (men and women) Condom use Sexual behavior Cannabis use

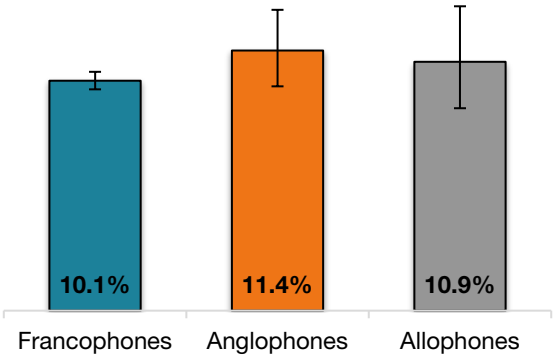
4 Physical and mental health status

4.1 Perceived overall health

A self-assessment of overall health status is a subjective but reliable way to measure a person's state of health. It aligns well with certain objective aspects of health (e.g., physical health problems, functional capacity, activity limitations, mental and social health status, lifestyle habits, or individual health behaviors) (Camirand, Traoré, and Baulne, 2016; Statistics Canada, 2016).

In Québec, in 2014–2015, the proportions of francophones, anglophones, and allophones who perceived their health as fair or poor were comparable (10% or 11%) (Figure 8).

Figure 8 Overall health perceived as poor or fair, 2014-2015



Language spoken at home and immigrant status

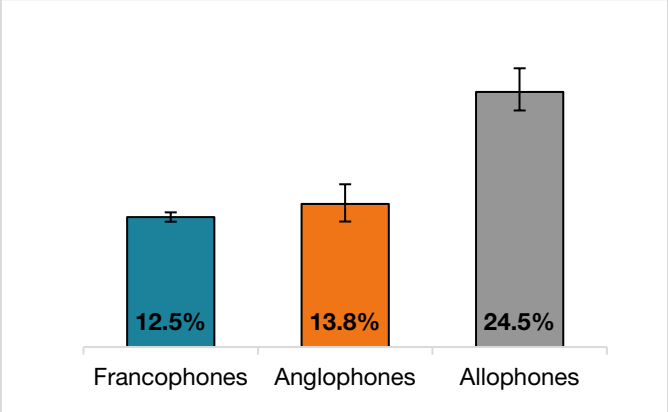
- Among individuals born in Canada, the proportion of the population who perceived themselves as not being in good health was comparable among francophones (10%) and anglophones (11%).
- Among immigrants, the proportions were comparable for all three language communities: 10% of francophones, 12% of anglophones and 11% of allophones perceived their health as poor or fair.

4.2 Perceived oral health

Individuals' perceptions of their own oral health provide a better understanding of oral health as a whole by taking into account functional and social dimensions (Institut national de santé publique du Québec).

In Québec, in 2014–2015, the proportions of francophones and anglophones who perceived their oral health as fair or poor were comparable (14% and 13% respectively). Almost twice as many allophones did not think their oral health was good (25%) (Figure 9).

Figure 9 Oral health perceived as poor or fair, 2014-2015



Language spoken at home and immigrant status

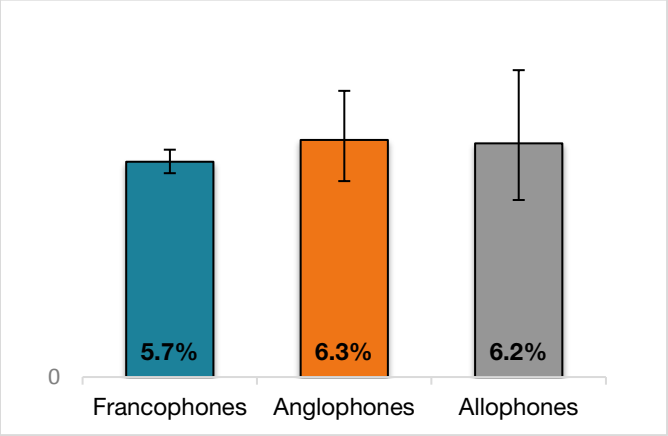
- Comparable proportions of anglophones and francophones born in Canada did not consider themselves as having good oral health (12% and 13% respectively).
- A smaller proportion of immigrant anglophones (16%) than immigrant francophones (22%) rated their oral health as poor or fair. The proportion for immigrant allophones was comparable to that for francophones (25%).

4.3 Dissatisfaction with social life

Satisfaction with social life is a subjective assessment of a person's state of well-being and an important aspect of mental health. It is often associated with an individual's social environment (Camirand, Traoré, and Baulne, 2016; Statistics Canada, 2017b).

In Québec, in 2014-2015 the results for francophones, anglophones and allophones were comparable in terms of dissatisfaction with social life (6%) (Figure 10).

Figure 10 Dissatisfaction with social life, 2014-2015



Language spoken at home and immigrant status

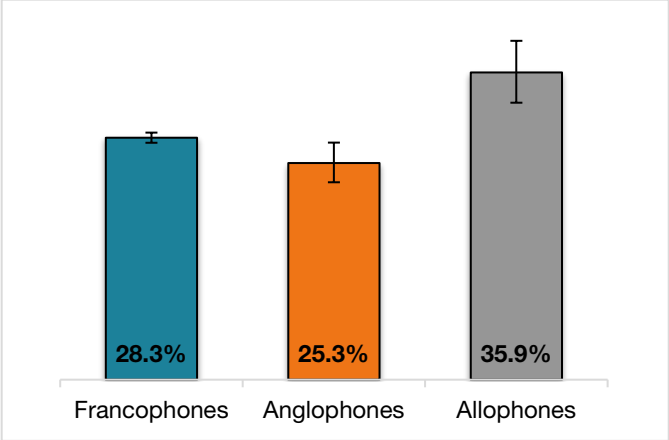
- Among people born in Canada, a comparable proportion of anglophones and francophones were dissatisfied with their social life (6%).
- Among immigrants, statistical biases among anglophones and allophones are too significant to comment on potential differences between linguistic communities in regard to dissatisfaction with social life.

4.4 Psychological distress

Psychological distress is the result of a set of negative emotions experienced by individuals that, when they persist, can lead to depression and anxiety syndromes. The psychological distress scale is a non-specific mental health status measurement that provides a snapshot of the general population's mental health (Camirand, Traoré,and Baulne, 2016; Camirand and Nanhou, 2008).

In Québec, in 2014–201, proportionately fewer anglophones (25%) than francophones (28%) were at the high end of the psychological distress scale. The proportion was highest among allophones (36%) (Figure 11).

Figure 11 High level on the psychological distress scale, 2014-2015



Language spoken at home and immigrant status

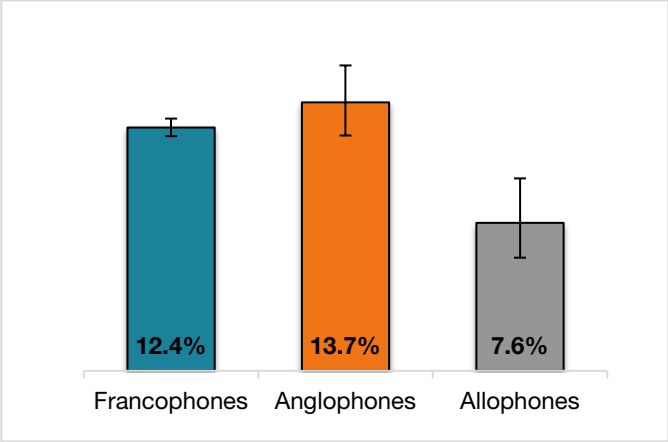
- Levels of psychological distress among anglophones (26%) and francophones (28%) born in Canada were comparable.
- Among immigrants, there were proportionately more francophones (32%) than anglophones (25%) at the high end of the psychological distress scale. The proportion for immigrant allophones was comparable to that of francophones (35%).

4.5 Unintentional injuries

The Québec Population Health Survey defines unintentional injuries as those severe enough to limit the normal activities of individuals. Their effects can be serious. Such injuries are among the leading causes of mortality and morbidity worldwide (Camirand, Traoré, and Baulne, 2016.

In Québec, in 2014–2015, a comparable proportions of anglophones (14%) and francophones (12%) suffered unintentional injuries during the previous 12 months. Allophones (8%) had the lowest proportion of unintentional injuries (Figure 12).

Figure 12 Unintentional injuries, 2014-2015



Language spoken at home and immigrant status

- Among people born in Canada, more anglophones (16%) than francophones (13%) experienced unintentional injuries during the previous 12 months.
- Among immigrants, the proportions of allophones (8%) and francophones (9%) were comparable.

4.6 At a glance – Physical and mental health status

Table 2 Physical and mental health status

ANGLOPHONES			
	Total	**Born in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones	Psychological distress		Perceived oral health Psychological distress
Are comparable to francophones	Perceived overall health Perceived oral health Dissatisfaction with social life Unintentional injuries	Perceived overall health Perceived oral health Dissatisfaction with social life Psychological distress	Perceived overall health
Compare **UNFAVORABLY** to francophones		Unintentional injuries	
Not presented for methodological considerations			Dissatisfaction with social life Unintentional injuries

ALLOPHONES			
	Total	**Born in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones	Unintentional injuries		
Are comparable to francophones	Perceived overall health Dissatisfaction with social life		Perceived overall health Perceived oral health Psychological distress Unintentional injuries
Compare **UNFAVORABLY** to francophones	Perceived oral health Psychological distress		
Not presented for methodological considerations		Perceived overall health Perceived oral health Dissatisfaction with social life Psychological distress Unintentional injuries	Dissatisfaction with social life

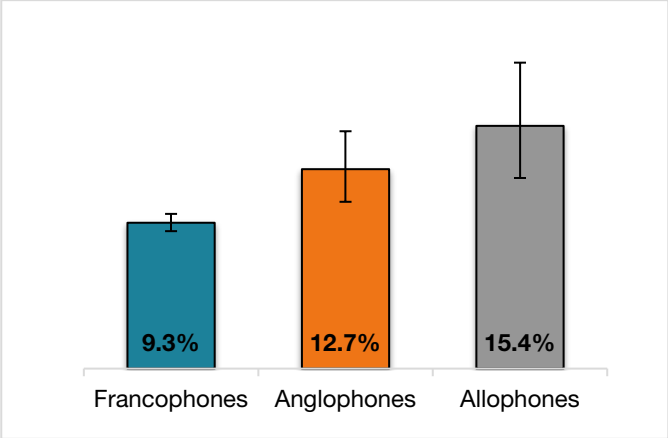
5 Occupational health

5.1 Work/Life balance

When people have difficulty balancing their work responsibilities with their personal life, their mental and physical health can suffer. In this context, working conditions in relation to work schedules are crucial to work/life balance[4] (Institut national de santé publique du Québec; Allen et al., 2000; Camirand, Traoré, and Baulne, 2016).

In Québec, in 2014–2015, proportionately more anglophones (13%) and allophones (15%) struggled with work/life balance than did francophones (9%).

Figure 13 Workers who struggled with work/life balance, 2014-2015



Language spoken at home and immigrant status

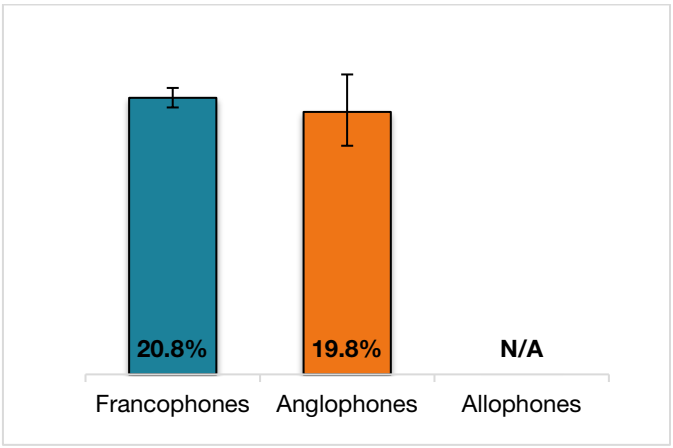
- Among Canadian-born workers, a higher proportion of anglophones (13%) than francophones (9%) struggled with work/life balance.
- The proportions of immigrant workers who struggled with work/life balance were comparable for francophones (14%) and allophones (17%).

5.2 Recognition at work

Lack of recognition at work may be financial, social, or organizational. Workers who are exposed to low recognition at work are more likely to report psychological distress, symptoms of depression, and a negative perception of their health status (Institut national de santé publique du Québec; Vézina et al., 2011; Memmi et al., 2016).

In Québec, in 2014–2015 comparable proportions of francophones (21%) and anglophones (20%) were exposed to a low level of recognition at work (Figure 14).

Figure 14 Workers exposed to a low level of recognition at work, 2014-2015



Language spoken at home and immigrant status

- There was no difference between the proportion of workers exposed to low recognition at work among anglophones (20%) and francophones (21%) born in Canada.
- Among immigrants the proportion of workers exposed to low recognition at work was comparable for anglophones (20%) and francophones (24%).

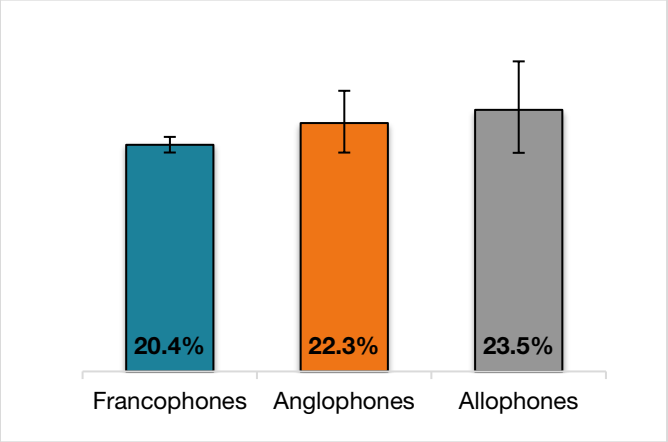
[4] The indicator used to estimate a poor work/life balance was “difficulty in reconciling working hours with social and family commitments.”

5.3 Psychological harassment at work

The *Act respecting labour standards* defines psychological harassment as “vexatious behaviour in the form of repeated and hostile or unwanted conduct, verbal comments, actions or gestures, that affects an employee’s dignity or psychological or physical integrity and that results in a harmful work environment for the employee” (Institut national de santé publique du Québec; Camirand, Traoré, and Baulne, 2016).

In Québec, in 2014–2015 the proportion of anglophone workers (22%) who had suffered psychological harassment at work was comparable to the proportions of francophones (20%) and allophones (24%) (Figure 15).

Figure 15 **Workers who had suffered psychological harassment at work, 2014-2015**



Language spoken at home and immigrant status

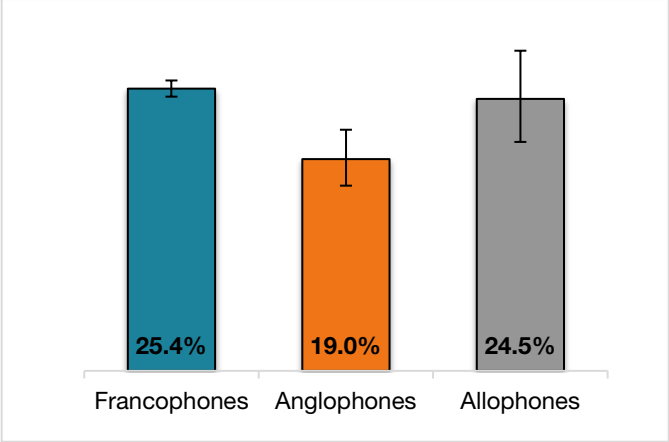
- Among people born in Canada, the proportion of anglophones who had experienced psychological harassment in the workplace was comparable to the portion of francophones (20%).
- Among immigrants, the proportions of anglophone (22%) and allophone (22%) workers who had experienced psychological harassment in the workplace were comparable to the statistic for francophones (26%).

5.4 Non-traumatic work-related musculoskeletal disorders

Musculoskeletal disorders (MSDs) are inflammatory or degenerative symptoms or injuries that affect the neck, back, or upper or lower limbs. The prevention of non-traumatic work-related musculoskeletal disorders is a priority for the Programme national de santé publique and the Strategic Plan of Commission des normes, de l’équité, de la santé et de la sécurité du travail (CNESST) (Camirand, Traoré, and Baulne, 2016).

In Québec, in 2014–2015 a lower proportion of anglophones (19%) than francophones (25%) experienced non-traumatic work-related MSDs. Allophones (25%) did not stand out from the two other linguistic groups (Figure 16).

Figure 16 **Workers experiencing non-traumatic work-related musculoskeletal disorders, 2014-2015**



Language spoken at home and immigrant status

- Among people born in Canada, anglophones (19%) were less likely to experience non-traumatic work-related MSDs than francophones (26%).
- Among immigrants, the proportions of anglophone (19%) and allophone (24%) workers who experienced non-traumatic work-related MSDS were similar to the proportion of francophones (23%).

5.5 At a glance – Occupational health

Table 3 Occupational health

ANGLOPHONES			
	Total	**Born in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones	Non-traumatic work-related musculoskeletal disorders	Non-traumatic work-related musculoskeletal disorders	
Are comparable to francophones	Recognition at work Psychological harassment at work	Recognition at work Psychological harassment at work	Recognition at work Psychological harassment at work Non-traumatic work-related musculoskeletal disorders
Compare **UNFAVORABLY** to francophones	Work/life balance	Work/life balance	
Not presented for methodological considerations			Work/life balance

ALLOPHONES			
	Total	**Born in Canada**	**Immigrants**
Compare **FAVORABLY** to francophones			
Are comparable to francophones	Psychological harassment at work Non-traumatic work-related musculoskeletal disorders		Work/life balance Psychological harassment at work Non-traumatic work-related musculoskeletal disorders
Compare **UNFAVORABLY** to francophones	Work/life balance		
Not presented for methodological considerations	Recognition at work	Work/life balance Recognition at work Psychological harassment at work Non-traumatic work-related musculoskeletal disorders	Recognition at work

6 Conclusion

The objective of this report was to broaden the knowledge about the health status of linguistic communities in Québec by comparing minority communities (anglophone and allophone) to the francophone majority. Analyses had already shown that Quebecers in a linguistic minority situation are more socio-economically vulnerable, with higher unemployment rates and greater income disparities (Lussier, 2012). Other studies based on government data have shown discrepancies in certain health indicators that are reportedly favorable to English speakers (Trempe et al., 2013; Auger, Park, and Harper, 2012; Burrows, Auger, and Lo, 2016).

A review of the data from the 2014–2015 Québec Population Health Survey (QPHS) showed that there is no generalized vulnerability among minority language communities (anglophone or allophone). For the majority of the indicators studied in this health profile, anglophones were comparable, proportionately speaking, to francophones. Among allophones, half of the results for indicators with no methodological obstacles were comparable to the situation among francophones.

However, there were still some differences: Anglophones had a favorable profile for consistent condom use, psychological distress, and non-traumatic work-related musculoskeletal disorders, but were proportionately less likely to use contraception and more likely to use cannabis and struggle with work-life balance.

Allophones, on the other hand, compared unfavorably to francophones for four selected indicators (Pap test, perceived oral health, psychological distress, and work-life balance) and favorably for one indicator (unintentional injuries).

Cross-analysis between language of expression and immigrant status revealed that, apart from a higher propensity to experience unintentional injuries and a higher proportion of women who had had a Pap test in the previous three years, the profile of Canadian-born anglophones was consistent with the profile for all anglophones.

Among immigrants, there were few differences between each of the linguistic minorities and francophones. Among the differences, immigrant anglophones had a favorable profile in terms of psychological distress and perceived oral health compared to immigrant francophones. Allophone immigrant women, on the other hand, were less likely than francophone immigrant women to have had a Pap test in the previous three years.

7 References

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Appendix: Complete Data

The following table shows all the data highlighted in the report in addition to the data with a coefficient of variation greater than 15% but less than or equal to 25%, and partial non-response rates greater than 10% but less than or equal to 15%. Such data is presented for information purposes and should be interpreted or used with caution. Data with a coefficient of variation greater than 25% or with a partial non-response rate greater than 15% is not shown (N/A).

Table 4 Results and confidence intervals of selected QPHS indicators by language spoken at home and immigrant status, Québec, 2014-2015

	TOTAL			BORN IN CANADA			IMMIGRANTS		
	FR	ENG	OTHER	FR	ENG	OTHER	FR	ENG	OTHER
Behaviors related to prevention and health promotion									
Tooth brushing twice a day	74.5 [73.9; 75.0]	75.2 [73.0; 77.3]	76.3 [73.1; 79.3]	73.8 [73.3; 74.4]	74.2 [71.6; 76.7]	74.9[b] [64.6; 83]	80.1 [78.2; 81.9]	77.5 [73.4; 81.1]	76.5 [73.1; 79.6]
Use of contraceptives among women in the previous 12 months	86.0 [85.0; 86.9]	79.1 [74.6; 83.0]	77.6[b] [70.6; 83.4]	87.0 [86.1; 88.0]	78.9 [73.3; 83.5]	77.8[b] [53; 91.6]	77.8 [73.7; 81.5]	79.8 [69.5; 87.2]	77.6[b] [70.1; 83.7]
Use of contraceptives among men in the previous 12 months	72.1 [71.2; 73.0]	65.7 [61.5; 69.6]	66.1[b] [60.5; 71.2]	72.5 [71.5; 73.4]	69.1 [64.4; 73.5]	N/A	68.7 [65.1; 72]	57.0[b] [48.7; 64.9]	64.6[b] [58.8; 70.1]
Consistent use of condoms during the previous 12 months	10.3 [9.8; 10.8]	17.6 [15.1; 20.3]	16.7[b] [13.4; 20.6]	10.0 [9.5; 10.6]	17.7 [14.8; 21]	N/A	12.4 [10.7; 14.3]	17.3 [13.1; 22.5]	15.4[b] [12.1; 19.4]
Between two and four sexual partners in the previous 12 months	10.5 [10.0; 11.1]	11.6 [9.7; 13.8]	8.5[a,b] [6.3; 11.4]	10.6 [10.1; 11.2]	13.0 [10.7; 15.7]	N/A	9.6 [8.1; 11.4]	7.9[a] [5; 12.3]	7.7[a,b] [5.5; 10.8]
Cannabis use in the previous 12 months	15.3 [14.9; 15.8]	17.4 [15.4; 19.6]	6.7[a] [5.0; 9.0]	16.1 [15.6; 16.6]	22.1 [19.6; 24.8]	20.3[a,b] [12.9; 30.6]	9.0 [7.6; 10.6]	6.5[a] [4.6; 9.1]	5.4[a] [3.7; 7.7]
Pap test in the last three years	67.7 [66.8; 68.5]	70.0 [66.5; 73.3]	52.7 [46.9; 58.4]	68.3 [67.3; 69.2]	74.0 [69.9; 77.7]	52.8[a] [34.5; 70.4]	62.6 [59.4; 65.7]	61.1 [53.9; 67.9]	52.7 [46.6; 58.7]

	TOTAL			BORN IN CANADA			IMMIGRANTS		
	FR	EN	OTHER	FR	EN	OTHER	FR	EN	OTHER
Physical and mental health status									
Health perceived as fair or poor	10.1 [9.7; 10.5]	11.4 [9.8; 13.2]	10.9 [8.9; 13.4]	10.1 [9.7; 10.5]	11.0 [9.1; 13.2]	N/A	10.2 [9.0; 11.7]	12.4 [9.7; 15.8]	11.4 [9.2; 14.1]
Oral health perceived as fair or poor	12.5 [12.1; 12.9]	13.8 [12.1; 15.6]	24.5 [21.5; 27.8]	11.5 [11.1; 11.9]	12.9 [11.0; 15.2]	24.1[a,b] [16.1; 34.4]	21.5 [19.7; 23.4]	15.7 [12.6; 19.3]	24.6 [21.3; 28.1]
Dissatisfaction with social life	5.7 [5.4; 6.0]	6.3 [5.2; 7.6]	6.2 [4.7; 8.1]	5.7 [5.4; 6]	5.7 [4.4; 7.2]	N/A	6.0 [5.0; 7.1]	7.7[a] [5.5; 10.8]	5.6[a] [4.1; 7.6]
High score on the psychological distress scale in the previous 12 months	28.3 [27.7; 28.9]	25.3 [23.1; 27.7]	35.9 [32.4; 39.6]	27.9 [27.3; 28.5]	25.7 [22.9; 28.7]	46.9[b] [35.4; 58.8]	31.7 [29.6; 33.9]	24.6 [20.7; 28.8]	34.8 [31.2; 38.6]
Unintentional injuries in the previous 12 months	12.4 [12.0; 12.9]	13.7 [12.0; 15.6]	7.6 [5.8; 9.8]	12.8 [12.4; 13.3]	16.2 [14.0; 18.7]	N/A	9.1 [7.8; 10.6]	8.0[a] [5.9; 10.8]	7.6 [5.7; 10]
Occupational health									
Struggle with work/life balance	9.3 [8.7; 9.8]	12.7 [10.6; 15.1]	15.4 [12.1; 19.4]	8.7 [8.2; 9.3]	13.0 [10.6; 16]	N/A	14.3 [12.4; 16.4]	11.7[a] [8.1; 16.6]	16.8 [13.1; 21.2]
Low recognition at work	20.8 [20.1; 21.6]	19.8 [17.2; 22.6]	19.3[b] [15.4; 23.8]	20.5 [19.8; 21.3]	19.6 [16.7; 22.9]	N/A	23.5 [20.9; 26.3]	20.2 [15.4; 26.2]	18.1[b] [14.3; 22.6]
Psychological harassment at work	20.4 [19.7; 21.1]	22.3 [19.7; 25.2]	23.5 [19.7; 27.9]	19.8 [19.1; 20.5]	22.4 [19.4; 25.7]	34.2[a] [21.4; 49.8]	25.6 [23.2; 28.2]	22.3 [17.4; 28]	22.4 [18.4; 27]
Non-traumatic work-related musculoskeletal disorders in the previous 12 months	25.4 [24.7; 26.1]	19.0 [16.7; 21.7]	24.5 [20.6; 28.8]	25.6 [24.8; 26.4]	19.2 [16.6; 22.1]	N/A	23.3 [20.9; 25.8]	18.5 [13.9; 24.2]	24.2 [20.3; 28.6]

[a] Coefficient of variation greater than 15% but less than or equal to 25%. The value for the percentage must be interpreted with caution.

[b] Partial non-response rate greater than 10% but less than or equal to 15%. The value for the percentage must be interpreted with caution.

N/A Data not presented because the coefficient of variation is greater than 25% or the partial non-response rate is greater than 15%.

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