An intersectional analysis of client satisfaction with home care in Canada

by

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Executive Summary

Introduction

Home care is a priority for all Canadians but evidence from literature suggests that the home care system is generally prone to inequality. Client satisfaction is an integral component of home care, which measures the quality of home care. This study used the intersectional framework of gender and Indigenous identity to analyze client satisfaction with home care among home care recipients in Canada to determine the existence of inequalities in client satisfaction with home care.

Methodology and Methods

The study design was based on secondary data analysis. The data source was the Canadian Community Health Survey 2021. The study population was respondents who received home care in the last 12 months. Intersectional strata (dummy variables) were created from gender and Indigenous identity. The outcome variable was client satisfaction (a binary variable with 0 “Not satisfied/Undecided” and 1 “Satisfied”). The control variables were age, income, sexual orientation, and language often spoken. Provincial/Territory variable was used for clustering the standard errors to account for heteroscedasticity across the clusters of observations. Quantitative analyses were conducted using frequencies, percentages, and multiple linear regression model. Statistical significance was set at $p<0.05$.

Key findings

The non-Indigenous men and the non-Indigenous women together accounted for about 75 percent of the respondents, while the Indigenous men and the Indigenous women together accounted for about three percent of the respondents. Among the non-Indigenous men and the non-Indigenous women, 90.7 percent and 90.1 percent respectively expressed satisfaction with home care; meanwhile, 82.0 percent of Indigenous men and 88.8 percent of Indigenous women respectively expressed satisfaction with home care. Overall, 90.4 percent of the respondents were satisfied with home care. After controlling for age, income, sexual orientations, and languages, the regression analysis identified the Indigenous women and the non-Indigenous women as significantly ($p<0.05$) having a 9.6 percentage point and a 10.2 percentage point lower satisfaction with home care respectively, relative to “men with other identities”.

Options to consider and Recommendations.

The study findings suggest the existence of inequalities in client satisfaction with home care, which is a barrier to the fundamental objectives of the program in Canada. The inequality in client satisfaction with home care identified in this study can be tackled in two ways. One approach involves community-based intervention, where experts lead strategy development and the community helps carry it out, gradually taking over responsibility. Alternatively, community development work emphasizes empowering community groups to identify and address disparities themselves, focusing on long-term sustainability and community empowerment. This approach prioritizes community involvement in resolving underlying issues.

Acknowledgement

I acknowledge and respect the Lək̓ʷəŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day, I would like to acknowledge that this work took place on the ancestral, traditional, and unceded homelands Canadians. Thank you for sharing the wisdom of the land-based teachings and the importance of reciprocity!

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Dedication

I dedicate this thesis to Almighty God for seeing me through the degree. I also dedicate it to my husband, who never wavered in his conviction of my strengths and abilities. For your unconditional love and for supporting me through tears, fears, triumphs, and believing in me. I also dedicate to my children, who sacrificed events, vacations, and time together for this pursuit. I also dedicate this dissertation to my mother. Thank you for instilling the belief that I could achieve any goal with hard work and commitment.

1. Introduction

Home care is a main concern for all Canadians including for patients and their caregivers, for health care providers and governments (CHCA CFPC & CNA, 2016). It is also an important part of health care reform in Canada (Statistics Canada, 2021). As of 2015/2016, the prevalence of unmet home care needs in Canada was about 35%, meaning an estimated 433,000 people, did not have those needs met (Gilmour, 2018b). It is believed that if some types of care are provided in the home instead of in a hospital or institution, both patients and the healthcare system would benefit (Statistics Canada, 2021). Home care entails the provision of care for people with special needs in their homes. It could be for individuals of different ages, gender, and sexes, the aging, the chronically ill, the recuperating, or people with a disability (MedlinePlus, 2021). Home care can be diverse depending on the needs of a care recipient; it may include providing personal care (helping with bathing, washing hair, or getting dressed), doing household chores (cleaning, yard work, and laundry), cooking for a person at the person's home, or delivering meals to a person; and providing health care (nursing care, specialized medical services, laboratory workups, etc.) through a home health aide or telehealth (Johns Hopkins Medicine, n.d.; MedlinePlus, 2021).

An integral component of home care is client satisfaction which is an indicator of the quality of care or service quality (Laferriere, 1993). Client satisfaction is synonymous with patient satisfaction which has been used to evaluate care programs including rehabilitation programs, discharge and home follow-up programs, care process and management practices, and new care protocols and treatments (Abusalem et al., 2013). Therefore, adequate knowledge of client satisfaction as an indicator of the quality of home care becomes necessary for planning and implementing quality improvement strategies (Möckli et al., 2021). Given the significance of client satisfaction, many empirical studies have been conducted to develop and test the reliability and validity of different instruments for measuring homecare client satisfaction (Geron et al., 2000; Hsieh, 2017; Laferriere, 1993; Westra et al., 1995).

1.1 Defining the Problem

The problem addressed in this study is the inequality in client satisfaction with home care among home care recipients given the scale of home care program in Canada. Despite the high possibility of getting positive feedback on client satisfaction with home care in Canada, the home care system is still faced with a few challenges including underfunding, understaffing, and inequitable access to care (Kelly et al., 2023; Vafaei et al., 2023; Yakerson, 2018). A recent study on the home care system in Canada reveals that directly-funded (DF) home care, the type of home care program in which government funds are provided to people who need assistance with their daily living activities to allow them to arrange their services, is a privilege only afforded to some and in regions where clients and families are allowed to apply directly-funded home care through home care agencies, clients who are low-income individuals, those with

limited social supports, and clients with limited English may inadvertently experience barriers to home care (Kelly et al., 2023). In another study, utilization of home care is seen to increase with level of income, wealth, and education; and the study concludes that home care is not only determined by individual need but also decisively influenced by socio-economic restrictions (Englert et al., 2023). It is evident that inequity and inequality exist within the home care program, yet client satisfaction with home care seems to be high. However, there may be some vulnerable subgroups within the population of home care recipients who might still not be satisfied with home care services they receive. Consequently, it is imperative to identify these groups and potentially provide them with access to government-funded services that could rebalance social and individual inequities in home care use and client satisfaction (Vafaei et al., 2023).

1.2 Project Objectives

The goal of this thesis is to analyze client satisfaction with home care with intersectionality of gender and Indigenous identity of home care recipients in Canada to determine inequalities in client satisfaction with home care. The study disaggregated client satisfaction across different subgroups of home care recipients and compared the probabilities of client satisfaction with home care in among the intersectional strata or groups to determine inequalities in client satisfaction with home care.

The study goal was achieved through a secondary analysis of quantitative data. Although alternative approaches including qualitative methods, mixed methods, cross-sectional survey, etc. could have also been used to examine the research topic, funding and time constraints made these alternative approaches not feasible for the researcher. The scope of this study was limited to individuals aged 18 years and above who received home care such as palliative care, nursing care, support services (meal preparation, helping with bathing or housework, etc.) in the past 12 months in Canada. The study however excluded post-partum care, and help from family, friends, or neighbors (Statistics Canada, 2021). The scope of the study was also limited to the intersectional strata created by intersections of gender [male, female, and others], and Indigenous identity—the non-Indigenous, the Indigenous [defined as First Nations (North American Indian), the Métis, and the Inuk (Inuit)] and the other identities. The choice of the two intrinsic variables was informed by the consideration for inequality of opportunity which acknowledges that circumstances of birth are essential to life outcomes and thus requires a fair starting point for all (Department of Economic and Social Affairs, 2015).

1.3 Research Questions

In support of this research to address the problem of client satisfaction with home care among home care recipients, the following research questions were utilized:

RQ1: What was the level of client satisfaction among home care recipients in the last 12 months?

RQ2: What was the distribution of home care recipients by the strata of intersectionality of gender and Indigenous identity?

RQ3: What were the level of client satisfaction with home care in each of the strata of intersectionality of gender and Indigenous identity?

RQ4: Does the level of client satisfaction with home care vary significantly across different strata of intersectionality of gender and Indigenous identity?

RQ5: Does the level of client satisfaction with home care vary significantly across different strata of intersectionality of gender and Indigenous identity after controlling for other factors?

1.4 Hypotheses

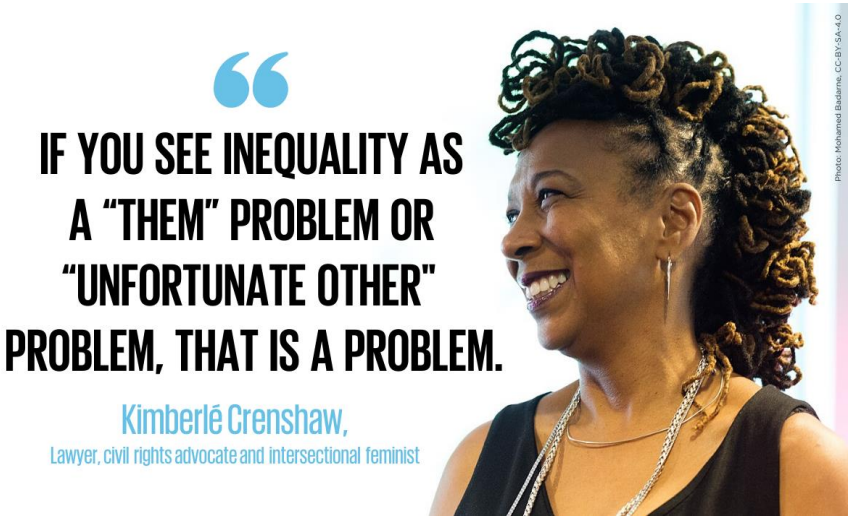
H4o: The level of client satisfaction does not significantly vary across different strata of intersectionality of gender and Indigenous identity.

H4a: The level of client satisfaction significantly varies across different strata of intersectionality of gender and Indigenous identity.

H5o: The level of client satisfaction does not significantly vary across different strata of intersectionality of gender and Indigenous identity after controlling for other factors.

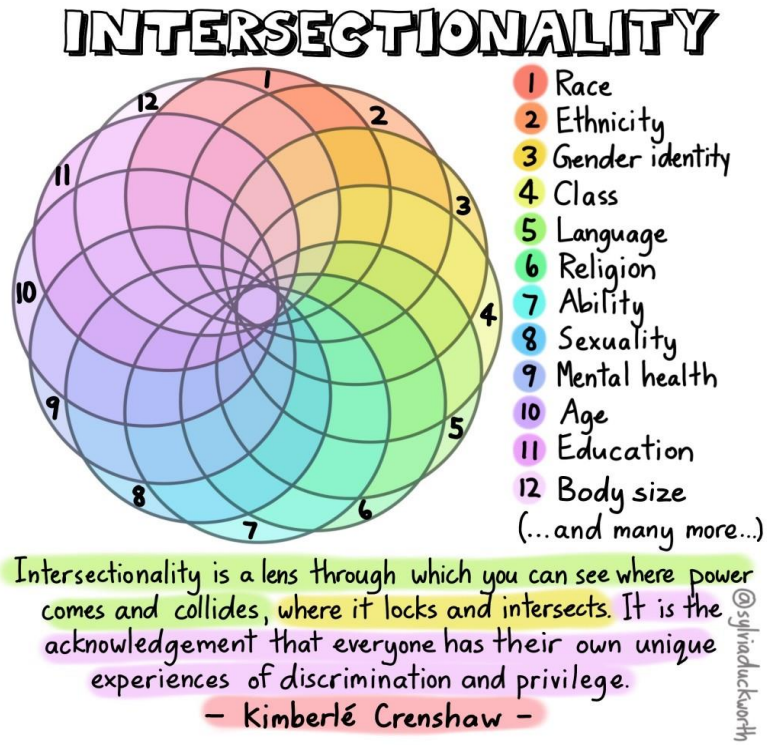
H5a: The level of client satisfaction significantly varies across different strata of intersectionality of gender and Indigenous identity after controlling for other factors.

1.5 Theoretical Framework



Source: UN Women, 2020

The theoretical framework for this study is based on the theory of Intersectionality. The intersectionality theory came from the groundbreaking works of black feminist scholar-activists in the 1970s, but the term "intersectionality" was originally coined and popularized by an American critical legal race scholar Kimberlé Williams Crenshaw in 1989 (Crenshaw, 1989). The term was used by Crenshaw to refer to "*the double discrimination of racism and sexism faced by Black women in the legal cases wherein women were required to choose between bringing a claim of racism or sexism and could not say that they had been discriminated against due to the combined effects of race and sex*" (Crenshaw, 1989). It is a metaphor for comprehending how multiple forms of inequality or disadvantage could sometimes compound themselves to create barriers that are often not understood among conventional ways of thinking (APS Group Scotland, 2022).



Source: Duckworth, 2020

Intersectionality theory "offers a useful theoretical lens to better understand the etiology of, and potential areas of intervention against, avoidable and systematic health and social inequalities" (Public Health Agency of Canada, 2022, p. 45). The theory has been used across a wide range of disciplines, including, more recently, in quantitative research (Atewologun, 2018). It forms the theoretical underlining of the Gender Based Analysis PLUS (GBA PLUS) of the Federal Government of Canada (Women and Gender Equality Canada, 2022). The intersectionality principle adopted for this study is known as intersecting categories. It is one of the eight principles of the Intersectionality-Based Policy Analysis (IBPA) Framework (Hankivsky et al., 2014). This principle focusses on how intersectionality conceptualizes social categories as interacting with and co-constituting one another to create unique social locations that vary according to time and place. These intersections and their effects are of concern in an intersectionality analysis (Hankivsky et al., 2014).

1.6 Positionality Statement

As a Master of Art student in Community Development, I am aware of and understand the roles and responsibilities that surround the ethical conduct of this research as contained in the TCPS2 policy. I am also aware that an effective research design is crucial to any research activity (Pole & Lampard, 2015). However, I am a self-funded foreign student with an academic background in human resources management, and more than 10 years of progressive work experience in public service, banking, accounting, and recently home care service delivery in Canada. I have limited

financial resources and a study timeline to conduct this study. I also have little or no hands-on experience in conducting qualitative research and analysis. Therefore, I consider using the secondary data analysis method to find the answer to the research question and achieve the primary objectives. Thus, the TCPS2 policy does not apply to my research.

In my previous consultancy job, I worked as a research data assistant with a monitoring and evaluation (quantitative research) team, and I was somewhat exposed to quantitative research methods and effective management of service delivery and research data. I am somewhat biased towards the use of quantitative research and data management approach more than qualitative research and data management. However, I do not consider myself holding any power or privilege which may influence my research process.

1.7 Background

Client satisfaction remains an integral component of home care, serving as an indicator of the quality of care or service quality (Laferriere, 1993). Therefore, the results of research on client satisfaction with home care can lead to advancements that would enhance client-and family-centered care, accessible care, accountable care, evidence-informed care, integrated care, sustainable care, etc. Hence, Statistics Canada periodically conducts surveys in the country to identify which groups are receiving home care and which groups are not; to determine the health status of the groups; compare how the groups are using other health services and understand whether homecare is working as planned (Statistics Canada, 2021). Also, there are quite a few studies on client satisfaction with home care, but most these studies have examined client satisfaction from a traditional conceptual framework that sees different drivers of client satisfaction as autonomous. Some of these drivers include diversity in the client's background characteristics such as gender, age, marital status, sexual orientation, race/ethnicity, pre-retirement occupation, source of financial resources, mode of residence, and culture (Hengelaar et al., 2023; Wang et al., 2024).

The significance of this research therefore lies in the use of intersectional framework which considers the drivers of client satisfaction with home care as interconnected. Besides, the intersectional approach is relevant in providing more precise information on the existence (or the absence) of inequalities in client satisfaction with home care delivery and guides subsequent interventions to address the inequalities according to the principle of proportionate universalism which suggests that health interventions and policies should not be targeted, but rather be universal with intensity and scale proportionate to the level of social need and/or disadvantage (Klepac Pogrmilovic et al., 2021; NHS, 2014; Wemrell et al., 2021). Also, studying the strata of diversity across intersections and adopting an intersectional perspective can make room for a more nuanced understanding of client satisfaction with home care in Canada; identifying and quantifying variances in the level of client satisfaction with home care across different client groups; and providing opportunities for testing community-based interventions to reduce inequalities and inequities in the home care system.

One of the harmonized principles for home care in Canada, is for home care to be integrated community-based care that meets client's needs through clinical and service-level planning and delivery across multiple professionals and organizations. Thus, what matters to Canadians is that home care team works together to help clients get home care and support needed outside the hospital (Canadian Home Care Association, 2017). This research therefore fits in the field of community development because community development recognizes and seeks to challenge inequalities and inequities that exist in human societies, and the way some people, subgroups or communities are oppressed or excluded, and thus ensures fairness for all citizens (SCDC, n.d.). This research can produce results that enhance quality of living for home care recipients, which is one of the principles of community development focusing on quality of living and well-being (Hasan, 2022a).

1.8 Structure of the Report

Chapter 2 contains a comprehensive critical review with relevant research and theories related to the research questions. The chapter focuses on the literature to support the understanding of client satisfaction with home care in relation to intersectionality of gender and Indigenous identity. Chapter 3 explains the research methodology, including data source, instrumentation, and data analysis processes used in the study. Chapter 4 provides the results of the analysis, and Chapter 5 details how the results of this study support or do not support studies discussed in the literature review.

2. Literature review

2.1 Introduction

The problem addressed in this thesis is inequality and inequity in client satisfaction with home care. The literature review is a critical review, with overarching purpose of providing a summary of the main studies and attempt to build on ideas and findings already developed. The review prioritizes studies related to home care system in Canada; factors associated with home care utilization; inequality or inequity in home care system; client satisfaction with home care and its determinants; Indigenous gender-based framework; and intersectional approach to research on home care and client satisfaction; and the gaps in knowledge. The review reveals strengths, weaknesses, contradictions, controversies, inconsistencies, and/or other important issues with respect to theories, hypotheses, research methods and results on intersectionality in client satisfaction with the home care system (Paré & Kitsiou, 2017).

2.2 Mapping the process.

The investigator used the University of Victoria Libraries Databases to locate PubMed database used to obtain scholarly articles, books, and other publications deemed relevant to the topic of study. The keywords used to search the databases are presented in Table 1. The UVic databases makes licensed resources available for the investigator's convenience and the use of these resources is voluntary. PubMed is a research database, for medical and biology resources (Indeed Editorial Team, 2022). The choice of PubMed was based on the inclination of this research to care. The search was limited to from 2013 to 2024. The database outputs were critically screened based on relevance by reading through the abstract and searching for the keywords.

Table 1. Search Strategy Keywords and Search results.

Keywords	PubMed search results
Home care	443,002
Home care in Canada	28,315
Client satisfaction with home care in Canada	14,033
Determinants of client satisfaction with home care	6,044
Client satisfaction with home care and its determinants	1,359
Intersectional theory, intersectional analysis or intersectionality or intersectional framework	3,739
Inequality in home care	1,037
Indigenous gender-based analysis	18
Community Development and Home care	16,931

2.3 Main Themes

Home care system in Canada

Home care has been a priority for all Canadians including patients, caregivers, health care providers, and governments (CHCA CFPC & CNA, 2016). It is run as a decentralized long-term care, like many other western countries. It makes recipients of the care feel more like a person than a patient (Smith-Carrier et al., 2017). A few years back (2015/2016), a descriptive analysis of home care use by socioeconomic characteristics and type of care showed that about 6.4% of households (881,800) in Canada received home care typically delivered by health care providers or volunteer organizations (formal home care) in the past year—prominently nursing (46%) and personal/home support services (46%) (Gilmour, 2018). Incidentally during the same period, the unmet needs for home care in the country were more prevalent among those needing "Personal or Home support" than among those needing home health care (nursing or palliative) (Gilmour, 2018b).

The costs of home care in the country are largely borne by governments and government support seems to be most inclined to covering the cost of home nursing care. Gilmour (2018) reported that households that only received home nursing care were more likely to have their costs entirely covered by government, while those that only received home support care were more likely to pay out-of-pocket costs (Gilmour, 2018). Similarly, over the last decade, more studies on home care have been devoted to nursing care and palliative or "end-of-life" care with little or no studies on "Personal or home support" (Andrade et al., 2017; Gomes et al., 2013; Parab et al., 2013; Sarmento et al., 2017), even though home nursing care (46%) and personal/home support services compare favorably as the formal home care most frequently received in the country (Gilmour, 2018a). In Canada, the governments run a home care program known as directly funded (DF) home care which provides funds to older people, people with disabilities, and caregivers to allow them to arrange their own assistance and services with their activities of daily living. However, a recent study on the program reports that there are still out-of-pocket expenses reported by most participants, with agency clients describing administrative fees (Kelly et al., 2023).

In 2020, the home care program in Canada suffered a significant set back from COVID-19 pandemic as the country recorded the worst statistics among wealthy nations for COVID-19-related deaths at the long-term care facilities for older people (Webster, 2021). One of the stakeholders blamed the incident on the lack of government oversight (resulting in under-training and poor treatment of caregivers, substandard and ageing facilities, overcrowding, and poor infection control capabilities) and accountability to residents of long-term care facilities, especially the privately owned, profit-oriented ones which accounted for slightly more than half of the facilities in the country (Webster, 2021).

However, in recent time, home care has been evolving with a wide range of innovative ideas to improve quality of care, job satisfaction for caregivers and client satisfaction for home care recipients. These ideas include the use a prediction tool (nomogram) or model for predicting the risk of deterioration on the Cognitive Performance Scale (CPS) score over six months among home care clients (Guthrie et al., 2023), and the use of mobile telepresence robots in long-term care (LTC) homes (Wada et al., 2023). Other innovative ideas for optimizing home care nursing include ensuring that home care nursing workforce works to full scope, ensuring appropriate staffing and skills mix working in teams, role clarity and leadership support, which are supported by technology and quality practice environments to meet the complex needs of clients needing home nursing care (Ganann et al., 2019).

Factors associated with utilization of home care

Individuals and families use home care for different reasons. Empirical studies have highlighted some of the factors influencing home care use. A study conducted to examine individual- and neighborhood-level racial, ethnic, and socioeconomic factors associated with the use of high-quality home health agencies showed that some of the disparities in high-quality agency use were attributable to neighborhood-level factors— racial composition and socioeconomic disadvantage (Fashaw-Walters et al., 2022). Another quantitative study conducted to identify the determinants of the propensity to receive publicly funded home care for the elderly in Canada linked household arrangement, dependence on help with activities of daily living, health status, and income with the propensity to receive both publicly funded home care (Mery et al., 2016). Household arrangement is further confirmed as a major driver of home care use according to a study that showed that households with parents and adult children (age 25 or older), one-person households, and households with lower socioeconomic status were most likely to have received formal home care (Gilmour, 2018).

Disability is one of the drivers of home care use. It often leads to dependence on help with activities of daily living. A retrospective incident cohort study conducted among clients with spinal cord injury in Ontario, Canada to describe utilization of home care shows that in the first 2 years, personal support/homemaking was the most utilized service (Chan et al., 2020). Another study on visual impairment revealed that the use of any home care (informal or formal) was greater in those with visual impairment than in those without visual impairment even after adjusting for demographics and health (Aljied et al., 2019).

Income and gender are another driver of home care use. A study conducted in Austria, analyzing the importance of older people's resources for the use of home care in a cash-for-care scheme, showed a pro-rich bias in home care use among single-living people, with high-income single people being less likely to move to a care home, while there are no significant income differences present for non-singles (Schmidt, 2017). The study also showed that female care recipients co-residing with a partner are more likely to use formal care than men, reflecting that men's traditional gender roles involve less unpaid care work than women's (Schmidt, 2017). Unlike gender, sex differences may not be playing any role in home care use. A quantitative

study conducted to assess sex differences in the quality of publicly funded home care services in Ontario, Canada found that in the adjusted analysis, sex differences have no significant association with home care quality indicators, unless in the unadjusted analysis.

Besides the sociodemographic and disability factors, extrinsic factors such as administrative barriers and inefficiency of agency providers could also influence the use of home care. A recent study on DF home care amplifies the significance of agency providers mediating some of the administrative barriers and emotional strain of using DF home care, especially for family caregivers who also work or have additional care responsibilities, to facilitate home use (Kelly et al., 2023). The study also highlights the general ineffectiveness of agencies in handling linguistic and/or cultural matching between workers and families, which is a major influencer of DF home care use (Kelly et al., 2023).

Inequality in home care system

Home care has its challenges despite its countless benefits. Empirical evidence from the literature also shows that home care system is generally prone to inequality. For instance, the home care system in Canada is somewhat underfunded, understaffed, and inequitable in access to care, while the policies strategically remain blinded to the harsh realities of the home care sector to justify cost cutting, deregulation, and privatization of services (Yakerson, 2019). Clients and their family members sometimes deliberately resort to DF home care because of their negative experiences with other public service options (Kelly et al., 2023). The inequality problems with home care however include inequities in rural access to home care, inequitable access to home care program by people of lower socio-economic backgrounds, and poor social outcomes for linguistics, cultural and sexual minorities (Chan et al., 2020). Home care especially the DF home care is also a privilege only afforded to some people (Kelly et al., 2023) to the extent that all public home care options need to be open to all who need it, regardless of their ability to pay, degree of social support, or competence in the English language given the growing inequalities that exist in Canadian society (Kelly et al., 2023).

At individual level, a study examined the inequality in home care and found that care types and resources among disabled older adults were unequal based on gender, marital status and socioeconomic status under the cultural phenomenon and contextual circumstances (Jang & Kawachi, 2019). In another study, an intersectional approach was used to examine social inequalities in loneliness among older adults receiving eldercare before and during the early phase of the COVID-19 pandemic. The results showed inequalities in loneliness arising particularly in the intersection of country of birth, income, and residential setting (Gustafsson et al., 2022). Another study examined the individual- and neighborhood-level racial, ethnic, and socioeconomic factors associated with the use of high-quality home health agencies and showed that inequalities or disparities in high-quality agency use attributable to neighborhood-level factors exist (Fashaw-Walters et al., 2022).

Client satisfaction with home care and its determinants

There is no denying the fact that home care has its challenges. However, studies have consistently reported high rates of client satisfaction with home care (Grant et al., 2015b, 2015a; Kelly et al., 2023; Kouli et al., 2013). A recent qualitative study on home care in Canada also documented high rates of satisfaction with home care regardless of whether clients use agency providers (Kelly et al., 2023). Perhaps there are factors influencing client satisfaction with home care despite its challenges. Studies have identified a few of the factors that could influence client satisfaction with home care. These include the presence of telehealth services which include the use of web portal for videoconferencing and electronic messaging between home care nurses and clients, ordering of health-related and home care, having access to health-related information and the Internet in home care agencies (Finkelstein et al., 2011; Grant et al., 2015b, 2015a); opting for directly-funded home care which is the Canadian niche option (Kelly et al., 2023); caregivers' or staff's behavior, attitude and skills and organizational aspects of home care (Kouli et al., 2013). Client satisfaction experience could also be influenced by diversity in the client's background characteristics such as gender, age, marital status, sexual orientation, race/ethnicity, pre-retirement occupation, source of financial resources, mode of residence, and culture (Hengelaar et al., 2023; Wang et al., 2024). Client satisfaction is also linked with client-centered home care because client-centered home care allows clients and their family members including partners to get involved in home care (Sanerma et al., 2020). Client satisfaction with home care may also improve when performance monitoring of home care centers is enhanced, when modern technologies are employed to promote and improve home care quality, when human resources are empowered, when insurance coverage for home care is provided, and when the bylaws are reviewed and decolonized (Shahriari et al., 2024).

However, there is still a gap in knowledge from this critical review as many previous studies reviewed are not able to provide a more nuanced understanding of client satisfaction experience with home care which rather comes from studying the effects of dimensions of diversity across the intersections of client's characteristics (Hengelaar et al., 2023). The gap in knowledge is further exacerbated by the paucity of studies on the use of intersectional frameworks for examining client satisfaction with home care among clients and studies using quantitative research methods to explore the intersectionality in client satisfaction with home care from clients' perspectives.

Indigenous Gender-Based Frameworks

Gender inequality persists in human societies possibly for many reasons including social defenses at different levels, and the equally resistant-to-change wider cultural beliefs (Padavic et al., 2020). Therefore, the need to address gender inequality in governmental policies, programs, and research cannot be overemphasized (Sanchez-Pimienta et al., 2021). In the same vein, there exists a dichotomy between the western worldview and the set of beliefs and values that are honored and withheld by several Indigenous societies (Joseph, 2016). The dichotomy generally makes the two worldviews subscribe to opposite approaches to knowledge, connectedness, and science (Joseph, 2016). In the context of Canada, the tools or frameworks required to address

gender inequality are expected to be culturally grounded, be able to account for the impacts of colonialism on Indigenous Peoples' lives and lands, and situate the understanding of gender identities, roles, and responsibilities within and across diverse Indigenous contexts (Rotz et al., 2022; Sanchez-Pimienta et al., 2021).

Although several Indigenous gender-based frameworks have been developed and used to inform several research and address gendered problems in human societies, few of these frameworks are reviewed in this section. Title IX is a policy analysis model developed and used in the United Sates, to address the problem of sexual harassment including intimate partner violence. The model incorporates Indigenous values, feminist perspectives, tribal critical race theory, and social construction and historical contexts. However, a study showed that despite the intentions of Title IX to promote Indigenous values of empowerment and interdependence, the model failed to account for the historical marginalization of certain Indigenous people and the tendency of those Indigenous women to distrust law enforcement. Another framework is Indigenous gender-based analysis (GBA) framework. The day-to-day principles and practices that may arise when implementing the framework in the context of research include embracing Two-Eyed Seeing or Etuaptmumk while making space for Indigenous leadership; trusting the expertise that stems from the lived experiences and relationships of researchers and team members; and shifting the emphasis from 'gender-based analysis' to 'gender-based relationality' in the implementation of gender-related research considerations (Sanchez-Pimienta et al., 2021). The AMBER framework (Aims, Methods, Barriers, Evidence for practice, and Research recommendations) is another innovative tool that has been used to research gender-based violence in the Global South with Indigenous communities and draw out the relevance for research practice. This framework outlines the objectives, methodologies, and challenges associated with participatory research in this context. It also provides best practice recommendations and directions for future research, focusing on ensuring safety of participants and researchers; redressing power inequalities within the research process; embedding locally responsive ethical frameworks; and understanding cultural context and respecting cultural norms (Thomas et al., 2022).

However, a study was conducted to critically examine the uptake and implementation of culturally relevant gender-based analysis (CRGBA) and practices of sex and gender analysis in health research. The study findings reveal that attention to date has focused on representation (human and data) while deeper justice issues that are attentive to intersectionality, positionality and reflexivity remain ambiguous (Rotz et al., 2022). For example, a study among the Inuit on smoking correlates, utilizing an Inuit social determinants of health framework, aimed to describe the associations between current smoking and selected socio-demographic characteristics among Inuit men and women aged 18 or older living in Inuit Nunangat. The study revealed that some smoking correlates were specific to one sex (Bougie & Kohen, 2018).

Significance of Home care in Community Development

Community development is a process and a holistic approach of empowering community members to be able to identify and proffer sustainable solutions to their problems by themselves

and or take collective actions on issues that are important to them with or without support from community development professionals or agencies (Smart, 2023). It is grounded on the principles of human rights, empowerment and resilience, community leadership and ownership, inclusion, social justice, self-determination, bottom-up approach, collective action, quality of living, community participation and engagement, community assets/capital and resource mobilization, partnership and collaboration, sustainability, respect for Indigenous and local culture (Hasan, 2022b).

Home care, being an array of health and support services provided in the home, retirement communities, group homes, and other community settings to people with acute, chronic, palliative, or rehabilitative health care needs (Canadian Home Care Association, 2017), situates well more as a community development work than as a community-based work. Home care as a community development work, is longer term in duration with desired outcomes of increasing the community members' capacities and bringing about change at neighborhood and community level. Also, in home care system, the power relations between community members and agency are constantly negotiated; problems or issues are first named by community before they are defined in a way that advances the shared interests of the community and the agency (Smart, 2023). For instance, optimal palliative care at home relies on close collaboration and communication among the patient, family, home care nurses, and the general practitioner (Danielsen et al., 2018). The DF home care which provides government funds to people who need assistance with the activities of daily living, allowing and empowering home recipients to arrange their own services, also presents home care as a community development work (Centre for Independent Living in Toronto (CILT), 2012).

2.4 Conclusion

Home care has been a priority for all Canadians including patients, caregivers, health care providers, and governments (CHCA CFPC & CNA, 2016). Individuals and families use home care for different reasons and empirical studies have highlighted some of the factors influencing home care use. Home care has its challenges despite its countless benefits. A recent qualitative study examined the challenges of home care and identified two main categories of challenges – infrastructural challenges and challenges related to the processes of home care services provision comprising challenges of improving the quality of home care services and the challenge of facilities for service provision (Shahriari et al., 2024). Despite the challenges of home care, studies have consistently reported high rates of client satisfaction with home care (Grant et al., 2015b, 2015a; Kelly et al., 2023; Kouli et al., 2013). Studies have also identified several factors influencing client satisfaction with home care, such as client's background characteristics, efficiency of agency, improvement in service delivery, use of technology, etc.

Gender inequality persists in human societies because of many reasons including social defenses at different levels, and the equally resistant-to-change wider cultural beliefs (Padavic et al., 2020). The dichotomy between the Indigenous and the Western worldviews (Joseph, 2016) is

not likely disappear. Therefore, these social inequalities underscore the need for frameworks which are culturally grounded, able to account for the impacts of colonialism on Indigenous Peoples' lives and lands, and situate the understanding of gender identities, roles, and responsibilities within and across diverse Indigenous contexts (Rotz et al., 2022; Sanchez-Pimienta et al., 2021).

2.5 Analytical Framework

Although it seems as though few investigators have used an intersectional framework to examine client satisfaction with home care (Greenwood et al., 2017; Hengelaar et al., 2023; Tong et al., 2016; Wittenberg et al., 2019), there are more of such studies among caregivers than among clients. Meanwhile, those who used the framework to examine client satisfaction among clients used qualitative research methods instead of quantitative methods (Kelly et al., 2023; Tong et al., 2016). One of the studies reported that clients and family caregivers identified three types of safety concerns (physical, spatial, and interpersonal) which were largely multi-dimensional and intersectional (Tong et al., 2016). A more recent study also used intersectional framework to examine if and how intersecting social identities could predict home care use among older Canadian adults (Vafaei et al., 2023). Another study employed an intersectional approach to investigate social inequalities in loneliness among older adults receiving eldercare in Sweden, both before and during the early phase of the pandemic. The study findings showed inequalities in loneliness arising particularly in the intersection of country of birth, income, and residential setting (Jang & Kawachi, 2019).

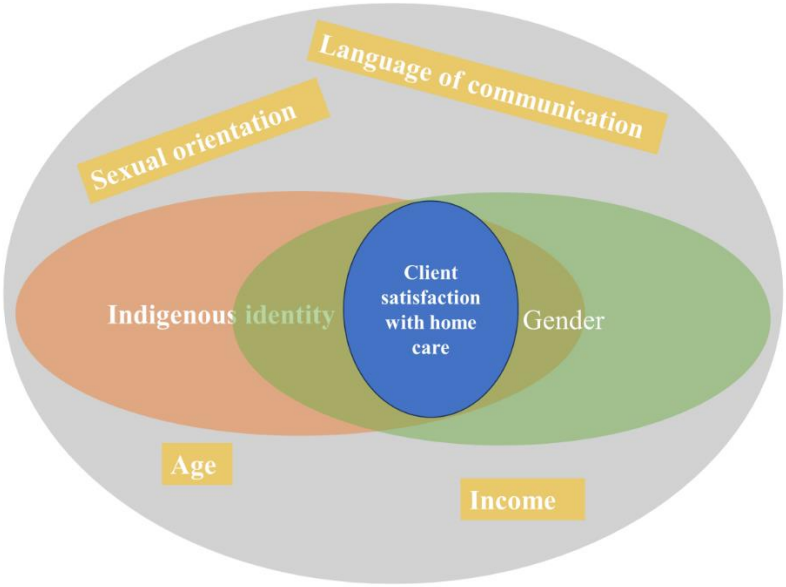


Figure 1 Analytical framework for analysis of client satisfaction with intersectionality of gender and Indigenous identity.

Figure 1 presents the analytical framework for the study based on the principle of intersectional categories. The framework explored the relationship between client satisfaction with home care and intersectionality of gender and Indigenous identity. The framework also considers some other variables that could modify or compound the relationship between client satisfaction with home care and the intersectionality of gender and Indigenous identity.

3. Methodology and Methods

Client satisfaction remains an integral component of home care, serving as an indicator of the quality of care or service quality (Laferriere, 1993). Hence, Statistics Canada periodically conducts surveys in the country to identify which groups are receiving home care and which groups are not; to determine the health status of the groups; compare how the groups are using other health services and understand whether homecare is working as planned (Statistics Canada, 2021). Given the significance of client satisfaction, many empirical studies have been conducted to develop and test the reliability and validity of different instruments for measuring homecare client satisfaction (Geron et al., 2000; Hsieh, 2017; Laferriere, 1993; Westra et al., 1995). Therefore, the problem addressed in this study was measuring and analyzing client satisfaction with home care with an intersectionality framework of gender and Indigenous identity to see if inequality exists in client satisfaction with home care among different intersectional strata of the population of home care recipients in Canada.

3.1 Methodology

The researcher therefore considered quantitative research and a secondary survey analysis as more appropriate research methodology to address the research problem. The researcher also considered qualitative data analysis as more appropriate since the study data were quantitative. The research methodology—Secondary Survey Analysis of pre-collected nationally representative survey data in original research— created an opportunity for the researcher to complete the research thesis economically in terms of money and time (Kiecolt & Nathan, 2011). The research methodology primarily entailed the use of data collected by other researchers to address different questions (Wickham, 2019).

The 2021 CCHS microdata was required for the research because it was recent and available for use on request. The primary reason for choosing the CCHS microdata –as opposed to alternative data access methods such as Public Use Microdata Files, Remote Access, or custom tabulations– was its ability to provide relevant information about the characteristics of the survey respondents such as the level of satisfaction with the home care received, gender, Indigenous identity, including age, income, sexual orientation, and language. The selected variables and data allowed an in-depth understanding of the interaction between the level of satisfaction with the home care received and the intersections between gender and Indigenous identity, while keeping other variables controlled or constant (World Bank, n.d.).

The study dataset was devoid of personally identifiable information (PII) such as name, address, phone number, email, social insurance number, etc. The dataset and the analysis outputs were also subjected to a thorough vetting procedure by the UVic RDC Data analyst to guarantee the confidentiality of the original respondents, and the weighted analysis outputs were allowed to be used for the study findings.

3.2 Methods

An application for the use of the 2021 Canadian Community Health Survey (CCHS) data was submitted to Statistics Canada to access the dataset. After obtaining the approval and gaining access to use the data, the dataset was reviewed and processed to meet the current study objective. The 2021 CCHS covered the population 12 years of age and over living in the ten provinces and the three territories. Excluded from the survey's coverage were persons living on reserves and other Aboriginal settlements in the provinces (according to the 2021 Census of Canada, about 37.5% of persons who are registered under the Indian Act of Canada live on reserve). Full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that were living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James were also excluded from the survey's coverage. Altogether, these exclusions represented less than 3% of the Canadian population aged 12 and over (Statistics Canada, 2021).

Each component of the CCHS questionnaire was developed in collaboration with specialists from Statistics Canada, other federal and provincial departments and/or academic fields. The CCHS questionnaire comprised groups of questions (referred to as modules), which focused on a particular theme of health. The modules comprised general health, chronic conditions, smoking, alcohol use, food security, home care, sedentary behavior and depression, and other respondent characteristics such as labor market activities, income, and sociodemographic (Statistics Canada, 2021).

3.3 Data Analysis

The study dataset which was "Home care recipient" specific was extracted from the larger 2021 Canadian Community Health Survey (CCHS) dataset. The study dataset has observations from all the provinces and territories except Nunavut and the Northwest Territories. Six dummy variables (intersectional strata) were created from intersecting the gender variable with the Indigenous identity variable as follows: *Indigenous men, Indigenous women, non-Indigenous men, non-Indigenous women, men with other identities and women with other identitie*s. The men and women with other identities were individuals who answered, "*Don't know*" or "*Refused to answer*" to the Question **SDC_Q015A**: "*Are you an Aboriginal person?*". The intersectional strata (dummy variables) were the primary independent variables while the dependent variable was "client satisfaction", a dummy/binary variable 1"Satisfied" and 0 "Not satisfied/undecided". The dependent variable was derived from the original variable which had four categories (HMC_Q030 Overall, what was the level of satisfaction for the home care services received? 1: Very satisfied, 2: Somewhat satisfied, 3: Neither satisfied nor dissatisfied, 4: Somewhat dissatisfied; and 5: Very dissatisfied). Other variables in the dataset considered as covariates were age (continuous numeric), income (continuous numeric), sexual orientations (a categorical variable split into dummy variables), and language often spoken (a categorical variable split into dummy variables). Descriptive statistics (frequency, percentage, mean and standard deviation) were used to summarize the data and the results are presented in tables and charts in the finding

section. A simple linear regression was used to regress client satisfaction on the intersectional strata (dummies) using “men with other identities” as the reference category. The selection of “men with other identities” as the reference group was randomly selected by the statistical software. A multiple linear regression model was also fitted to control for the effect of respondents’ age, income, language often spoken, and sexual orientation on the relationship between client satisfaction and the intersectional strata. Unlike more the complex models, a linear regression was used because it is a relatively easier concept to understand and apply, and its model generates an equation that shows how one variable affects another variable. The standard errors were also clustered with a variable that contained all provinces and the Yukon as units. The analyses were done with Stata SE version 13. Statistical significance was set at $p<0.05$.

3.4 Reliability and Validity: Establishing Credibility

The 2021 CCHS was a cross-sectional survey with a stratified sample and cross-sectional design, which collected information related to health status, health care utilization and health determinants for the Canadian population (Statistics Canada, 2023). The development of each content component of the CCHS questionnaire was collaboratively done by specialists from Statistics Canada, other federal and provincial departments and/or academic fields (Statistics Canada, 2023). The data collection was designed as such that questions were answered directly by the respondent via an online electronic questionnaire (EQ) complemented with follow-up phone calls or in-person visits by Statistics Canada interviewers using the same questionnaire to address non-responses (Statistics Canada, 2023). Non-sampling errors were minimized by ensuring that throughout the data collection process, control and monitoring measures were put in place and corrective action was timely taken (Statistics Canada, 2021, 2023).

3.5 Strengths and Limitations

Limitations – One of the limitations of the study was restricting the study to the available variables and records/cases in the primary dataset. The additional variable (s) of interest were derived or created from the existing variables. The study inherited both the systematic and the random errors in the original dataset. The apparent lack of data triangulation for the data was another limitation of the research methodology. In addition, the dataset was weighted because of confidentiality issues, so weighted outputs were reported instead of unweighted outputs. Lastly, excluding persons living on reserves and other Aboriginal settlements in the provinces from the survey's coverage conducts to incomplete and potentially misleading conclusions and understanding of client satisfaction among Indigenous populations. Indigenous individuals living on reserves and settlements may have different experiences and levels of satisfaction compared to those living off-reserve. Their exclusion means that the survey does not fully represent the diverse Indigenous population.

Strengths – The use of secondary data for the study was quite cost-effective as it saved the researcher another cost and time of conducting survey and collecting data. It also provided opportunities to work with a large dataset and perform statistical analysis with a robust dataset

that could produce estimates with good precision (reduced standard deviation). The study leveraged the strength of the methodology and sample size of the primary survey. It also provided opportunities to generate a new hypothesis, clarify the research question, avoid overburdening sensitive populations or investigate sensitive areas (Wickham, 2019).

4. Findings

4.1 Introduction

This section provides answers to the five research questions stated in the section 1.3. The findings include the general characteristics of the study population, the description of the type of care received by the respondents, the distribution of respondents by intersection strata (intersection of gender and Indigenous identity), and the level of client satisfaction in each intersectional strata and the overall level of client satisfaction. A simple linear regression model containing client satisfaction as the outcome variable and the intersectional strata is also presented; as well as the multivariate linear regression model comprising client satisfaction as the outcome variable, the intersection strata as the independent variables, adjusting for the control variables –age, income, sexual orientation, and language often spoken.

4.2 Main findings

Table 2 presents the summaries of socio-demographic and socio-economic characteristics of the respondents (home care recipients). Their mean age with its standard deviation was 59.3±20.4 years and their mean income was $112,419.67. Slightly more than half of the respondents were females. While about 3.3% of the respondents identified as Indigenous, the majority (75%) identified as non-Indigenous. More than two-third (68%) of the respondents could only speak English Language (s) well enough to conduct a conversation, meanwhile, about 16% could speak both English and French, and 14% could only speak French well enough to conduct a conversation. Most of the respondents were heterosexual (83%).

Table 2. Socio-demographic and socio-economic characteristics of the respondents

	Mean*	Standard deviation*
Age (years)	59.3	20.4
Income ($)	112,419.67	268,339.31
	N*	%*
Gender identity		
Men	737542	44.3
Women	926674	55.7
Are you an Indigenous person		
Yes	54741	3.3
No	1251227	75.2
Refused to answer/Don't know (Other identities)	358248	21.5
Language (s) spoken well enough to conduct a conversation		
English only	1131197	68.0
French only	226532	13.6
Both English and French	264668	15.9
Neither English nor French	23845	1.4
Others	17973	1.1
Sexual orientation		
Heterosexual	1375510	82.7
Gay & Lesbian	25645	1.5
Bisexual & Pan sexual	29353	1.8
Sexual orientation not elsewhere classified	11441	0.7
Others/VS/DK/R/NS	222265	13.4
N*	1664216	

*Weighted estimates

Figure 2. Distribution of respondents by type of home care received in the last 12 months.

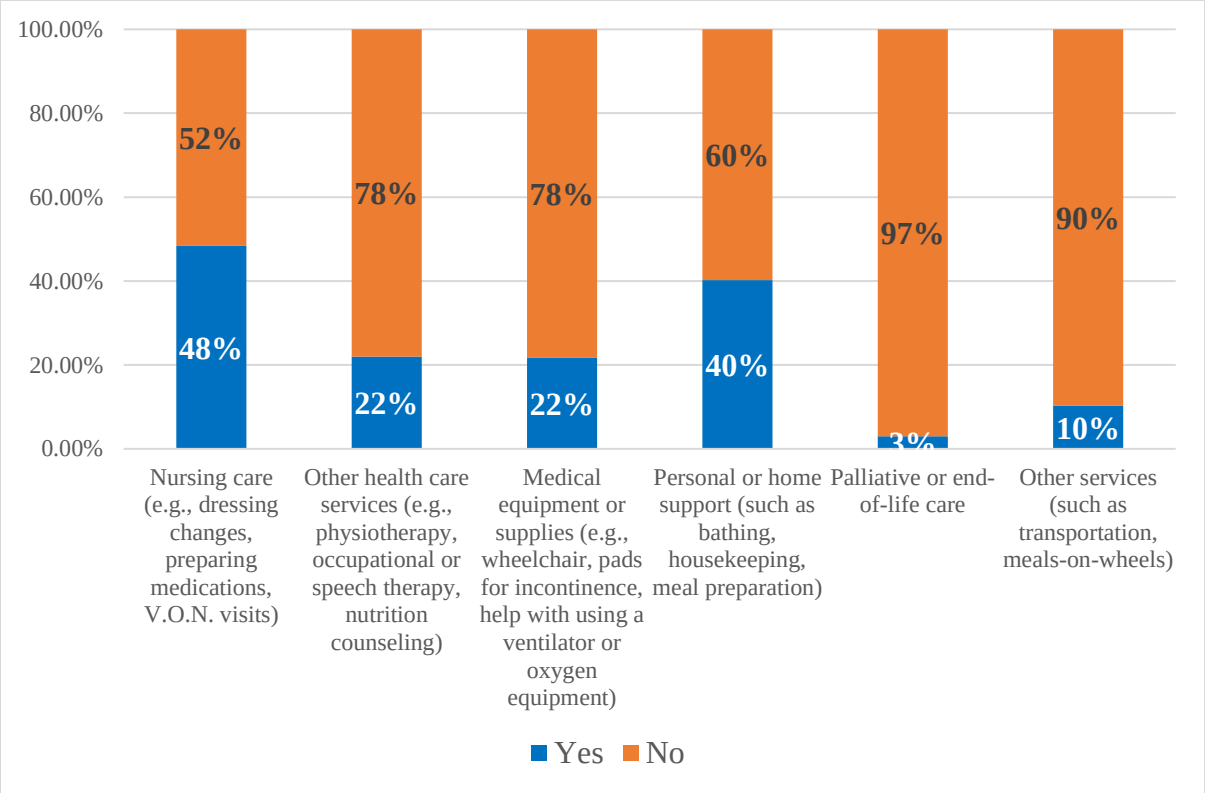


Figure 2 presents the multiple responses of the respondents on the type of home care received in the last 12 months. About 48% of the respondents received nursing care, about 40% received personal or home support, and very few (3%) received palliative or end of life care.

RQ1: What was the level of client satisfaction among home care recipients in the last 12 months?

Table 3 presents the distribution of the respondents by their level of satisfaction with home care received in the last 12 months in response to the 1st Research question. About 64% of the respondents were very satisfied with home care while about 26% were somewhat satisfied with the home care they received in the last 12 months. Overall, about 90% of the respondents were reportedly satisfied (very satisfied and somewhat satisfied combined) with home care received in the last 12 months. Very few respondents (2.6%) were neither satisfied nor dissatisfied. Those that were dissatisfied with the home care received accounted for about 5% of the respondents.

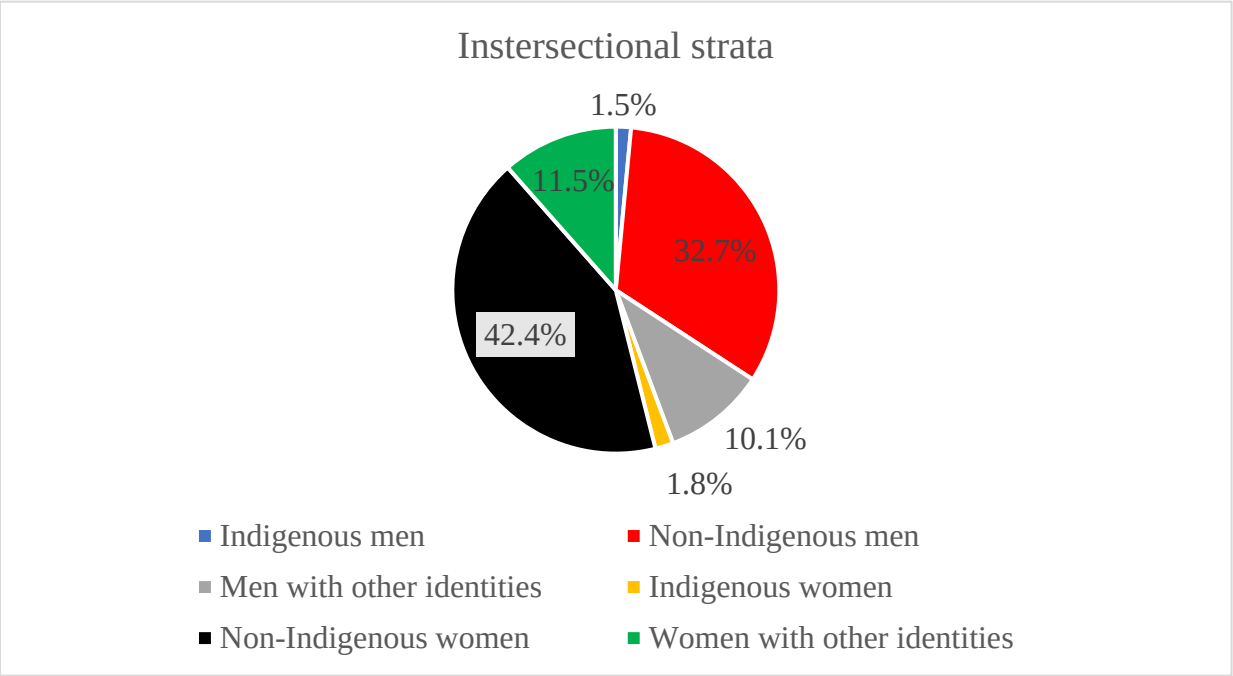
Table 3. Distribution of respondents by level of satisfaction with home care received.

Satisfaction home care received	N	%
Very satisfied	1072105	64.4
Somewhat satisfied	427226	25.7
Neither satisfied nor dissatisfied	42878	2.6
Somewhat dissatisfied	58388	3.5
Very dissatisfied	26935	1.6
Missing	30128	1.8
Refused to answer	1119	0.1
Don't know	5437	0.3
Overall satisfied	**1499331**	**90.1**

RQ2: What was the distribution of home care recipients by the strata of intersectionality of gender and Indigenous identity?

Figure 3 presents the distribution of study respondents by intersection of their gender and Indigenous identity in response to the 2nd research question. About 42% and 33% of the respondents were non-Indigenous women and non-Indigenous men respectively. The Indigenous men and the Indigenous women respectively accounted for about 1.5% and 1.8% of the study participants. Men and women who were neither Indigenous nor non-Indigenous respectively accounted for about 10% and 12% of the study respondents.

Figure 3. Distribution of respondents by intersection of gender and Indigenous identity



RQ3: What were the level of client satisfaction with home care in each of the strata of intersectionality of gender and Indigenous identity?

Table 4 shows the level of client satisfaction with home care across the six intersectional strata. The non-Indigenous men had the highest proportion (90.7%) of home care recipients who were satisfied with the home care received. Next to the non-Indigenous men, were the women with other identities and non-Indigenous women who respectively had 90.4% and 90.1% of their subgroups expressing satisfaction with home care received in the last 12 months. However, the Indigenous women and the Indigenous men respectively had 88.8% and 82.0% of their subgroups expressing satisfaction with home care received in the last 12 months.

Table 4. Proportion of respondents who were satisfied with home care received in the last 12 months.

Intersectional strata	Satisfied with home care	
	n*	%
Indigenous men	20645	82.0
Non-Indigenous men	494125	90.7
Men with other identities	149502	89.2
Indigenous women	26260	88.8
Non-Indigenous women	636447	90.1
Women with other identities	172352	90.4

RQ4: Does the level of client satisfaction with home care vary significantly across different strata of intersectionality of gender and Indigenous identity?

H4o: The level of client satisfaction does not significantly vary across different strata of intersectionality of gender and Indigenous identity.

H4a: The level of client satisfaction significantly varies across different strata of intersectionality of gender and Indigenous identity.

Table 5 provides answer to the 4th Research question. The linear regression analysis shows that relative to “Men with other identities”, the Indigenous men, the Indigenous women, the non-Indigenous men, and the non-Indigenous women significantly had a 15.9 percentage point, a 9.3 percentage point, a 7.5 percentage point, and a 7.5 percentage point lower satisfaction with home care respectively. The regression results therefore indicated that the level of client satisfaction did vary significantly across different strata of intersectionality of gender and Indigenous identity. Thus, the null hypothesis was rejected, and it is concluded that the level of client satisfaction varies significantly across the different intersectional strata (groups) of home care recipients.

Table 5. Linear regression of client satisfaction on the intersectional strata

	Simple Linear regression			
Intersectional strata	β	95% CI		P value
Indigenous men	-0.159	-0.300	-0.018	0.031
Non-Indigenous men	-0.075	-0.136	-0.013	0.022
Indigenous women	-0.093	-0.172	-0.014	0.026
Non-Indigenous women	-0.075	-0.130	-0.019	0.013
Women with other identities	0.019	-0.030	0.069	0.399
Constant	0.980	0.931	1.030	0.000

Reference category: Men with other identities.
R-squared=0.0019, Root MSE=0.294. Standard Error adjusted for 11 clusters in Provincial variable.

RQ5: Does the level of client satisfaction with home care vary significantly across different strata of intersectionality of gender and Indigenous identity after controlling for other factors?

H5o: The level of client satisfaction does not significantly vary across different strata of intersectionality of gender and Indigenous identity after controlling for other factors.

H5a: The level of client satisfaction significantly varies across different strata of intersectionality of gender and Indigenous identity after controlling for other factors.

Table 6 presents the results of the multivariate linear regression of client's satisfaction with home care on the intersectional strata, controlling for age, income, languages, and sexual orientations and adjusting for the clustering effect of the provinces. The analysis however showed that the both the Indigenous women and the non-Indigenous women respectively and significantly ($p<0.05$) had a 9.6 percentage point and 10.2 percentage point lower satisfaction with home care relative to men with other identities, controlling for other age, income, languages, and sexual orientations and adjusting for the clustering effect of the provinces.

The regression results therefore indicated that the level of client satisfaction did vary significantly across different strata of intersectionality of gender and Indigenous identity after controlling for age, income, languages, and sexual orientations. Thus, the null hypothesis was rejected, and it is concluded that the level of client satisfaction varies significantly across the different intersectional strata (groups) of home care recipients after controlling for age, income, languages, and sexual orientations.

Table 6. Multiple linear regression model of client satisfaction with home care in Canada

	B	Robust S.E.	95% CI		p-value
Intersectional strata					
Indigenous men	-0.145	0.068	-0.299	0.007	0.061
Non-Indigenous men	-0.097	0.044	-0.196	0.000	0.052
Indigenous women	-0.096	0.036	-0.178	-0.014	0.025
Non-Indigenous women	-0.102	0.038	-0.188	-0.015	0.025
Women with other identities	-0.001	0.043	-0102	0.090	0.887
Age	0.001	0.001	-0.001	0.005	0.244
Income	-5.94e-08	6.77e-08	-2.10e-07	9.14e-08	0.401
English only **spoken well enough to conduct a conversation**	0.006	0.029	-0.058	0.072	0.825
French only **spoken well enough to conduct a conversation**	0.048	0.037	-0.035	0.132	0.229
Both English and French **spoken well enough to conduct a conversation**	0.004	0.041	-0.088	0.097	0.921
Neither English nor French **spoken well enough to conduct a conversation**	0.076	0.101	-0.150	0.302	0.470
Heterosexual	0.030	0.016	-0.007	0.068	0.106
Homosexual	0.116	0.024	-0.061	0.171	0.001
Bisexual	-0.203	0.093	-0.410	0.004	0.054
Other sexual orientations	0.160	0.044	0.060	0.260	0.005
Constant	0.886	0.084	0.698	1.074	0.000

Reference category: Men with other identities.
Adjusted R-squared=0.0349, Root MSE=0.289, Standard Erro adjusted for 11 clusters in Provincial variable.

4.3 Summary

According to the findings of this study, the overall level of client satisfaction with home care among home care recipients in the last 12 months was about 90%. The distribution of home care recipients by the strata of intersectionality of gender and Indigenous identity as shown by the frequency distribution showed that the non-Indigenous men and women respectively accounted 42% and 33% of the home care recipient population. On the other hand, the Indigenous men and women respectively accounted for 1.5% and 1.8% of the home care recipient population. The men and women with other identities respectively accounted for the remaining 10% and 12% of the home care recipient population.

Looking at the level of client satisfaction with home care in each of the strata of intersectionality of gender and Indigenous identity, the non-Indigenous men seemed to have the highest proportion (90.7%) of home care recipients who were satisfied with the home care received in the last 12 months, while the Indigenous men seemed to have the lowest proportion (82.0%) of home care recipients who were satisfied with the home care received in the last 12 months. The multiple linear regression model without the covariates however confirmed that the level of client satisfaction with home care varied significantly across the different strata of intersectionality of gender and Indigenous identity. The crude estimates showed that the non-Indigenous men, the non-Indigenous women, the Indigenous men and the Indigenous woman respectively had a 15.9 percentage point, a 9.3 percentage point, a 7.5 percentage point, and a 7.5 percentage point lower satisfaction with home care received in the last 12 months relative to men with other identities (the reference category).

However, when covariates such as age, income, sexual orientation, and language of spoken were introduced into the regression model, the adjusted estimates showed that only the Indigenous women and the non-Indigenous women significantly ($p<0.05$) had a 9.6 percentage point and 10.2 percentage point lower satisfaction with home care respectively, relative to the men with other identifies. The adjusted R-squared of the multivariate model is very low, suggesting that the model could only explain about 3.5% of the variance in client satisfaction with home care.

5. Discussion and Analysis

This section aims to interpret and describe the significance of the findings of this research considering what was already known about the research problem investigated and to explain the new understanding and insights that emerged because of studying the problem. Home care has been and may remain a priority for all Canadians including patients, caregivers, health care providers, and governments (CHCA CFPC & CNA, 2016). Home care has its challenges despite its countless benefits. Despite the challenges of home care, studies have consistently reported high rates of client satisfaction with home care (Grant et al., 2015b, 2015a; Kelly et al., 2023; Kouli et al., 2013). Studies have also identified several factors influencing client satisfaction with home care, such as client's background characteristics, efficiency of agency, improvement in service delivery, use of technology, etc. Given the scale of home care program in Canada, this research investigated the existence of inequality in client satisfaction with home care among home care recipients using an intersectional framework of gender and Indigenous identities. Five research questions were posed and answered to achieve the goal of this research which was to analyze client satisfaction with home care with intersectionality of gender and Indigenous identity of home care recipients in Canada to determine inequalities in client satisfaction with home care.

This study applied the concept of intersectionality to describe how systems of inequality based on gender and Indigenous identity "intersect" to create unique dynamics and effects that could influence client satisfaction with home care. Because these inequalities can mutually reinforce each other, they thus need to be analyzed and addressed simultaneously to prevent them from reinforcing each other. Similarly in the context of client satisfaction with home care, one form of inequality is likely to be reinforced by other forms of inequality; so, tackling one form of inequality separately – without including the other dimension, – could be ineffective and inefficient if the goal is to improve client satisfaction with home care across different subgroups of home care recipients (Center for Intersectional Justice, n.d.).

5.1 Answering the Research Questions

There is no gainsaying the fact that the level of client satisfaction with home care in Canada is high. Previous studies have reported a high level of client satisfaction with home care (Grant et al., 2015b, 2015a; Kelly et al., 2023; Kouli et al., 2013a). The current study also confirms the high level of client satisfaction with home care even across the different intersectional strata. The observed high level of satisfaction could be due to the DF home care program which allows adults with physical disabilities to take full responsibility for managing a budget, hiring, and supervising their own attendants (Centre for Independent Living in Toronto (CILT), 2012). A recent study also showed that families and clients are more satisfied with DF home care especially as compared to government home care services due to the improved consistency and increased flexibility in the timing and types of their care workers can do (Kelly et al., 2023).

Client satisfaction with home care is high among home care recipients.

The high level of client satisfaction therefore has some implications for monitoring the overall goal of home care program and quality control. Statistics Canada periodically conducts surveys in the country to identify which groups are receiving home care and which groups are not; to determine the health status of the groups; compare how the groups are using other health services and understand whether homecare is working as planned (Statistics Canada, 2021). So, as an indicator of quality of home care, achieving high level of client satisfaction with home would make everyone believe home care is working as planned. However, the flipside of the implication is that if a high level of client satisfaction is consistently obtained in a population of home care recipients having some subgroups overrepresented and other underrepresented, and the high level of client satisfaction is not consistent across the subgroups, then the high level of client satisfaction with home care becomes a hoax.

There might be an inequitable access to home care among potential home care recipients.

As seen in this study, the distribution of home care recipients by the strata of intersectionality of gender and Indigenous identity clearly shows that some subgroups especially the non-Indigenous men and women could be overrepresented in the home care recipient population in Canada. Meanwhile, some other subgroups such as the Indigenous men, the Indigenous women, the men with other identities and women other identities respectively could be underrepresented. The underrepresentation of those subgroups of home care recipients could have serious implications on the surveys being conducted by Statistics Canada in identifying which groups are receiving home care and which groups are not; in determining the health status of the groups; and in comparing how the groups are using other health services to understand whether home care is working as planned (Statistics Canada, 2021). Another implication of the underrepresentation is that it suggests the possibility of inequitable access to home care by some subgroups. The inequitable access could however arise from the economic inequalities among these subgroups, which could make some subgroups more unable to purchase services from agencies primarily to reduce the administrative burden and stress of arranging DF home care as an individual employer (Kelly et al., 2023). Another previous study had also underscored the need to continuously monitor access to DF programs by people of lower-socioeconomic backgrounds in Canada and the need to discourage any policy design that would require independent self-management and could disadvantage people with compromised decision-making capacities (Kelly et al., 2021).

There might be inequalities in client satisfaction with home care among home recipients.

The study findings therefore suggest that inequalities exist in client satisfaction with home care among home care recipients when they are examined through the intersectional framework of gender and Indigenous identity. Based on the findings of this study, the Indigenous women and the non-Indigenous women seem to be the subgroups that might not be too satisfied with home care. Although, providing definitive explanations for these findings might be uneasy based on

the scope of this study and the paucity of previous studies that compare favourably with the current study, a previous similar study conducted to identify the predictors of satisfaction with prenatal care among Canadian women identified improving quality of care, provider interpersonal style and patient-centered decision making, and improving the structural characteristics of care as significant predictors of women's satisfaction and utilization of care (Gregory et al., 2020).

Generally, previous studies are quite equivocal about how gender and Indigenous identity relate to home care satisfaction. For instance, a study reported that home care satisfaction was not related to gender or race (Geron et al., 2000b), but another study associated home care satisfaction with ethnicity (Townsend & Kosloski, 2002). The major gap in most of these previous studies is the non-use of intersectional framework to combine some of these characteristics together, especially gender with Indigenous identity or other factors, to create more realistic individuals and subgroups to be studied. The current study however examined client satisfaction in each of the intersectional strata created. The data analyzed in this study suggest that gender on its own might not be an important factor to consider when studying client satisfaction with home care, but based on the findings of this study, it could an important factor to consider from an intersectional perspective.

Indigenous identity on the other hand is a construct that is grounded on the issue of worldviews. It is intuitive to acknowledge the conflict between different worldviews, and its potential influence on client satisfaction with home care. At the barest minimum, the Indigenous worldviews distinctively differ from the Western worldviews in many ways. For instance, in the Indigenous worldview, feeling comfortable is measured by the quality of one's relationships with people, while in the Western worldview, feeling comfortable is related to how successful one feels one has been in achieving one's goals (Joseph, 2016). Combining these two intrinsic factors from an intersectional perspective could create some kind of unique dynamics and effects. Additional inquiry is necessary to delve into the unique perspectives of individuals across diverse intersectional backgrounds, particularly examining how Indigenous identity and gender intertwine to shape their perspectives. These viewpoints may significantly impact how they perceive client satisfaction with home care services. This research not only highlights disparities in client satisfaction levels among different subgroups, such as Indigenous and non-Indigenous women. It also proposes that the interplay of gender and Indigenous identity among home care recipients influences their exposure to factors which either bolster or diminish client satisfaction levels. These exposures could accumulate over time, impacting the behaviors, conditions, and outcomes observed in client satisfaction with home care (NHS, 2014).

The main point being made therefore is that combining the inequalities in the intrinsic factors such gender and Indigenous identity using an intersectionality framework can provide a much deeper insight into the entrenched inequality that exists with client satisfaction with home care in the country. The findings of this study may have several implications for home care system in the country. However, beyond the intrinsic factors, the literature is replete with inexhaustible list

of extrinsic factors that influence client satisfaction with home care. Some of these extrinsic factors include technical quality of care, interpersonal relationships, communication, support and guidance, delivery of consumables, use of equipment, care worker's behavior, attitude, and skills (Kouli et al., 2013b; Laferriere, 1993b; Ponsignon et al., 2023). If the extrinsic factors were to be juxtaposed with the intersectional strata in the current study, it could be deduced that home care recipients in each of the intersectional strata may respond uniquely and differently to some of these core concepts of client satisfaction with home care. Thus, one of the implications of these findings is that using "one size fits all" approach to programming for home care may prove inadequate because of the inherent diversity among home care recipients, particularly concerning their levels of client satisfaction within the intersection of gender and Indigenous identities. Home care recipients are heterogeneous, existing along a continuum, each with their own unique experiences, needs, and perspectives shaped by the interplay of their gender and Indigenous identities. Therefore, an attempt to apply a uniform approach to programming may prove abortive because it may fail to acknowledge and accommodate these varying levels of satisfaction and the nuanced factors that contribute to them. Therefore, a more tailored, culturally sensitive, and inclusive approach to programming is needed to address the diverse needs and preferences of home care recipients, especially the least satisfied. This approach should recognize and respect the intersectionality of identities, ensuring that services are adapted to meet the specific requirements of individuals situated within different gender and Indigenous identity intersections. By doing so, home care providers can better address the unique challenges and promote greater satisfaction among all recipients.

5.2 Strategic Implications

The findings of the current research have a few strategic implications. The high client satisfaction in home care implies enhanced care quality, ongoing quality improvement efforts, and strong trust in the system, potentially leading to improved health outcomes and lower healthcare costs. However, the underrepresentation of certain subgroups may signal inequitable access, potentially exacerbating health disparities, increasing caregiver burden, and raising healthcare costs. The disparities in client satisfaction could further widen health inequalities, erode confidence in the home care system, pose ethical and legal challenges, and create difficulties in resource allocation.

The study findings also have implications for planning and decision-making by families of home care recipients, caregivers and home care agencies seeking to improve quality of care and increase client satisfaction. For instance, knowing that being an Indigenous or non-Indigenous woman is associated with being least satisfied with home care is valuable information to families, caregivers, and agencies. Reducing the social gradient in the level of client satisfaction with home care however requires universal intervention with a scale and intensity which is proportionate to the level of disadvantage. Therefore, these findings implies that home care is universally available not only for the most dissatisfied but also able to respond to the level of presenting needs of every home care recipient (NHS, 2014).

The study findings could also trigger further research on intersectional analysis of client satisfaction with home care to either validate or dispute the findings of this study, and to know further beyond knowing who could be more satisfied to why are they more satisfied with home care.

5.3 Limitations of Analysis

The analysis faced several limitations, including econometric challenges such as heteroscedasticity (unequal variance of errors across observations in a regression model), an imbalanced dataset, a low adjusted R-squared statistic, and the omission of some control variables (such as provinces and territories, and area of residence—rural and urban) that could affect the results if included. The dataset was imbalanced due to the underrepresentation of some intersectional strata and the overrepresentation of respondents who were satisfied with home care. The low adjusted R-squared statistic of the study model indicates that more factors need to be included in the model to better explain the variance in client satisfaction. These limitations could reduce the generalizability of the study findings by negatively impacting the accuracy of the regression models, potentially leading to overfitting the majority class, and ignoring the minority class.

5.4 Areas for Further Research

The purpose of this quantitative research was to use the intersectional framework of gender and Indigenous identity to analyze client satisfaction with home care among home care recipients and determine if there was any significant difference suggesting inequalities in client satisfaction with home care. This study was to establish that client satisfaction with home care differed across the intersectional strata, suggesting the existence of inequalities in client satisfaction among different subgroups. The study therefore identified the Indigenous and the non-Indigenous women as having the negative propensity to be satisfied with home care.

Therefore, future studies should examine the same study using primary data and adequate sample size which would preclude the problem of imbalanced dataset. Future studies should also examine the same study using a qualitative research design and community-based participatory research (CBPR) which is a relevant, important, and promising research framework that can guide the implementation of more effective, culturally appropriate, socially just, and sustainable community-based research (Collins et al., 2018). The findings of these different research designs and frameworks should also be compared.

5.5 Summary and Revisiting the Analytical Framework

The current study used the intersectional framework of gender and Indigenous identity to analyze client satisfaction with home care. The framework created a construct from the gender identities and the Indigenous identity of home care recipients that shaped the individual home care recipient and group exposures to the unknown factors which promoted or eroded client satisfaction, with those exposures accumulating over time to generate the behaviours, conditions

and outcomes known as client satisfaction with home care (NHS, 2014). The framework also considered some other variables that could modify or compound the relationship between client satisfaction with home care and the intersectionality of gender and Indigenous identity.

Considering the insights gleaned from this study, it is imperative for future research to reassess the analytical framework used in this study. This involves expanding the scope of intersectional factors beyond gender and Indigenous identities to encompass variables such as the type of home care and other intrinsic factors. Additionally, expanding the range of control variables to include factors like area of residence (rural or urban), household wealth index, provincial/territory variables, health insurance coverage, etc. could enrich the analysis. However, broadening the framework necessitates a substantially larger sample size to adequately explore client satisfaction with home care through an intersectional lens.

6. Options to Consider and Recommendations

6.1 Introduction

The existence of inequalities in client satisfaction with home care is a barrier to the fundamental objectives of home care program in Canada. This study shows that combining two intrinsic factors— gender and Indigenous identity— together in the context of intersectional framework could create some unique dynamics and effects which could help disaggregate client satisfaction with home care among the population of home care recipients and identify certain groups who could either be more likely or less likely satisfied with home care than a reference group. In this case, the study identified Indigenous women and the non-Indigenous women as the only subgroups with lower percentage point satisfaction with home care relative to the men with other identities (reference category).

6.2 Options to Consider

The problem identified in this study can therefore be addressed from two approaches:

6.2.1 Option 1: The first approach is to see it as community-based work and the second approach is to consider it a community development work. The first approach starts with agencies and professionals defining this problem and developing strategies to solve the problem before involving community members in the strategies and then handing over the ongoing responsibility for the intervention to community members and community groups (SCDC, n.d.; Smart, 2023). Such strategies may include integrating some of the findings of this study into a training curriculum and health education programs for caregivers who provide home care; policy makers, agencies and care home managers using these findings to design or redesign and improve home care program operations to become more inclusive, diverse and women friendly. A recent study on challenges of home care even recommends enhancement of performance monitoring of home care centers, and employment of modern technology to promote and improve the quality of home care services, in addition to human resource empowerment, provision of insurance coverage for the services, acculturalization and review of the bylaws (Shahriari et al., 2024).

6.2.2 Option 2: The second approach which is a longer term and more sustainable approach, starts with empowering the community groups to identify the inequalities in client satisfaction include access to the program, and plan and implement strategies to mitigate their concerns and solve their issues (SCDC, n.d.; Smart, 2023). With focus on Indigenous women and non-Indigenous women, they as home care recipients might require more information to identify their issues and plan actions, more information on local data, good practices around home care, relevant programs, and resources available to them (Smart, 2023). Community development practitioners could therefore connect with these subgroups and support them to build their local networks and leaders; undertake community engagement, deliver, and evaluate projects and programs with these subgroups (Smart, 2023).

6.3 Recommendations

1. Conducting further research is highly recommended:

I. Future/further studies should examine the same or similar study topic using primary data and adequate sample size which would preclude the problem of underrepresentation or overrepresentation of some subgroups in a dataset.
II. Further/further studies should also examine the same study or similar study topic using a qualitative research design or community-based participatory research methodology (Collins et al., 2018).

2. Employing a Community Development approach to address the inequality in client satisfaction with home and access to home care.

6.4 Implementation Strategy

Community-based work strategies: Integrating the study findings into caregiver training and health education programs, while policymakers and care managers refine home care operations to better serve women's needs.

- Review home caregivers' training curricula and health education programs.
- Policymakers, agencies, and care homes to redesign and improve home care program operations.
- Enhance performance monitoring of home care centers.
- Employ modern technologies.
- Empower Human resources.
- Provide insurance coverage for home care.
- Decolonizing, acculturalization, and review of the bylaws (Shahriari et al., 2024).

Community Development Work strategies: Community groups identify disparities and lead efforts to address them, focusing on indigenous and non-indigenous women. These groups need support in accessing data, best practices, and resources, with community development practitioners playing a key role in facilitating engagement and evaluating impact. Through these actions, communities can actively work towards greater equity and inclusivity in home care.

- Empower the community groups to identify and mitigate inequalities (SCDC, n.d.; Smart, 2023).
- Provide more information to the underserved (Smart, 2023).
- Community development practitioners connect with and support the underserved (Smart, 2023).

7. Conclusion

The purpose of this study was to use the intersectional framework of gender and Indigenous identity to analyze client satisfaction with home care among home care recipients in Canada using secondary survey data and determine if there was any significant difference suggesting inequalities in client satisfaction with home care among home care recipients. The study was able to establish that client satisfaction with home care varied significantly across the intersectional strata, suggesting the existence of inequalities in client satisfaction among different subgroups. The study therefore identified the Indigenous and the non-Indigenous women as having the negative propensity to be satisfied with home care.

The main gap in the literature addressed by this study was the influence of intersectionality of gender and indigenous identity on client satisfaction with home care. This study shows that combining the two intrinsic factors— gender and Indigenous identity— together in the context of intersectional framework could create some unique dynamics and effects which could help disaggregate client satisfaction with home care among the population home care recipients and identify certain groups who could either be more likely or less likely be satisfied with home care than others. In other words, this study shows that some groups of home care recipients are more likely to be exposed to some factors which promote or destroy client satisfaction with home care than others.

The observed variation in client satisfaction among different groups contradicts the home care program's mandate to provide effective, reliable, and responsive community health care services. The program is designed to support independent living, develop appropriate care options with clients and/or families, and facilitate admission into long-term care facilities when community living is no longer feasible (Winnipeg Regional Health Authority, n.d.). The larger significance of these findings is that the study identified some groups that received home care less than others and found some groups less satisfied with home care than others showing whether homecare is working as planned (Statistics Canada, 2021).

The inequality in client satisfaction with home care identified in this study can be tackled in two ways. One approach involves community-based intervention, where experts lead strategy development and the community helps carry it out, gradually taking over responsibility. Alternatively, community development work emphasizes empowering community groups to identify and address disparities themselves, focusing on long-term sustainability and community empowerment. This approach prioritizes community involvement in resolving underlying issues.

Therefore, integrating these findings into training curricula and health education programs for caregivers who provide home care, with focus on Equity, Diversity, and Inclusion (EDI) is paramount. EDI training is necessary for improving client satisfaction as it closes knowledge gap of home caregivers, addresses health equity and improves care for underserved populations (Arif et al., 2023). By investing in EDI training, home care managers and agencies can ensure that current and future home care givers are prepared to deliver culturally competent care and

promote health equity that contribute to meeting and exceeding the diverse needs and expectations of home care recipients, leading to greater client satisfaction (Wright et al., 2021). Policy makers and home care managers may use this evidence to redesign and improve their service to include integration of diversity with every discipline of care. Finally, further studies with primary data collections and much improved study designs are necessary to validate the findings of this study, and to generate more high-quality evidence for decision-making in the home care ecosystem.

In summary, this study uncovers significant disparities in client satisfaction across different groups receiving home care in Canada, despite overall satisfaction being high. These inequalities challenge the program's objectives, particularly concerning Indigenous and non-Indigenous women who report lower satisfaction levels. To address this, adopting a community development approach rooted in human rights and equity may offer a framework for fostering inclusive and responsive home care services.

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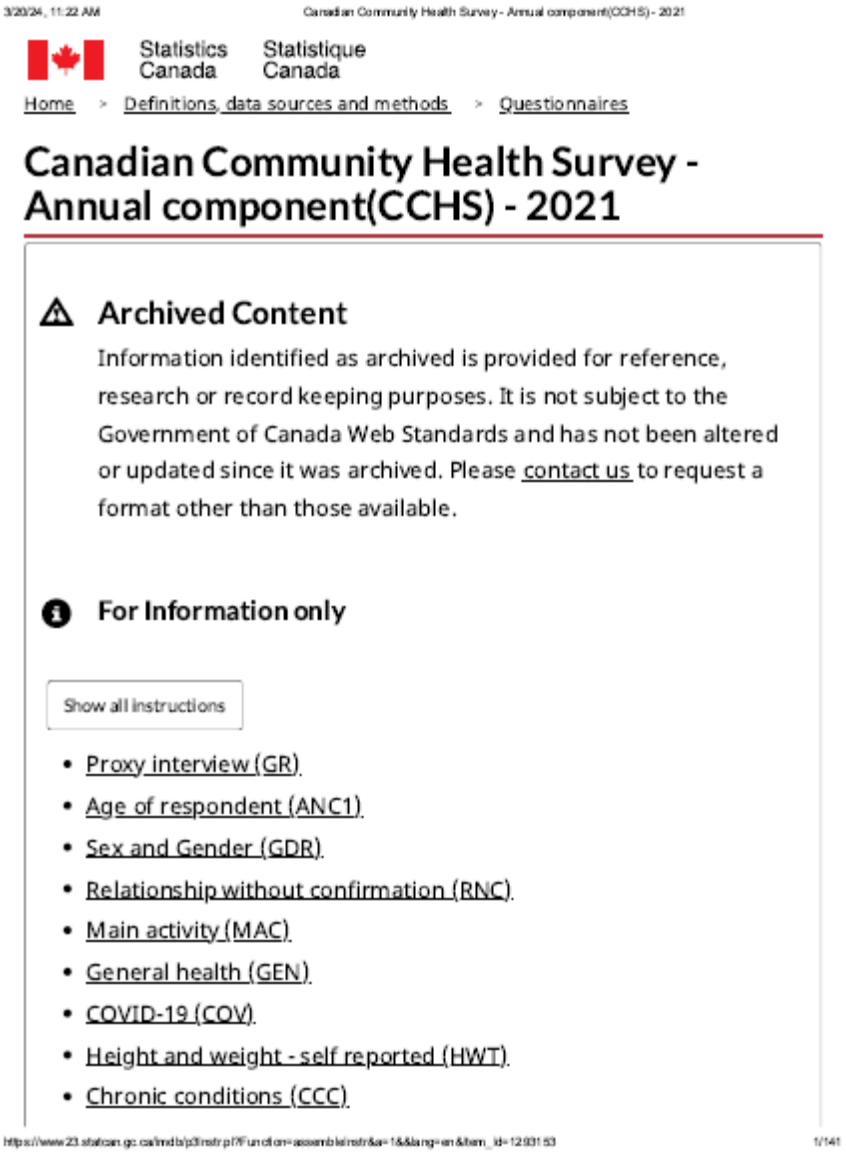
Appendices

Questionnaire



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- COVID-19 (COV)
- Height and weight - self reported (HWT)
- Chronic conditions (CCC)

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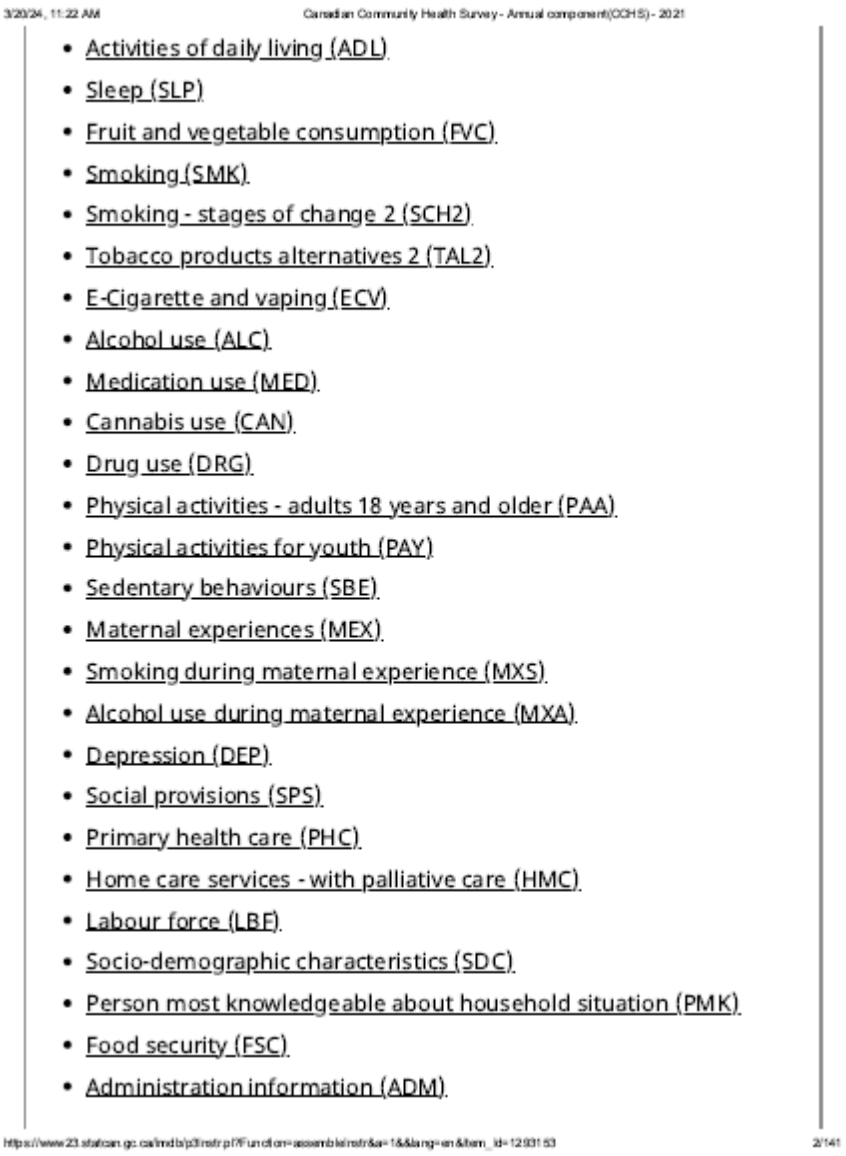
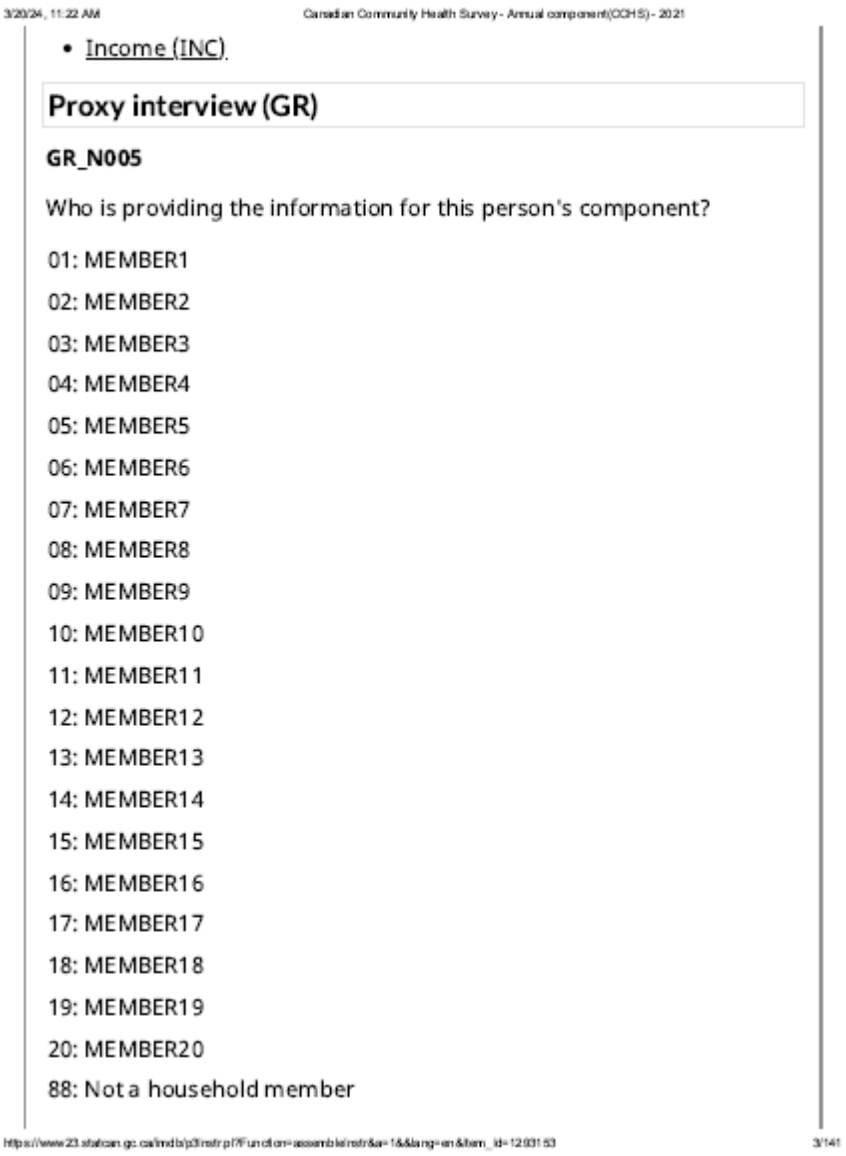


- Activities of daily living (ADL)
- Sleep (SLP)
- Fruit and vegetable consumption (FVC)
- Smoking (SMK)
- Smoking - stages of change 2 (SCH2)
- Tobacco products alternatives 2 (TAL2)
- E-Cigarette and vaping (ECV)
- Alcohol use (ALC)
- Medication use (MED)
- Cannabis use (CAN)
- Drug use (DRG)
- Physical activities - adults 18 years and older (PAA)
- Physical activities for youth (PAY)
- Sedentary behaviours (SBE)
- Maternal experiences (MEX)
- Smoking during maternal experience (MXS)
- Alcohol use during maternal experience (MXA)
- Depression (DEP)
- Social provisions (SPS)
- Primary health care (PHC)
- Home care services - with palliative care (HMC)
- Labour force (LBF)
- Socio-demographic characteristics (SDC)
- Person most knowledgeable about household situation (PMK)
- Food security (FSC)
- Administration information (ADM)



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- Income (INC)

Proxy interview (GR)

GR_N005

Who is providing the information for this person's component?

01: MEMBER1
02: MEMBER2
03: MEMBER3
04: MEMBER4
05: MEMBER5
06: MEMBER6
07: MEMBER7
08: MEMBER8
09: MEMBER9
10: MEMBER10
11: MEMBER11
12: MEMBER12
13: MEMBER13
14: MEMBER14
15: MEMBER15
16: MEMBER16
17: MEMBER17
18: MEMBER18
19: MEMBER19
20: MEMBER20
88: Not a household member

https://www23.statcan.gc.ca/imdb/p3Instr.pl?Function=assembleInstr&a=1&&lang=en&Item_Id=1293153 3/141

03: March

04: April

05: May

06: June

07: July

08: August

09: September

10: October

11: November

12: December

98: RF

99: DK

ANC1_Q03

What is [Name of specific respondent]'s date of birth?

Min = 0; Max = 9997

ANC1_Q04

So [Name of specific respondent]'s age on [Reference system date] was [Age calculated based on the entered date of birth].
Is that correct?

1: Yes

2: No, return and correct date of birth

3: No, collect age

ANC1_Q05

What is [Name of specific respondent]'s age?

Min = 0; Max = 121

ANC1_R010

Because you are less than 12 years old, you are not eligible to participate in the Canadian Community Health Survey.

ANC1_R015

Because you are more than 17 years old, you are not eligible to participate in the Canadian Community Health Survey.

ANC1_R020

Because you are less than 18 years old, you are not eligible to participate in the Canadian Community Health Survey.

ANC1_N030

Please confirm the spelling of respondent's first name. Update first name, if necessary.

Original First Name: [First name]
Original Last Name: [Last name]

Long Answer Length = 25

ANC1_N035

Please confirm the spelling of respondent's last name. Update last name, if necessary.

Original First Name: [First name]

Original Last Name: [Last name]

Long Answer Length = 25

Sex and Gender (GDR)

GDR_R005

The following questions are about sex at birth and gender. Sex refers to sex assigned at birth. Gender refers to current gender which may be different from sex assigned at birth and may be different from what is indicated on legal documents.

GDR_Q005

What was your sex at birth?

1: Male

2: Female

8: RF

9: DK

GDR_Q010

What is your gender?

1: Male

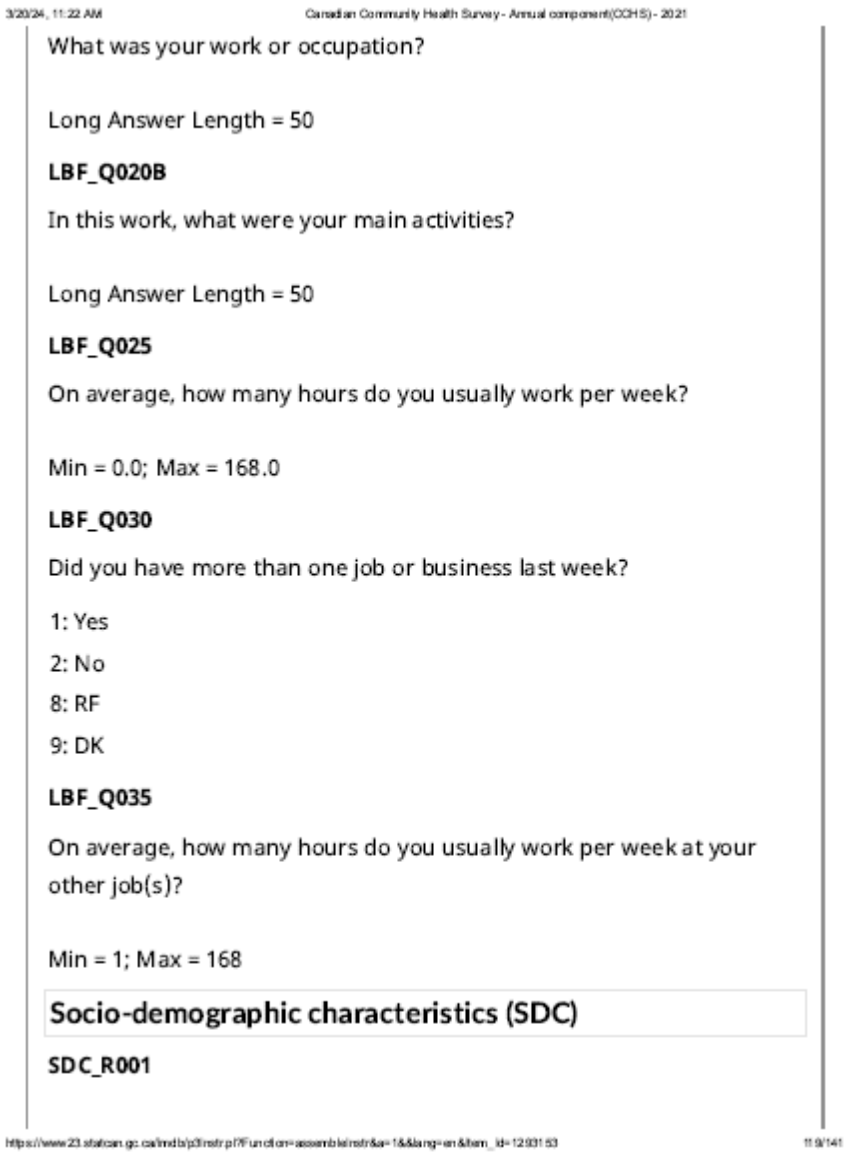
2: Female

3: Or please specify

8: RF

9: DK

GDR_R020



What was your work or occupation?

Long Answer Length = 50

LBF_Q020B

In this work, what were your main activities?

Long Answer Length = 50

LBF_Q025

On average, how many hours do you usually work per week?

Min = 0.0; Max = 168.0

LBF_Q030

Did you have more than one job or business last week?

1: Yes

2: No

8: RF

9: DK

LBF_Q035

On average, how many hours do you usually work per week at your other job(s)?

Min = 1; Max = 168

Socio-demographic characteristics (SDC)

SDC_R001

13: Portuguese

14: South Asian (e.g., East Indian, Pakistani, Sri Lankan)

15: Norwegian

16: Welsh

17: Swedish

18: First Nations (North American Indian)

19: Métis

20: Inuit

21: Other - Specify

98: RF

99: DK

SDC_Q015A

Are you an Aboriginal person, that is, First Nations, Métis or Inuk (Inuit)? First Nations includes Status and Non-Status Indians.

1: Yes

2: No

8: RF

9: DK

SDC_Q015B

Are you First Nations, Métis or Inuk (Inuit)?

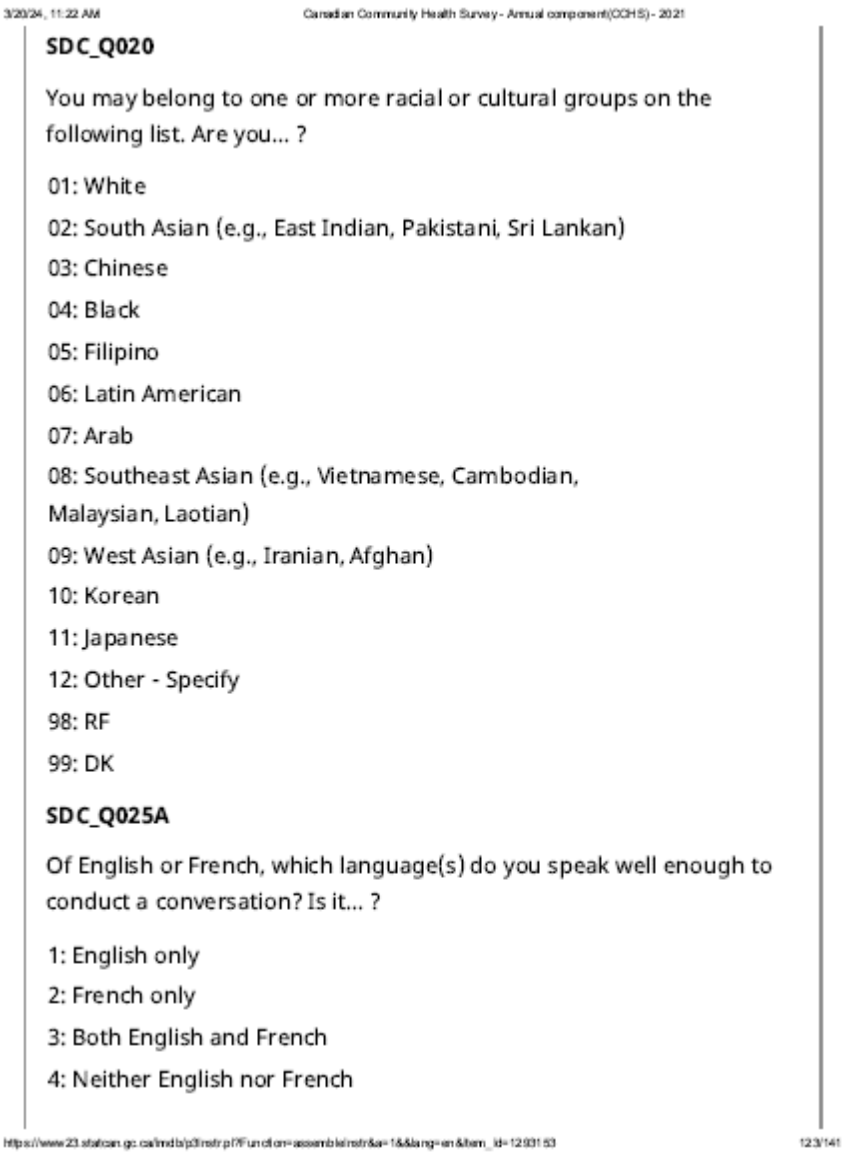
1: First Nations (North American Indian)

2: Métis

3: Inuk (Inuit)

8: RF

9: DK



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SDC_Q020

You may belong to one or more racial or cultural groups on the following list. Are you... ?

01: White

02: South Asian (e.g., East Indian, Pakistani, Sri Lankan)

03: Chinese

04: Black

05: Filipino

06: Latin American

07: Arab

08: Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian)

09: West Asian (e.g., Iranian, Afghan)

10: Korean

11: Japanese

12: Other - Specify

98: RF

99: DK

SDC_Q025A

Of English or French, which language(s) do you speak well enough to conduct a conversation? Is it... ?

1: English only

2: French only

3: Both English and French

4: Neither English nor French

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8: RF

9: DK

SDC_R035

Now, one additional background question which will help us compare the health of people in Canada.

SDC_Q037

What is your sexual orientation?

1: Heterosexual

2: Homosexual

3: Bisexual

4: Or please specify

8: RF

9: DK

Person most knowledgeable about household situation (PMK)

PMK_R010

For the last few questions, I would like to speak with someone who would be best able to answer questions about the entire household such as household income and food purchases.

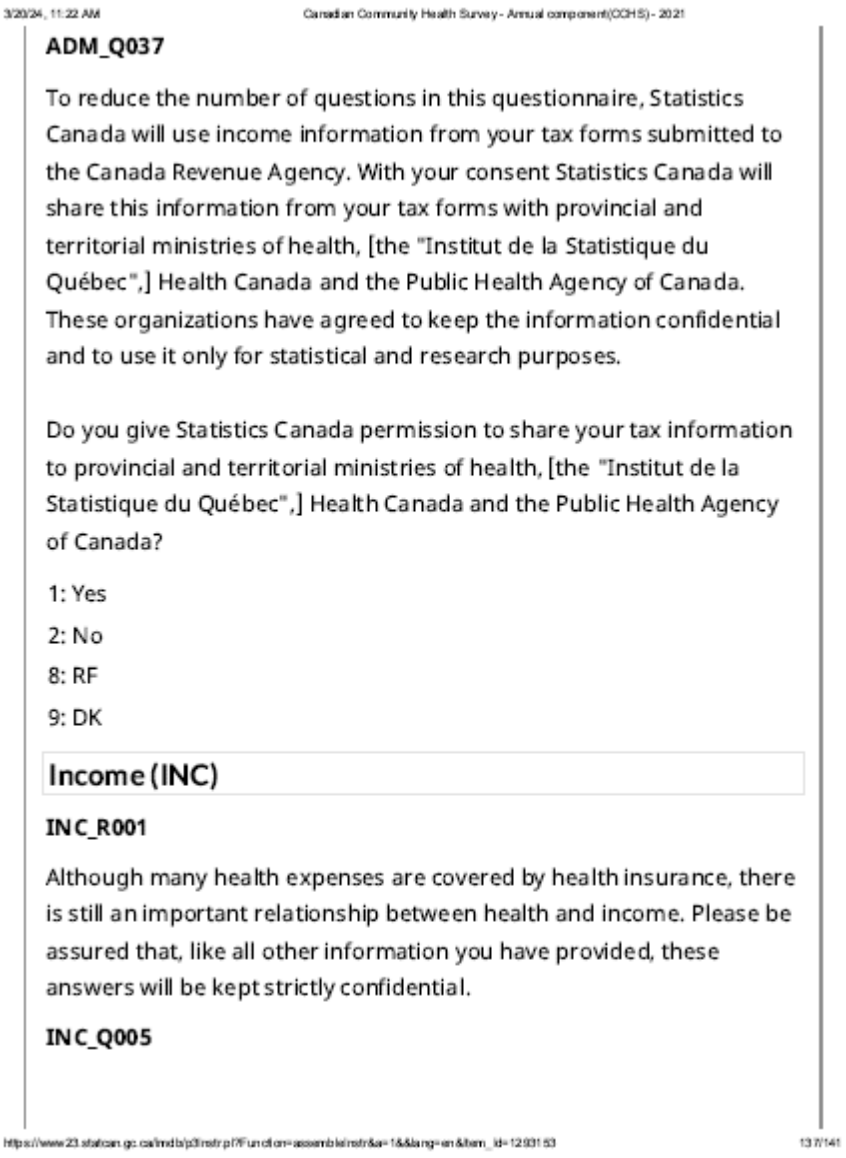
PMK_Q010

Who would this person be?

01: MEMBER1

02: MEMBER2

03: MEMBER3



ADM_Q037

To reduce the number of questions in this questionnaire, Statistics Canada will use income information from your tax forms submitted to the Canada Revenue Agency. With your consent Statistics Canada will share this information from your tax forms with provincial and territorial ministries of health, [the "Institut de la Statistique du Québec",] Health Canada and the Public Health Agency of Canada. These organizations have agreed to keep the information confidential and to use it only for statistical and research purposes.

Do you give Statistics Canada permission to share your tax information to provincial and territorial ministries of health, [the "Institut de la Statistique du Québec",] Health Canada and the Public Health Agency of Canada?

1: Yes

2: No

8: RF

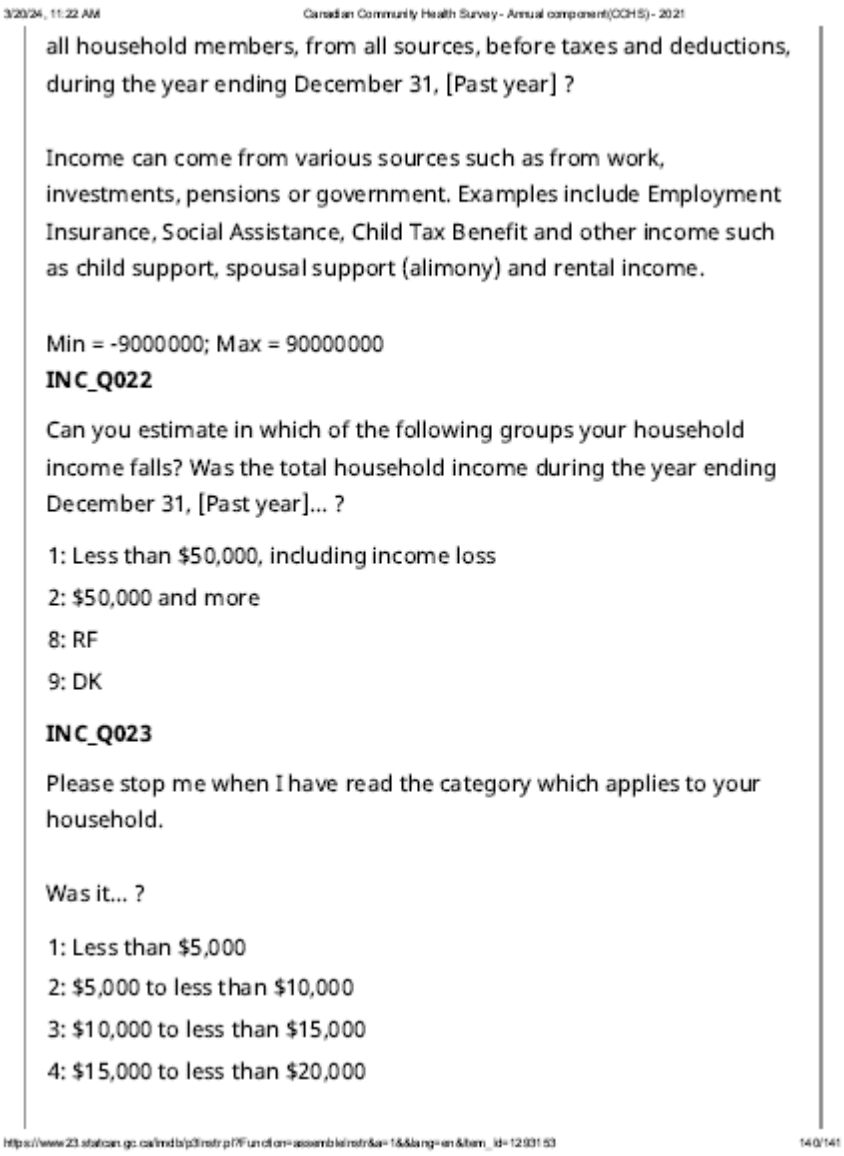
9: DK

Income (INC)

INC_R001

Although many health expenses are covered by health insurance, there is still an important relationship between health and income. Please be assured that, like all other information you have provided, these answers will be kept strictly confidential.

INC_Q005



all household members, from all sources, before taxes and deductions, during the year ending December 31, [Past year] ?

Income can come from various sources such as from work, investments, pensions or government. Examples include Employment Insurance, Social Assistance, Child Tax Benefit and other income such as child support, spousal support (alimony) and rental income.

Min = -9000000; Max = 90000000

INC_Q022

Can you estimate in which of the following groups your household income falls? Was the total household income during the year ending December 31, [Past year]... ?

1: Less than $50,000, including income loss

2: $50,000 and more

8: RF

9: DK

INC_Q023

Please stop me when I have read the category which applies to your household.

Was it... ?

1: Less than $5,000

2: $5,000 to less than $10,000

3: $10,000 to less than $15,000

4: $15,000 to less than $20,000