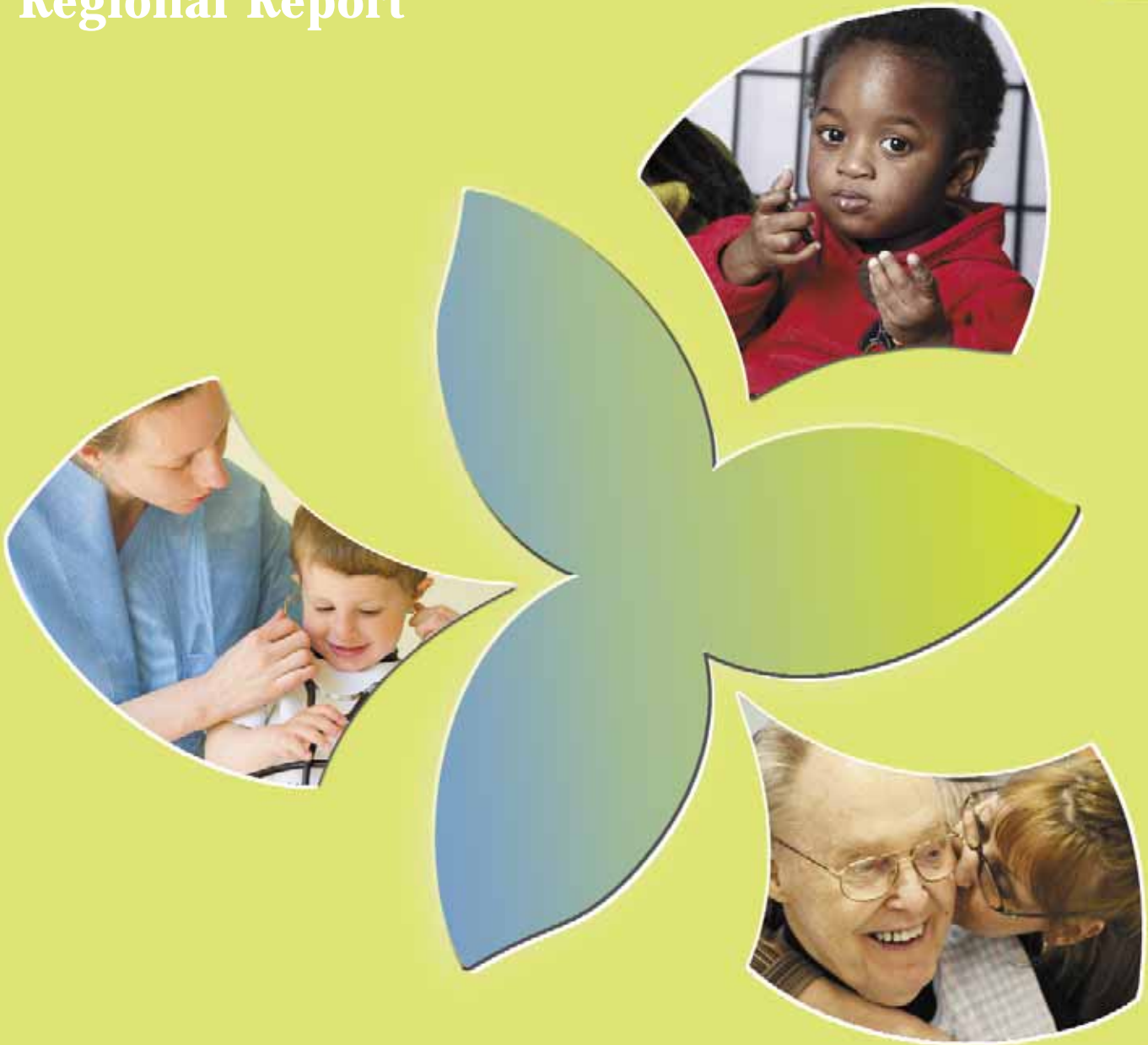


SETTING the STAGE

Primary Health Care In French In Southern Ontario

2006

Regional Report



Réseau franco-santé
du Sud de l'Ontario



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List of abbreviations

CCAC	Community Care Access Centre
CD	Census division
CFT	Centre Francophone de Toronto
CHC	Community Health Centre
CNFS	Consortium national de formation en santé
FHT	Family Health Team
FLHS	French language health services
FLSA	<i>French Language Services Act</i>
HHR	Health human resources
LHIN	Local Health Integration Network
MOHLTC	Ministry of Health and Long-Term Care
PHC	Primary health care
PHCTF	Primary Health Care Transition Fund
RIFSSSO	Regroupement des intervenants(e)s francophones en santé et en services sociaux de l'Ontario
SSF	Société Santé en français
STS	Setting the Stage
WHO	World Health Organization

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EXECUTIVE SUMMARY

Introduction

Setting the Stage is a French language health services planning project. It is a national initiative of the *Société Santé en français* (SSF) and is funded by Health Canada through the Primary Health Care Transition Fund (Official Language Minority Communities Envelope).

Over the past two years, Canada's 17 French language health networks, including the *Réseau franco-santé du Sud de l'Ontario* [Franco Health Network of Southern Ontario], have been conducting a study involving both field work and documentary research. The goal of the study was to achieve a better understanding of the health needs, gaps and priorities of Francophone minority communities and to develop potential solutions. One of the project's concrete deliverables has been all of the information and analyses now available that will facilitate decision making on the best ways of providing quality health care services to the Francophone population.

No guarantee

Access to French language health services in Ontario is by no means a new issue, having been of concern both to the community and the provincial government for some time. However, despite the progress that has been made since the adoption of the *French Language Services Act* (FLSA) in 1986, in Southern Ontario access to primary health care services in French is far from guaranteed.

At the heart of the problem are a number of factors—few or no recognized access points, a shortage of French-speaking human resources, poor utilization of the existing resources, programs poorly tailored to the needs of Southern Ontario's diverse Francophone communities, and Francophones' scant input into the planning and management of primary health care services.

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Setting the Stage... in action

Main components of the STS process

The Réseau franco-santé du Sud de l'Ontario and the communities it serves

The *Réseau franco-santé du Sud de l'Ontario* is a not-for-profit agency with the mission of ensuring that all Francophones in Southern Ontario have access, in French, to quality health services. Founded in 2003 through a networking initiative of the SSF, it brings together health professionals, health facilities, Francophone community organizations, postsecondary educational institutions, members of the Francophone community, government authorities and other partners.

The *Réseau* serves a vast territory extending from Penetanguishene in the North to Welland in the South, and from Peterborough in the East to Windsor in the West.

Southern Ontario is a region of contrasts, marked by diversity and urbanization. A majority of the Francophones belonging to a racial minority are found in Southern Ontario's major urban centres, along with a significant percentage of Francophones who were born outside the province. The region includes major urban centres such as Toronto, Mississauga, Hamilton, London and Windsor as well as rural areas like those of Simcoe and Essex counties and the municipalities of Niagara and Chatham-Kent.

The approximately 175,000 Francophones in Southern Ontario are spread over 27 census divisions and form part of a total regional population of over nine million. Although this Francophone population constitutes the second largest concentration of Francophones in the province, i.e. 31.9% of the provincial total, it makes up only 1.9% of the total population of Southern Ontario.

It is interesting to note that 43% of the Francophone population in the South lives in areas that are not designated under the FLSA.

Assimilation is a very important issue in the South, which has the lowest language retention rate and highest exogamy (mixed marriage) rate in the province.

The territory served by the *Réseau franco-santé du Sud de l'Ontario* can easily be divided into two regions, namely the central and southwest regions, and these differ substantially.

Southern Ontario is a region of contrasts, marked by diversity and urbanization.

Highlights of the central region

- Home to 138,000 Francophones, primarily concentrated in Greater Toronto, with smaller population centres in the Hamilton, Simcoe and Niagara regions
- A destination for newcomers
 - * More than one out of five Francophones is of multicultural origin
 - * Three out of five Francophones were born outside the province
- The percentage of Francophones with postsecondary training is higher than in the general population
 - * 19% of Francophones hold an undergraduate degree
- Francophones have a lower unemployment rate than the general population
- Francophones have higher average and total employment incomes than the general population and than Francophones in other regions

Highlights of the southwest region

- Home to approximately 35,000 Francophones, primarily concentrated in Essex and Middlesex counties and the municipality of Chatham-Kent
- A small demographic component
 - * Less than 3% of the total regional population
 - * 6.3% of the province's total Francophone population
- An aging Francophone population
 - * Nearly a quarter of Francophones are aged 65 years and over, compared to 14% of the general population
 - * Nearly a third are aged 45 to 64 years, compared to 23% of the general population
- A low labour market participation rate

The STS project

Ontario's four French language health networks joined forces for this project to ensure their plans were complementary. They adopted a two-part approach involving a common component and a component specific to each network. As a result, each network is submitting a two-volume report. The first volume, the *Provincial Report*, paints an overall portrait of the situation in Ontario. The *Regional Reports* contain the findings for each region, or, in this case, those for Southern Ontario.

Developing the methodological approach to be used was a major step forward. The *Réseau du Sud* devised a work plan and established an advisory committee to guide the research team through all phases of the project. The team also worked closely with Southern Ontario's seven regional French language health services consultants.



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It comes as no surprise that the two main conclusions of STS are that Southern Ontario is almost completely lacking in French language health services and that Francophones in the South wish to be served in their own language.

Primary components of the work plan:

- Concerted action by the four Ontario networks
- Collaboration with government authorities
- Collaboration with other provincial agencies
- Development of common definitions for “primary health care” and “Francophone”
- Identification of the territory to be studied—12 census divisions containing 90% of the region’s Francophones: Essex, Chatham-Kent, Middlesex, Waterloo, Niagara, Hamilton, Halton, Peel, Toronto, Simcoe, York and Durham
- Documentary and statistical analyses
- An inventory of family physicians and pediatricians able to speak French (according to data from the College of Physicians and Surgeons of Ontario website), community health centres, family health teams, public health services (clinical care, services delivered in schools, and the *Healthy Babies, Healthy Children program*), community care access centres (home care, including palliative care), mental health and addiction services, and Telehealth Ontario
- 108 interviews with key informants such as physicians, nurses, local health integration network (LHIN) representatives, leaders of Francophone community organizations, etc.
- Nine focus groups held in both designated and non-designated areas (Pain Court, London, Cambridge, Thorold, Hamilton, Penetanguishene, Mississauga, Toronto and Oshawa)
- Development of an overview of the situation, including the needs, gaps, priorities and potential solutions
- Diagnosis of the situation
- Development of preliminary recommendations
- Validation of the recommendations by the Advisory Committee
- Approval of the recommendations by the Board of Directors

In French please!

It comes as no surprise that the two main conclusions of STS are that Southern Ontario is almost completely lacking in French language health services and that Francophones in the South wish to be served in their own language. Southern Ontario has only two Francophone community health centres and six other health agencies that are fully or partially designated under the FLSA.

A lack of availability and accessibility of primary health care services in French was noted throughout Southern Ontario. Here are a few of the observations to emerge from the consultations.

Gaps:

- Nine of the twelve census divisions studied are underserved areas
- Difficulties accessing health services are widespread and even more acute for services in French and in rural areas

- There is a lack of knowledge of the system and of the resources available in French
- The resources available in French are poorly integrated and coordinated
- It is difficult to obtain referrals to French language services and resources
- Health professionals, especially family physicians, nurse practitioners, nurses, speech-language pathologists and social workers are in short supply
- There is poor knowledge and poor utilization of existing resources
- Little core professional training and professional development is delivered in French
- There are difficulties recruiting and retaining French-speaking health professionals
- Young people are leaving the region
- There is a lack of culturally appropriate promotion and prevention resources in French
- There is a lack of French language health services in French language schools
- There is a lack of specific data on Francophones and the services they use

Priority sectors:

- Family medicine
- Mental health and addiction
- Services to children
- Services to seniors

Potential solutions:

- Creation of virtual or physical access points that build on existing resources, in partnership with organizations already working in this field. These access points must:
 - * be based on comprehensive knowledge of the services and resources available in French;
 - * be integrated into the health care system and other structures (education, social services, early childhood education);
 - * be tailored to local needs;
 - * facilitate navigation of the health care system;
 - * be based on a holistic approach to health and on multidisciplinary.
- Improved planning of human resources–
 - * Facilitate the integration of French-speaking professionals trained outside Ontario;
 - * Deliver core professional training and professional development in French;
 - * Develop provincial and local recruitment strategies;
 - * Improve the working conditions of French-speaking professionals.
- Improved planning of health services–
 - * Develop policies and programs.
- Participation by Francophones in decision making.



Four strategic priorities: access points; human resources; promotion and prevention; planning and management of services.

Recommendations

The recommendations of the *Réseau franco-santé du Sud de l'Ontario* address the four strategic priorities identified at the provincial level, namely access points, human resources, promotion and prevention, and the planning and management of services. These priorities are keys to the development and implementation in Ontario of quality primary health care in French.

1. That the government develop the policies and mechanisms needed to implement the recommendations set out below and that the government see to their implementation in all health structures.

Access points

2. That support be provided for an integrated and inter-sectoral approach to French language health services and the networking of services.
3. That the creation, expansion and maintenance of access or entry points to French language primary health care services that are tailored to the needs and capacities in each region be supported and that some priority be given to the establishment of Francophone governance structures.
4. That ongoing awareness campaigns be instituted to: increase the visibility of the French language services available in the health care system; inform Francophones about their rights, convince them of the added value of French, and encourage them to request services; and make Anglophone agencies as well as Anglophone and Francophone professionals aware of Francophone culture in all its diversity and of the importance to Francophones of being served in their own language.
5. That support be provided for the establishment of adequately funded cultural interpretation and medical accompaniment services.

Human resources

6. That a permanent inventory of services and of health and social service professionals able to provide quality services in French be compiled and maintained.
7. That support be provided for the development of recruitment and retention strategies for professionals able to provide quality French language services, so as to meet regional priorities and needs.
8. That support be provided for the integration of French-speaking health professionals from abroad.
9. That stakeholders work together to assess needs in the area of core training and professional development programs delivered in

French in Southern Ontario, and that support be provided for the establishment of training programs to meet those needs.

10. That networking among health and social service professionals, by region and profession, be supported through the provision of virtual and physical meeting places.
11. That efforts by the *Regroupement des intervenant(e)s francophones en santé et en services sociaux de l'Ontario* (RIFSSSO), the *Consortium national de formation en santé* (CNFS) and the French Language Health Services (FLHS) Office of the Ministry of Health and Long-Term Care to raise young people's awareness of careers in health and social services continue to be supported.
12. That young Francophones be made aware of the financial support available to students in health and social service programs and that Francophone communities be mobilized to create new programs and strategies encouraging young Francophones to return to their home regions following their studies.

Promotion and prevention

13. That health promotion and disease prevention form the cornerstones of Francophones' efforts to take responsibility for their health, and that these approaches be based on a holistic vision of health and an emphasis on health determinants, while also taking vulnerable groups into account.
14. That necessary measures be taken to ensure that public health units plan and deliver their programs in French, after tailoring them to Francophone communities.

Planning and management

15. That programs be established which are designed to encourage Francophones to volunteer for positions on the boards of directors and working committees of health agencies, professional colleges and associations, and decision-making bodies such as LHINs.
16. That integrated French language health service plans be developed that identify clear priorities, propose concrete action, and define accountability measures.
17. That support be provided for research designed to produce a detailed profile of the Francophone communities in Southern Ontario by LHIN based on objective data.



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Conclusion

A starting point for French language primary health care

Setting the Stage has drawn a fairly detailed portrait of the current state of the primary health care services available in French in Southern Ontario. However, this is only the starting point on the road to improved access to services.

The *Réseau franco-santé du Sud de l'Ontario* has already started taking steps to implement some of the recommendations in this report. For instance, it has developed a new project, "*Santé primaire en action*" [primary health care in action], which, if funded, will create conditions favourable to increasing the accessibility of primary health care and services and improving Francophones' health status.

The *Réseau* will pursue its work with government authorities so that, together, we may find ways of implementing some of these recommendations. The *Réseau* will also continue working with its partners to improve our knowledge of the health status of Francophones in minority communities. Success will hinge on people's willingness to work together to improve the health of Francophones in Southern Ontario.

*This is only
the starting point
on the road to
improved access
to services.*



Introduction

Access to French language health services has been an issue for Ontario's Francophone community for a very long time. Since the adoption of the *French Language Services Act* (FLSA) in 1986, if not before, it has also been an issue for the provincial government. However, despite the framework created by the Act and the progress made over the past 20 years, many improvements are still needed before Francophones in a minority situation will enjoy equal access to French language health services. *Setting the Stage* (STS) is designed to support such improvements in Southern Ontario.

Setting the Stage is a national initiative of the *Société Santé en français* (SSF) and is funded by Health Canada through the Primary Health Care Transition Fund (PHCTF). The objective of the project is to support the planning of primary health care in French in all regions of Canada, except Quebec, in order to improve access to such services for minority Francophone communities.

One of this project's most important concrete objectives is to provide the leaders of Ontario's health care system with a body of information and analyses that will support their decision making with respect to the best ways of delivering quality health care services to the Francophone population.

Canada's 17 French language health networks are responsible for implementing the project in their respective regions. Four of these networks are found in Ontario. The *Réseau Francophone de santé du Nord de l'Ontario*, the *Réseau de santé en français du Moyen-Nord de l'Ontario* and the *Réseau franco-santé du Sud de l'Ontario* have been in place since 2003, and the *Réseau des services de santé en français de l'Est de l'Ontario* since 1999.

The four networks have joined forces to ensure their plans are complementary. They have therefore adopted an approach that includes a common component plus a component specific to each network. In this way they can accommodate the sometimes wide variations in circumstances in each region. The networks have also worked closely with the Ontario Ministry of Health and Long-Term Care (MOHLTC)—which is responsible for health care delivery—to ensure their efforts are aligned with provincial priorities.

Thus, each network is submitting a two-volume report. The first volume, the *Provincial Report*, paints a general portrait of the situation in Ontario. The regional reports contain the findings specific to each region. This document examines the situation in Southern Ontario. Each two-volume set forms a whole, with the

Introduction

Provincial Report being integral to an understanding of each *Regional Report*. The analyses and recommendations contained in the *Provincial Report* are primarily based on the field research conducted in each region.

This report considers French language health services in Southern Ontario. It begins with a short description of the *Réseau franco santé du Sud de l'Ontario*, then explains the methodology employed. It profiles the Francophone communities in Southern Ontario, describes the current context in which French language health care services are being delivered, and examines the primary health care services currently available in French in the region. After reviewing the community consultations that were conducted and analysing the findings and potential solutions that emerged from the consultations, it concludes with recommendations designed to lay the groundwork for future action plans.

CHAPTER 1 : The *Réseau franco-santé du Sud de l'Ontario*

The *Réseau franco-santé du Sud de l'Ontario* is working to improve access to French language health services in Southern Ontario. The *Réseau*, founded in 2003 through a networking initiative of the SSF, brings together different participants from the health field and the Francophone community, including health professionals, health facilities, Francophone community agencies, postsecondary educational institutions, members of the Francophone community, government authorities and other partners. It brings together leaders in this sector, with the ultimate goal of improving the health of Francophones.

The *Réseau* is a not-for-profit agency managed by a volunteer board of directors composed of nine members from differing backgrounds who make their valuable expertise available to the *Réseau*. The *Réseau* and its projects are currently funded by Health Canada via the SSF.

1.1 Its role

The *Réseau* plays a leadership and support role in all matters related to the delivery of French language health services. It facilitates the implementation of local and regional initiatives that improve access to French language health services and support the training, recruitment and retention of French-speaking health professionals.

1.2 Its mission

To ensure that all Francophones in Southern Ontario have access to quality health services in French.

The Réseau's mission: to ensure that all Francophones in Southern Ontario have access to quality health services in French.

1.3 Its primary objectives

- To act as spokesperson for Francophones on health matters to various government and association officials.
- To actively promote French language health services to members of the community, stakeholders and health agencies.
- To foster community involvement.
- To forge the partnerships required to fulfill its mandate, which involves tasks such as helping to assess the state of French language services, identify needs, plan services, and develop recruitment and retention strategies for health professionals.
- To ensure that relevant Francophone initiatives are implemented, and to support local projects in various ways.

1.4 Its territory

The *Réseau* serves central and southwest Ontario, a vast territory that extends from Penetanguishene in the North to Welland in the South, and from Peterborough in the East to Windsor in the West.

There are 174,115 Francophones in Southern Ontario. They represent 31.9% of the province's Francophone population but only 1.9% of the region's total population. Across the South, there is a high assimilation rate.

Between 1996 and 2001, Central Ontario saw its percentage of Francophones increase, with a quarter of all Ontario Francophones now calling this region home. Toronto is one of the two main destinations for newcomers to Ontario. Francophones in Central Ontario have a higher level of education than the general population, which translates into a lower unemployment rate and higher incomes.

Francophones in the Southwest form an aging population. Nearly a quarter of the region's Francophones are 65 years of age or over and nearly a third are 45 to 64 years of age, which compares to 14% and 23%, respectively, in the general population. As a result, Francophones' labour market participation rate here is lower than elsewhere in Ontario.¹

An upcoming section of this report provides further information on the territory covered by the *Réseau*.



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¹. Office of Francophone Affairs, Francophones in Ontario – Statistical Profile – General Profile, 2005, p. 22, [<http://www.ofa.gov.on.ca/docs/stats-general-en.pdf>].

Chapter 2: Methodology

2.1 Provincial and regional perspectives

The four Ontario networks serve regions with sometimes very different historical, socio-economic and demographic characteristics, and this same diversity applies to health issues. For STS, each of the four networks was tasked with producing a primary health care plan reflecting the circumstances specific to its region. In addition, the four plans had to be complementary so that a provincial plan could be developed; this provincial plan constitutes the first volume of this report.

The planning process therefore involved two components:

- a common component; and
- a component specific to each network.

2.2 Regional approach

Developing the methodological approach was a major step forward. The Réseau du Sud worked with the other three Ontario networks and the provincial team to develop the common elements of the methodological approach.

Overall, the project involved the following phases:

- developing the methodological approach and work plan;
- developing the definitions and defining the context;
- conducting a review of the literature and statistical analyses;
- preparing an inventory of primary health care services available in French in the South and identifying needs and potential solutions;
- developing recommendations;
- writing the final report.

2.3 Regional implementation

2.3.1 *Regional Advisory Committee*

A key element of the project was the creation of a Regional Advisory Committee made up of professionals from the French language health services field and representatives of the community as a whole. This committee reflected the region's diversity. It was tasked with validating the various project phases and ensuring that the project accurately reflected circumstances in the South. It also carried out an initial validation of the project's recommendations.

2.3.2 **Work plan**

To implement the methodological approach selected, the *Réseau du Sud* developed a detailed work plan, which was modified along the way to take account of the time constraints and the data that had been collected to that point.

Over a hundred interviews, nine focus groups.

2.3.3 Community consultations

To better understand the real-life circumstances experienced by Francophones living in Southern Ontario communities, the team conducted 108 interviews with key informants and community leaders. These informants included health and social service professionals, health facility managers, French language health services regional consultants, and representatives of the local health integration networks (LHINs), the educational system, public health units, the long-term care sector, and provincial and regional community agencies.

The objective of the interviews was to obtain, with the help of a bilingual interview guide, informants' input on issues related to primary health care in French, including the:

- needs and gaps in French language primary health care services;
- communities' capacity to provide primary health care services;
- main challenges, barriers and issues related to services;
- changes required in order to improve the primary health care system.

The team worked very closely with the seven French language health services (FLHS) regional consultants in the South. Given their unique role in service implementation, the team developed an interview questionnaire specifically for them.

Finally, the research team organized a series of nine focus groups in different areas of Southern Ontario, both designated and non-designated. The groups were held in Hamilton, Toronto, London, Pain Court, Oshawa, Cambridge, Thorold, Mississauga and Penetanguishene. The goal was to reach the largest possible number of participants, especially users of health care services. The focus groups served to corroborate the team's preliminary analyses of the findings that emerged from the key informant interviews. The interviews had identified issues specific to the various regions, as well as more general trends and potential solutions. Over 125 people took part in the focus groups.

2.3.4 Validation of the findings and potential solutions

The team analysed the responses gathered during the key informant interviews and compiled an overview of the needs and gaps in primary health care. This overview provided some insight into the main issues affecting access to primary health care in the South as a whole and in its various regions.

The team then attempted to make a diagnosis of the situation, both regionally and provincially, which generated some preliminary recommendations.

Validating the findings and proposed potential solutions was an important step. The focus groups provided some initial feedback on the preliminary analyses of the interviews. The Regional Advisory Committee went on to conduct a thorough analysis of the potential solutions and proposed recommendations. Finally, the Réseau's Board of Directors validated and approved the recommendations in the report.



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2.4 Definitions

The four networks agreed on common terminology. The two main terms defined were “primary health care” and “Francophone.”

2.4.1 Primary health care

The definition of “primary health care” can be found on page 12 of the *Provincial Report*.

Since primary health care is a very broad field, the networks selected the following components for inclusion in this study:

- family physicians and pediatricians;
- community health centres (CHCs);
- family health teams (FHTs);
- public health services (clinical care);
- community care access centres (CCACs) (home nursing care, including palliative care);
- Telehealth Ontario (a provincial service).

With the Regional Advisory Committee’s approval, the *Réseau du Sud* added community mental health and addiction services, and, for public health units, services delivered in schools, and the *Healthy Babies, Healthy Children* program.

2.4.1 Francophone

The networks’ definition of Francophone includes both people whose mother tongue is French and people whose first official language spoken is French. The full definition is found on page 12 of the *Provincial Report*.

*The South’s
174,115
Francophones
make up Ontario’s
second largest
concentration of
Francophones next
to Eastern Ontario.*

2.5 Regions chosen for the project

Statistics Canada data are broken down by “census division.” Roughly speaking, a “census division” corresponds to a county, regional municipality or regional district. The territory covered by the *Réseau du Sud* includes 27 census divisions (CDs) that contain more than 79% of the province’s population and 10 of its 14 LHINs. The South’s 174,115 Francophones make up Ontario’s second largest concentration of Francophones next to Eastern Ontario.

Given the size of its territory and population, the *Réseau du Sud* had to limit its investigations and determine which regions it would study.

Table 1 lists the census divisions together with the number of Francophones (mother tongue) in each division and the percentage of the total population they represent.

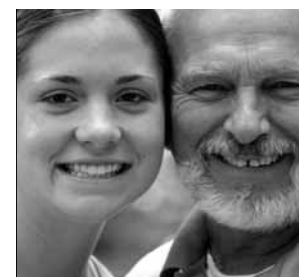


Table 1 : Distribution of “French mother tongue” population by census division and percentage of total population²

Census division	LHIN	French mother tongue population	Total population	Percentage of Francophones
Brant County	Hamilton Niagara Haldimand Brant	1,425	118,485	1.2
Bruce County	South West	685	63,890	1.1
Chatham-Kent* Division	Erie St. Clair	3,745	107,710	3.5
Dufferin County	Central West	660	51,015	1.3
Regional Municipality of Durham	Central East	10,555	506,905	2.1
Elgin County	South West	865	81,550	1.1
Essex County*	Erie St. Clair	16,760	374,975	4.5
Grey County	South West, Waterloo Wellington, North Simcoe Muskoka	815	89,070	0.9
Regional Municipality of Haldimand-Norfolk	South West, Hamilton Niagara Haldimand Brant	1,125	104,670	1.1
Haliburton County	Central East	145	15,085	1.0
Regional Municipality of Halton	Hamilton Niagara Haldimand Brant, Mississauga Halton	8,475	375,230	2.3
Hamilton Division*	Hamilton Niagara Haldimand Brant	8,075	490,270	1.6
Huron County	South West	475	59,705	0.8
Kawartha Lakes	Central West	740	69,175	1.1
Lambton County	Erie St. Clair	3,180	126,970	2.5
Middlesex County*	South West	6,215	403,185	1.5
Regional Municipality of Niagara*	Hamilton Niagara Haldimand Brant	15,630	410,570	3.8
Northumberland County	Central East, South East	1,040	77,495	1.3
Oxford County	South West	1,125	99,270	1.1
Regional Municipality of Peel*	Central West, Mississauga Halton	16,515	988,950	1.7
Perth County	South West	465	73,675	0.6
Peterborough County	Central East	1,565	128,855	1.2
Simcoe County*	Central, North Simcoe Muskoka	11,175	377,050	3.0
Toronto Division*	Central West, Mississauga Halton, Toronto Central, Central, Central East	42,780	2,481,495	1.7
Regional Municipality of Waterloo	Waterloo Wellington	6,840	438,515	1.6
Wellington County	Waterloo Wellington	2,820	187,315	1.5
Regional Municipality of York	Central West, Central	10,220	729,255	1.4
Total		174,115	9,027,330	1.9

* Area fully or partially designated under the *French Language Services Act*.

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The Réseau opted to concentrate its efforts on the following 12 CDs (listed alphabetically): Chatham-Kent Division, Regional Municipality of Durham, Essex County, Regional Municipality of Halton, Hamilton Division, Middlesex County, Regional Municipality of Niagara, Regional Municipality of Peel, Simcoe County, Toronto Division, Regional Municipality of Waterloo and Regional Municipality of York.

These 12 divisions are home to 156,985 Francophones or 90.2% of the region's total Francophone population and contain all the designated areas in Southern Ontario. The 10 LHINs in the South, Erie St. Clair, South West, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West, Mississauga Halton, Toronto Central, Centre, Central East and North Simcoe Muskoka, are also found within these divisions.

CHAPTER 3: Environmental Scan

3.1 Profile of Southern Ontario's Francophone communities

Studies indicate that “the contribution of medicine and health care [to population health] is quite limited” and that “the key factors which influence population health are income and social status, social support networks, education, employment/working conditions, social environments, physical environments, [...] and culture.”³ Therefore, it is important to make the connection between certain demographic data and health determinants.

Southern Ontario is a region of contrasts, marked by diversity and urbanization. Although the South's 174,115 Francophones make up Ontario's second largest concentration of Francophones next to Eastern Ontario, this population represents only 1.9% of the region's total population.⁴ Furthermore, more and more of these Francophones reside in areas that are not designated under the FLSA. In fact, nearly 43% of the region's Francophones live in non-designated areas. This extreme minority status—in combination with other factors such as the shortage of human resources, the repercussions of the transformations underway in the health care system, and assimilation—pose a major challenge to improving access to French language health services.

The territory served by the Réseau franco-santé du Sud de l'Ontario can easily be divided into two regions, namely the central and southwest regions, and these differ substantially. This division is reflected in the following analyses.

³ Public Health Agency of Canada, “What determines health?”, February 2004. [<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html>].

⁴ The statistical data in this section were drawn primarily from the data bank Portrait of Official Language Communities in Canada – 2001 Census, available on CD-ROM from Statistics Canada.

It is important to make the connection between certain demographic data and health determinants.

The central region contains the following 17 CDs: Brant County, Dufferin County, Haliburton County, Northumberland County, Peterborough County, Simcoe County, Wellington County, Hamilton Division, Kawartha Lakes Division, Toronto Division, Regional Municipality of Durham, Regional Municipality of Haldimand-Norfolk, Regional Municipality of Halton, Regional Municipality of Niagara, Regional Municipality of Peel, Regional Municipality of York and Regional Municipality of Waterloo. Of these 17 divisions, Simcoe, Hamilton, Toronto, Durham, Halton, Niagara, Peel, York and Waterloo are included in this study.

The southwest region contains the following 10 CDs: Bruce County, Essex County, Elgin County, Grey County, Huron County, Lambton County, Middlesex County, Oxford County, Perth County, and Chatham-Kent Division. Only the Essex, Middlesex and Chatham-Kent CDs are included in the study.

3.1.1 Central region

More than 138,000 Francophones live in the central region. The largest numbers are found in Greater Toronto, for both those with French as their mother tongue and those with French as their first official language spoken. Smaller population centres are found in Hamilton, Simcoe and Niagara.

A majority (60%) of Francophones belonging to a racial minority live in Central Ontario, where they account for more than one Francophone in five. Three Francophones out of five in the central region were born outside the province, with more than a third being born in Quebec. Francophones in Central Ontario do very well in comparison with the region's general population. The percentage of Francophones with postsecondary training is higher than in the general population. Some 19% of Francophones in this region have an undergraduate degree.

The unemployment rate among Francophones is lower than in the general population and Francophones have a higher labour market participation rate. In addition, the average employment income and average total income of Francophones in the region are substantially higher than those for the general population. Given the higher level of education in the central region, it is not surprising that Francophones' average employment income and average total income are higher than in the other regions.⁵

⁵. Office of Francophone Affairs, Statistical Profile – Francophones in Ontario – General Profile, Government of Ontario, September 2005. p. 22.



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The central region has the largest number of Francophones belonging to a visible minority.

Age

Generally speaking, the largest numbers of young Francophones are found in urban centres. The regional municipalities of York and Peel have the highest percentages of Francophones aged 14 years and under (mother tongue and first official language spoken), whereas Toronto, followed by the regional municipalities of Waterloo and Peel, have the highest percentages of young Francophones aged 15 to 29.

In regions further from Toronto with smaller numbers of Francophones, the population is aging. For example, the regions of Hamilton, Simcoe and Niagara have the highest percentages of Francophones aged 55 and over. This phenomenon will affect the need for primary health care services and make access to French language services all the more essential.

Identity and mobility

The central region has the largest number of Francophones belonging to a visible minority; this population is concentrated primarily in Toronto and neighbouring areas. For example, of the 61,585 Toronto residents with French as their first official language spoken, 20,455, or 33.21%, self-identify as belonging to a visible minority. After Toronto, the regional municipalities of York and Peel as well as the Hamilton Division have the highest percentages of people belonging to a visible minority.

According to the Office of Francophone Affairs:

[...] Close to three quarters of Francophones from racial minorities are born outside the country, compared to 6.8% of the general Francophone population and 27.9% of the total population of the province. [...] The level of education of Francophones from racial minorities tends to be higher than for Francophones in general, racial minorities overall, and the province's population as a whole. The unemployment rate among Francophones from racial minorities is distinctly higher than among the Francophone population as a whole and racial minorities in general. Employment income of Francophones from racial minorities is lower than that of Francophones in general. The percentage of individuals who live below the low-income cut-off is twice as high among Francophones from racial minorities as among the general Francophone population. This percentage is also higher than among racial minorities as a whole.⁶

With the exception of high levels of education, all the other factors mentioned are likely to have an adverse impact on the health status of Francophone visible minorities.

As the preceding quote indicates, immigration is an important factor in Central Ontario. As well, Central Ontario, especially Toronto, has the highest mobility rate for Francophones in Ontario.

⁶ Office of Francophone Affairs, Statistical Profile – Francophone Racial Minorities in Ontario, Government of Ontario, September 2005. p. 5. [<http://www.ofa.gov.on.ca/docs/stats-minorities.pdf>].

Education

People's level of education also plays an important role in their health. According to the Public Health Agency of Canada:

People's health status and life expectancy increase in tandem with their levels of education. For example:

- Women with higher levels of education are more likely to have normal birthweight babies (Canadian Institute of Child Health, Healthy Pregnancy and Childbirth). [...]
- Canada's 1996-97 Population Health Survey found that almost twice as many university graduates as people with a grade school education rate their health as "excellent" (30 per cent compared to 19 per cent). [...].⁷

Literacy also has an impact on individuals' health.⁸ Various studies have demonstrated that "low literacy levels have a major negative impact on health. [...] However health is defined or measured, people with limited literacy skills are worse off than others with higher literacy skills [...]."⁹

Overall, Francophones in the central region have a fairly high level of education. For example, except for the Niagara and Simcoe regions, the percentage of Francophones with postsecondary education is higher than in the general population.¹⁰ This phenomenon is most striking in Toronto, where more than 65% of Francophones (first official language spoken) have pursued postsecondary studies. The corresponding figures are 63% in York, 58% in Halton, 57% in Peel, 47% in Durham, 46% in Waterloo and 42% in Hamilton. In contrast, only 32% and 38% of Francophones in the Niagara and Simcoe regions, respectively, have pursued postsecondary education.

Nevertheless, the percentage of the population with less than a grade 9 education remains high at 9.5%, compared to 8.2% of the general population. Historically, a higher percentage of the Francophone population than of the general population has not pursued secondary education—11.9% compared to 8.1% (2001 census). Having less than a grade 9 education is one of the factors used to analyse illiteracy within a given population.¹¹ Once again, the Niagara and Simcoe regions stand out in this regard.

The relatively high percentage of Francophones who have not obtained a high school diploma could have implications for the delivery of primary

7. Public Health Agency of Canada, *How Does Education Affect Health?*, September 2004.

[<http://www.canadian-health-network.ca/servlet/ContentServer?cid=1005636&pagename=CHN-RCS%2FCHNResource%2FFAQCHNResourceTemplate&c=CHNResource&lang=En>].

8. Public Health Agency of Canada, "What determines health?", February 2004. [<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html#education>].

9. Public Health Agency of Canada, *How does Literacy Affect the Health of Canadians, Profile Study*, prepared by Burt Perrin, Burt Perrin Associates, 1998. [<http://www.phac-aspc.gc.ca/ph-sp/phdd/literacy/literacy2.html>].

10. Office of Francophone Affairs, *Statistical Profile – Francophones in Ontario – General Profile*, Government of Ontario, September 2005. p. 12-13. [<http://www.ofa.gov.on.ca/docs/stats-general-en.pdf>].

11. *Ibid.*, p. 11.



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health care services such as health promotion and disease prevention programs.

Marital status

Another major health determinant is social support. According to the Public Health Agency of Canada:

Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems.¹²

An important indicator of the social support to which an individual has access is marital status. In all the selected CDs, except Toronto, between 45% and 53% of Francophones are legally married, while a significant minority, i.e. between 28% and 34%, have never been married. However, the situation is quite different in Toronto. There only 34% of people with French as their mother tongue and 39% of people with French as their first official language spoken are legally married. These data point to a potential lack of social support

Exogamy and language retention

Another important factor often related to marital status is language retention. Mother tongue language retention is measured based on the home language spoken by people with French as their mother tongue. Province-wide, French is the language most often spoken at home by 56.5% of Francophones. In Central Ontario, however, the level of language retention is 33%; this represents a drop compared to the 1996 figure of 34.3%.¹³

One of the factors accounting for the drop in retention of French is the number of exogamous (mixed) unions. The percentage of exogamous unions is increasing across the province, especially in the central region. According to 2001 statistics, among families with children where at least one of the partners was Francophone, 81.5% of unions were exogamous. When both parents have French as their mother tongue, the vast majority of children retain French (91.7%). When only the mother has French as her mother tongue, 34.2% of children retain French, and when only the father has French as his mother tongue, this percentage falls to 14.6%.¹⁴

¹². Public Health Agency of Canada, Population Health, Underlying Premises and Evidence, February 2004. Consulted on January 3, 2006. [<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html#evidence>].

¹³. Office of Francophone Affairs, Statistical Profile – Francophones in Ontario, 1999. p. 10, [<http://www.ofa.gov.on.ca/docs/overv-e.pdf>] and Statistical Profile – Francophones in Ontario – General Profile, 2005. pp. 9-10, [<http://www.ofa.gov.on.ca/docs/stats-general-en.pdf>].

¹⁴. *Ibid.*

The relatively high percentage of Francophones who have not obtained a high school diploma could have implications for the delivery of primary health care services.

Exogamy thus has serious consequences for the future of French in Central Ontario. The community consultations also uncovered problems related to Francophones' sense of belonging and pride with respect to their language and culture. As the *Second Report on the Health of Francophones* noted, this feeling of belonging has an impact on health.

Income

The Public Health Agency of Canada rates income as one of the two most important determinants of health. Health status improves with every step up the income and social status ladder. Some of the relevant factors the Agency cites in support of this hypothesis include:

- Only 47% of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73% of Canadians in the highest income group. [...]
- Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole.¹⁵

The income structure in the central region is fairly similar across census divisions. More than 60% of Francophones aged 15 and over have total incomes over \$20,000. Most earn between \$20,000 and \$49,999. However, the Niagara region has the highest percentage of Francophones with incomes below \$20,000, followed by the Simcoe and Hamilton regions. Overall, more than 40% of the Francophone population in these three regions has an income of less than \$20,000.

Labour market

Employment clearly affects people's physical, mental and social health. Paid employment not only supplies income but also imparts a feeling of identity and usefulness, provides social contact, and creates potential for personal growth. Unemployed people have shorter life expectancy and significantly more health problems than do employed people.

A major study conducted for the World Health Organization (WHO) reported that high levels of unemployment and economic instability within a society lead to significant mental health problems and to adverse effects on the physical health of unemployed people, their families and their communities.¹⁶

¹⁵. *Public Health Agency of Canada, Population Health, Underlying Premises and Evidence, February 2004.* [<http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html#evidence>].

¹⁶. *Ibid.*



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The Southwest is characterized by an aging Francophone population.

Generally speaking, Francophones in the central region have a higher labour market participation rate than the corresponding general population (69.3% versus 68.1%).¹⁷ The two populations have similar unemployment rates (5.7% versus 5.8%),¹⁸ while the percentage of non-working people is higher in the Niagara (40.6%), Hamilton (37.23%) and Simcoe (36.34%) regions.

3.1.2 Southwest

Although the approximately 35,000 Francophones in the Southwest account for less than 3% of the region's total population, they account for 6.3% of the province's total French mother tongue population. Francophones in the Southwest are primarily found in Essex and Middlesex counties and the Chatham-Kent Division, with a smaller concentration in Lambton County.

The Southwest is characterized by an aging Francophone population. Nearly one-quarter of Francophones in the region are aged 65 years and over, compared to 14% of the general population. As a result, Francophones here have a lower labour market participation rate than elsewhere in Ontario.¹⁹

Age

As previously mentioned, an aging population has serious consequences for the health care system with respect to areas such as management of chronic illness. In the Southwest, most Francophones are in the 30-to-64 age group, although there is a significant older Francophone population as well. In Chatham-Kent and Essex County, for example, there are more people aged 65 and over than 29 and under. Bucking this trend, however, is Middlesex County, which has larger 29-and-under and 30-to-54 age groups and a smaller 65-and-over age group. Middlesex County thus more closely resembles areas in the central region.

Identity

The Southwest has the highest percentage of Francophone visible minorities after the central and eastern regions. The greatest numbers of visible minority Francophones are found in Essex and Middlesex counties. Like their counterparts in the central region, visible minority Francophones in the Southwest are better educated than the Francophone general population. On the other hand, the labour market participation rate of Francophone racial minorities is lower (61.6%) in the Southwest than elsewhere in Ontario and also lower than in the Francophone general population. Like their counterparts in the central region, Francophone racial minorities in the Southwest have a higher unemployment rate (16.8% versus 4.9%)²⁰ and lower total income than the Francophone

¹⁶. *Ibid.*

¹⁷. Office of Francophone Affairs, Statistical Profile – Francophones in Ontario – General Profile, September 2005. p. 14. [<http://www.ofa.gov.on.ca/docs/stats-general-en.pdf>], p. 14, [<http://www.ofa.gov.on.ca/docs/stats-general-fr.pdf>].

¹⁸. *Ibid.*

¹⁹. *Ibid.*, p. 22.

²⁰. Office of Francophone Affairs, Statistical Profile – Francophone Racial Minorities in Ontario, September 2005, pp. 15-16. [<http://www.ofa.gov.on.ca/docs/stats-minorities.pdf>].

general population in the region.²¹ As previously explained, these factors have negative repercussions on the health of individuals and their families.

Education

It is recognized that the level of education people attain is an important determinant of health. Within the CDs in the Southwest selected for this study, higher percentages of Francophones have not completed grade 9 (15.3% compared with 8.4% in the general population). These percentages are comparable to those in the Niagara and Simcoe areas of the central region. As well, with the exception of Middlesex County, a smaller number of Francophones have pursued postsecondary education.

Marital status

The important role of social support, including family support, as a determinant of health has already been discussed. In the Southwest, between 47% and 55% of the population is legally married. There is also a significant minority of people who have never been legally married, but this minority is smaller than in certain areas of the central region.

Exogamy and language retention

As previously mentioned, another important factor often linked to language retention is marital status. In the Southwest, the level of language retention is only 26.9%. This is the lowest level in the entire province and a drop in relation to the 1996 figure of 29.6%.²²

At 82.2%, the Southwest has the highest percentage of exogamous unions. This is undoubtedly one of the factors accounting for the drop in retention of French.²³

Income

The breakdown of total income earned by Francophones aged 15 and over is fairly similar in the various counties and divisions in the Southwest. In general, more Francophones have total incomes between \$10,000 and \$19,999 than between \$20,000 and \$34,999. In Essex County, 3,295 Francophones earn between \$10,000 and \$19,999, compared with 2,635 who earn between \$20,000 and \$34,999.

Middlesex County has a slightly higher percentage of Francophones aged 15 and over with total incomes between \$20,000 and \$34,999. The percentage of Francophones earning between \$35,000 and \$49,999 is also higher.

21. *Ibid.*, p. 21.

22. Office of Francophone Affairs, *Statistical Profile – Francophones in Ontario, 1999*. p. 10, [<http://www.ofa.gov.on.ca/docs/overv-e.pdf>] and *Statistical Profile – Francophones in Ontario –General Profile, 2005*. pp. 9-10, [<http://www.ofa.gov.on.ca/docs/stats-general-en.pdf>].

23. *Ibid.*



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At 82.2%, the Southwest has the highest percentage of exogamous unions.

Labour market

The most striking aspect of the labour market participation rate within the Francophone population in the Southwest is the very high proportion of non-working people. At 56.8%, Francophones' participation rate is the lowest in the province and significantly below the 66.7% rate for the region's general population. This observation is directly related to the region's high number of people aged 55 years and over. On the other hand, the unemployment rate is fairly low.

3.2 Health status of Ontario Francophones

Relatively few data are available on the health status of the Francophone population of Southern Ontario. However, some research is starting to explore this issue.

Published in 2005, the *Second Report on the Health of Francophones in Ontario* used the health determinants approach to generate an overview of the health status of Francophones, based primarily on the *2001-2002 Canadian Community Health Survey*.²⁴ For the first time, the report examined people's sense of belonging to a community as a health determinant. The research showed a positive link between a sense of belonging and health. Proportionally speaking, more Francophones than non-Francophones in the South and than other Francophones in the province state they have a "weak" sense of belonging. This same observation emerged from the community consultations.

Francophones generally have a poorer perception of their health than Anglophones. The exception to this general trend occurs in the central region, where Francophones are more likely than those in the other regions to perceive their health status as "very good or excellent." Notwithstanding this exception, Francophones' generally poorer perception of their health is borne out by the health index, an objective measurement of health status. A proportionally smaller number of Francophones than non-Francophones in the South obtain a "very good or excellent" rating on this index. On the other hand, more than half of Francophones state they have done "something" to improve their health, especially with respect to exercise, sports or physical activity. The only exception to this occurs in the Southwest, where proportionally fewer Francophones have taken action to improve their health. Francophones in the South are more likely to need assistance with daily activities than non-Francophones.

Among both Francophones and non-Francophones, the rates of chronic illnesses and serious injuries generally increase with age and diminish with increased income. In the South as a whole, Francophones are more subject to cardiovascular illnesses than non-Francophones, while in the Southwest, a higher percentage of Francophones have been diagnosed with asthma.

^{23.} *Ibid.*

^{24.} Picard, L. et al., *Report on the Health of Francophones in Ontario, 2005.*

Since the *First Report on the Health of Francophones in Ontario* was published in 2000, the rates at which both Francophones and non-Francophones consult health professionals, suffer depression, and experience work-related stress have increased. However, the same percentage of Francophones and non-Francophones report having high decision latitude at work. This percentage is higher in the South and especially in the central region. The findings also indicate that Francophone women are in poorer health than Francophone men. They consult physicians more often, have a higher rate of depression, and report higher levels of work-related stress.

With respect to health behaviours, proportionally more Francophones than non-Francophones in the South have smoked, been exposed to second-hand smoke, and consumed alcohol. On the other hand, proportionally more Francophone than non-Francophone women in the South have undergone screening tests. These are valuable observations from the health promotion perspective.

3.3 Delivery of French language health services in Southern Ontario

The framework for the delivery of French language health services in Ontario is determined primarily by the *French Language Services Act*. As explained in the *Provincial Report*, the Act provides for the designation of health agencies in the 25 designated areas of the province to deliver French language services. For this reason, MOHLTC’s efforts to implement the Act have focused on health facilities.

The Ministry gave district health councils (DHCs) the job of “identifying” health agencies (hospitals, long-term care facilities, community health centres) to deliver French language services and develop regional implementation plans. Some 172 agencies and programs were “identified” in the South to deliver French language services. However, implementation by agencies remains voluntary, and progress varies widely from region to region. To date, only nine of the “identified” agencies in the South have obtained full or partial designation.

To support their work, most of the DHCs established French language health services (FLHS) advisory committees. In addition, MOHLTC put together a team of FLHS regional consultants to support the DHCs and assist the “identified” agencies in implementing FLHS.

Despite the assistance that the FLHS regional consultants have provided to agencies, FLHS delivery remains sporadic. There are numerous barriers: difficulty recruiting health and social service professionals able to provide French language services, lack of commitment by agencies’ senior management and boards of directors, difficulty meeting all the designation criteria, and lack of interest in designation.



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Furthermore, a significant portion of primary health care falls outside the Act. All health professionals in private practice, for example, are excluded. For this reason, improving access to primary health care in French will necessarily involve looking beyond the Act.

As indicated in the *Provincial Report*, the entire health care landscape in Ontario is changing. In 2005, the government disbanded the DHCs, replacing them with LHINs that will henceforth be responsible for all aspects of health care service delivery at the local level. It will be their job to plan FLHS and engage the Francophone community in this planning process. The role of the regional consultants is also changing. They will be called upon to work closely with the LHINs and the community.

*A significant
portion of primary
health care falls
outside the
French Language
Services Act.*

Chapter 4: Findings

4.1 Review of services

The first step in this process was to consult secondary sources (agency lists, Internet, etc.) and compile an inventory of primary health care services in the 12 CDs selected for inclusion in this study. Most of the data collected was for with the following CDs: Chatham-Kent, Durham, Essex, Halton, Hamilton, Middlesex, Niagara, Peel, Toronto, Simcoe, Waterloo and York. A few data on other CDs were also included.

As indicated on page 14, the Southern Ontario study examined the following services:

- family physicians and pediatricians;
- community health centres (CHCs);
- family health teams (FHTs);
- public health services (clinical care, services delivered in schools, and the *Healthy Babies, Healthy Children* program);
- community care access centres (CACCs)(home nursing care, including palliative care);
- mental health and addiction services;
- Telehealth Ontario.

This inventory is intended simply as an initial look at the primary health care services available in some areas of the South, i.e. a preliminary analysis of the French language services provided. Additional research will be needed, primarily through the *Portail franco-santé du Sud* project.

4.1.1 Family physicians

For most people, family physicians in private practice are the entry point to the health care system. Therefore, the research team searched the College of Physicians and Surgeons of Ontario²⁵ website to identify physicians located in the main cities of Southern Ontario who list French as one of their languages of service. The resulting data are summarized in the following table. MOHLTC has identified many of these places as underserved areas.²⁶ The table also indicates the number of vacancies in some of them.

These data must be interpreted with care. First, very few of the identified physicians are accepting new patients. Second, their language skills have not been objectively evaluated, which means the quality of the services they provide remains unknown. Third, although a straightforward calculation in some regions would appear to suggest that there are enough physicians to care for

²⁵ The College of Physicians and Surgeons of Ontario, Doctor Search, [http://www.cpso.on.ca/Doctor_Search/dr_srch_hm.htm], consulted in July 2005.

²⁶ Ministry of Health and Long-Term Care, Primary Health Care Team, Underserved Area Program, List of Areas Designated as Underserved for General/Family Practitioners, April/May/June 2006.



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the number of Francophones (mother tongue), the actual situation is quite different. In general, these physicians serve the entire community and Francophones make up only a small portion of their practices. Francophones are often not aware of the services these physicians provide and so do not call on them. The community consultations did in fact identify a shortage of family physicians in most regions. This perception is not necessarily false.

Table 2 : Family physician offices in selected Southern Ontario census divisions

Census division	City	Number with French as a language of service	Authorized complement	Number of vacancies
Chatham-Kent†	Chatham*	4	69	20
Durham†	Ajax	6		
	Oshawa	3	101	38
	Pickering	1		
	Whitby*	1	63	11
Essex†	Belle River* (Lakeshore)**		(Lakeshore)	(Lakeshore)
		3	13	10
	Windsor*	20	164	37
Halton†	Burlington	13	109	13
	Milton*	2	30	3
	Oakville	15		
Hamilton	Hamilton	20		
Lambton†	Petrolia	1		
	Sarnia*	11	67	24
Middlesex†	London	19		
Niagara†	Niagara Falls*	8	56	23
	Port Colborne*	0	17	4
	St. Catharines*	13	95	15
	Welland*	4	35	16
Peel	Mississauga	33		
	Brampton	16		
Simcoe†	Barrie*	8	94	10
	Midland* (North Simcoe)***	5	(North Simcoe)	(North Simcoe)
			31	4
	Penetanguishene* (North Simcoe)***	3	(see Midland)	(see Midland)
Toronto	Toronto	316		
Waterloo†	Kitchener	8		
	Waterloo	3		
	Cambridge*	8	72	13
Wellington†	Guelph*	10	89	5
York†	Markham	7		
	Newmarket	4		

† CD with underserved areas

* Municipality eligible for MOHLTC incentive programs.

** Belle River is part of the new municipality of Lakeshore, along with the townships of Maidstone, Rochester, Tilbury North and Tilbury West. MOHLTC data apply to the whole municipality.

*** Midland and Penetanguishene are part of the new municipality of North Simcoe, along with the townships of Tay and Tiny. MOHLTC data apply to the whole municipality.

4.1.2 Community care access centres

Community care access centres (CCACs) provide access to the long-term care system. The CCACs assess clients' needs with respect to health and home support services, coordinate visits by the required professionals, authorize services for special needs children in schools, manage admissions to long-term care facilities, and make referrals to other community services. In addition, CCAC case managers determine clients' eligibility for home care.

The services provided through CCACs include nursing, physiotherapy, occupational therapy, speech-language therapy, dietician services, social work, personal support, and homemaking.²⁷ They are delivered by for-profit or not-for-profit external agencies that are under contract to the CCACs. Services are fully funded by MOHLTC.

There are a total of 27 CCACs in Southern Ontario. The following table lists the 16 CCACs within the 12 selected CDs. Of these 16 CCACs, 12 fall under the FLSA. However, the number and quality of the French language services they provide vary greatly from one region to another. The London and Middlesex CCAC, for example, provides French language services on a fairly proactive basis, while at the Toronto CCACs, French language services delivery remains sporadic.

Table 3 : Community care access centres in selected Southern Ontario census divisions

Census division	City	CCAC	FLSA
Chatham-Kent	Chatham	Chatham-Kent CCAC	✓
Durham	Whitby	Access to Care Durham	
Essex	Windsor	Windsor-Essex CCAC	✓
Halton	Burlington	Halton CCAC	
Hamilton	Hamilton	Hamilton CCAC	✓
Middlesex	London	London and Middlesex CCAC	✓
Niagara	St. Catharines	Niagara CCAC	✓
Peel	Brampton	Peel CCAC	✓
Simcoe	Barrie	Simcoe County CCAC	✓
Toronto	Toronto (East York)	East York CCAC	✓
	Toronto (Etobicoke)	Etobicoke and York CCAC	✓
	Toronto (North York)	North York CCAC	✓
	Toronto (Scarborough)	Scarborough CCAC	✓
	Toronto (downtown)	Toronto CCAC	✓
Waterloo	Kitchener	Waterloo Region CCAC	
York	Newmarket	York Region CCAC	

²⁷ Ministry of Health and Long-Term Care, "Facts about Community Care Access Centres," consulted on January 4, 2006. [http://www.health.gov.on.ca/english/public/contact/ccac/ccac_facts.html].



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4.1.3 Community health centres

Community health centres (CHCs) offer a range of services, including primary health care and health promotion programs. The CHCs emphasize health promotion and disease prevention. Their primary care teams typically include physicians, nurse practitioners, nurses, social workers, health promotion officers, community health workers and, often, chiropractors, nutritionists and dietitians. Most CHCs target specific groups such as Francophones, First Nations or at-risk populations.²⁸

The following table shows the number of CHCs in the 12 CDs covered by the study. Of the 33 CHCs in the South, only two, with four service points, are Francophone: the Hamilton/Niagara CHC and the *Centre Francophone de Toronto*. Two others, located in London and Toronto, provide some French language services.

In November 2005, MOHLTC announced the creation of 22 new CHCs and 17 satellite CHCs over the next three years. Some of the centres announced for the 12 CDs covered by the study include a CHC in Fort Erie-Port Colborne (Niagara) and two satellite CHCs in Toronto (for 2005-2006); a CHC in Chatham-Kent, a CHC in St. Catharines (Niagara) and a CHC in Brampton (Peel), with a satellite CHC in Toronto as well as three other satellite CHCs in Toronto (for 2006-2007); a CHC in Collingwood-Midland (Simcoe), a CHC in Niagara Falls (Niagara) and a CHC in Vaughn (York), with a satellite CHC in Toronto as well as two other satellite CHCs in York and Pickering (Durham) respectively, (for 2007-2008). It remains to be seen which of these facilities will offer services in French.

Of the 33 CHCs in the South, only two, with four service points, are Francophone.

Table 4 : Community health centres in selected Southern Ontario census divisions

Census division	City	Number of CHCs	Number offering FLHS
Chatham-Kent		0	0
Durham	Ajax	1	0
	Oshawa	1	0
Essex	Windsor	2	0
Halton		0	0
Hamilton	Hamilton	3	1
Middlesex	London	1	1
Niagara	Welland	1	1
Peel		0	0
Simcoe	Barrie	1	0
Toronto	Toronto	22	2 (1 has 2 service points)
Waterloo	Kitchener	1	0
York		0	0

²⁸. Ministry of Health and Long-Term Care, "Community Health Centres," consulted on January 4, 2006. [http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html].

4.1.4 Family health teams

Family Health Teams are locally driven primary health care delivery organizations which may include family physicians, nurse practitioners, nurses and a range of other health professionals who [...] provide comprehensive, accessible, coordinated primary health care services to a defined population. [...] Family Health Teams may include mental health workers, physician specialists, diagnostic services, linkages to home care services, and some outpatient surgery services. These teams will also serve as a focus for chronic disease management and health promotion and disease prevention activities in conjunction with local public health units and other community-based health care organizations.²⁹

The family health team model is new to Ontario. The first wave of teams was announced in April 2005, the second in December 2005, and the third in April 2006. Most of these teams are not yet delivering services. To date, only one FHT appears to be planning to provide French language services. The following table lists, by LHIN, the number of FHTs announced for each of the 12 selected CDs.



Table 5 : Family health teams announced in selected Southern Ontario census divisions

Census division	LHIN	Number of FHTs
Chatham-Kent	Erie St. Clair	2
Durham	Central East	1
Essex	Erie St. Clair	4
Halton	Hamilton Niagara Haldimand Brant	1
	Mississauga Halton	4
Hamilton	Hamilton Niagara Haldimand Brant	9
Middlesex	South West	2
Niagara	Hamilton Niagara Haldimand Brant	6
	Peel	1
Peel	Central West	1
	Mississauga-Halton	1.5
Simcoe	Central	1
	North Simcoe Muskoka	4
Toronto	Central West	1
	Mississauga Halton	1.5
	Toronto Central	10
	Central	2
Toronto	Central East	1
	Waterloo	4
Waterloo	Waterloo Wellington	4
York	Centre	3

29. Ministry of Health and Long-Term Care, "Introduction to Family Health Teams," December 2005, consulted on January 5, 2006. [http://www.health.gov.on.ca/transformation/fht/infokit/fht_intro.pdf]

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4.1.5 Public health services

A Public Health Unit is an official health agency established by a group of municipalities to provide public health services. [...].³⁰ Health units administer health promotion and disease prevention programs to inform the public about healthy lifestyles, communicable disease control (including education in STDs/AIDS), immunization, food premises inspection, healthy growth and development (including parenting education), health education for all age groups, and selected screening services.

Since they are part of municipal government, public health units are not subject to the FLSA. However, MOHLTC encourages health units in designated areas to deliver mandatory programs in French. The French language school boards also encourage the health units to provide their programs in French in French language schools. The volume of services offered in French and their quality vary greatly from one region to another.

Of the 23 public health units in the South, the following table lists those in the 12 selected CDs.

Table 6 : Public health units in selected Southern Ontario census divisions

Census division	City	Health unit	FLHS
Chatham-Kent	Chatham	Bureau de santé de Chatham-Kent	✓
Chatham-Kent	Chatham	Chatham-Kent Health Unit	✓
Durham	Whitby	Durham Health Department	
Essex	Windsor	Windsor-Essex County Health Unit	✓
Halton	Oakville	Halton Region Health Department	
Hamilton	Hamilton	Public Health	✓
Middlesex	London	Middlesex-London Health Unit	✓
Niagara	St. Catharines	Regional Niagara Public Health Department	✓
Peel	Brampton	Peel Public Health	✓
Simcoe	Barrie	Simcoe-Muskoka District Health Unit	✓
Toronto	Toronto	Toronto Public Health	✓
Waterloo	Kitchener	Region of Waterloo Public Health	
York	Newmarket	York Health Department Services	

³⁰. Ministry of Health and Long-Term Care, Public Information, Public Health Units, consulted in January 2006. [http://www.health.gov.on.ca/english/public/contact/phu/phu_mn.html].

Since they are part of municipal government, public health units are not subject to the FLSA.

4.1.6 Mental health and addiction services

The first point of contact for mental health services is most often a family physician, although other health professionals and other sectors may also refer people with mental health or addiction problems. Community health centres and family health teams also play an important role as entry points into the mental health and addiction care system, which provides both institutional and community-based care.

Ontario's mental health services are currently being delivered by four psychiatric hospitals, five specialty hospitals, 53 general hospital psychiatric units, and approximately 359 community mental health programs and 148 homes for special care.³¹ These agencies provide primary, secondary and tertiary services as well as support services to help clients find housing or employment, continue their education or maintain a stable income. They also provide support services to families.

The main specialty facilities identified in Southern Ontario to provide services in French are the Penetanguishene Mental Health Centre and the Centre for Addiction and Mental Health (CAMH). CAMH is based in Toronto but delivers services across the South through a network of local offices located in Pickering, Toronto, Mississauga, Hamilton, St. Catharines, Waterloo, Penetanguishene, Newmarket, Owen Sound, London, Chatham and Windsor.³²

MOHLTC has, in recent years, been implementing mental health reform. Under this reform, community services are playing an increasingly important role, with one of the goals being to ensure that services are truly centred on the needs of clients and their families.

Such an approach opens the door to a wide range of service models designed to meet very complex needs. Community service models include assertive community treatment teams, clubhouses, crisis intervention teams, early intervention in psychosis treatment teams, peer support groups, and others. Regardless of the model, case managers play a key role with clients and their families.

The following table provides an overview of the services available in the 12 CDs selected for this study. These data were drawn from lists of health service providers by LHIN, which were posted on the MOHLTC Web site.³³ According to the Ministry, these lists are intended as an overview and may not be complete. As for the actual offer of FLHS by "identified" agencies, service availability and quality vary enormously, even in a field where everything depends on effective communication. The community consultations revealed many needs in this area.

³¹. Ministry of Health and Long-term Care, Public Information, Mental Health Programs and Services, consulted in May 2006. [http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_services/services_mn.html].

³². Centre for Addiction and Mental Health, Ontario Regional Service, consulted in May 2006. [http://www.camh.net/About_CAMH/Ontario_Regional_Services/index.html].

³³. Ministry of Health and Long-Term Care, "Local Health Integration Networks: Geographic Boundaries and Supporting Information," [http://www.health.gov.on.ca/transformation/lhin/lhinmap_mn.html].



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Table 7 : Addiction, mental health and related community support services in selected Southern Ontario census divisions

Census division	LHIN	Service	Number	Number identified to provide FLHS
Chatham-Kent	Erie St. Clair	Addiction	2	2
		Community support	3	3
		Mental health	3	2
Durham	Central East	Addiction	1	0
		Community support	3	0
		Mental health	9	0
Essex	Erie St. Clair	Addiction	5	2
		Community support	2	2
		Mental health	6	4
Halton	Hamilton Niagara Haldimand Brant	Addiction	1	0
		Community support	2	0
		Mental health	2	0
	Mississauga Halton	Addiction	2	0
		Mental health	6	0
Hamilton	Hamilton Niagara Haldimand Brant	Addiction	8	3
		Community support	5	2
		Mental health	10	3
Middlesex	South West	Addiction	6	3
		Community support	4	3
		Mental health	14	5
Niagara	Hamilton Niagara Haldimand Brant	Addiction	6	4
		Community support	5	3
		Mental health	8	5
Peel	Central West	Addiction	1	0
		Community support	1	0
		Mental health	7	2
	Mississauga Halton	Addiction	1	0
		Community support	4	1
		Mental health	3	0
Simcoe	North Simcoe Muskoka	Addiction	4	2
		Community support	4	0
		Mental health	7	3
Toronto	Central West	Addiction	0	0
		Community support	0	0
		Mental health	1	2
	Mississauga Halton	Addiction	1	0
		Community support	0	0
		Mental health	1	0
	Toronto Central	Addiction	26	4
		Community support	5	1
		Mental health	71	8
	Centre	Addiction	3	0
		Community support	1	0
		Mental health	11	1
Central East	Addiction	2	0	
	Community support	0	0	
	Mental health	6	0	
Waterloo	Waterloo Wellington	Addiction	4	0
		Community support	5	0
		Mental health	8	0
York	Central East	Addiction	3	0
		Community support	2	0
		Mental health	11	0

Service availability and quality vary enormously, even in a field where everything depends on effective communication.

4.1.7 Telehealth Ontario

Telehealth Ontario is a free MOHLTC telephone service that provides health advice and general health information.

Users of the Telehealth service speak directly to a registered nurse who asks them to describe their symptoms and answer certain questions so that the seriousness of their problem can be assessed as accurately as possible. The nurse can then advise them on self-care, recommend that they consult a physician, or provide telephone numbers for the nearest community resources.

Telehealth Ontario provides service in French and English. A bilingual greeting on the toll-free number allows users to choose the language in which they wish to be served. If they choose French, they can count on a French-speaking nurse being available to handle their inquiry, 24 hours a day, 7 days a week.³⁴

A survey conducted in September 2005 confirmed that Telehealth provides services in French at all times. The survey also indicated that Francophone human resources are in place at all levels, including management, administration, reception and front-line services.

4.2 Summary of community consultations

To better understand the real-life conditions that Francophones experience in relation to primary health care, the research team consulted study participants in the 12 Southern Ontario census divisions. In so doing, the team was also able to collect information on the 10 planning regions (LHINs) within the territory served by the *Réseau*.

As explained in the *Methodology* section, between December 2005 and March 2006, the team interviewed 109 key informants and held nine discussion groups. To analyse the data, the team initially conducted an analysis by region according to certain broad categories and then summarized the regional findings, which revealed both general trends and regional characteristics. This process provided an overview of the needs of the populations in question, of existing gaps, and of some potential solutions to meet those needs. Finally, the team grouped the findings according to the four strategic priorities the four Ontario networks had identified as being key to the development and implementation of quality French language primary health care in Ontario, i.e. access points, human resources, promotion and prevention, and planning and management of services.

This report discusses the needs and gaps reported by participants, then looks at the potential solutions proposed in relation to the four strategic priorities and certain major categories within the priorities.

³⁴. Ministry of Health and Long-term Care, Public Information, Telehealth Ontario, consulted in September 2005. [http://www.health.gov.on.ca/english/public/program/telehealth/telehealth_mn.html].



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The most vulnerable groups find themselves at the greatest disadvantage in accessing primary care services in French.

4.2.1. Access points

“Access point” refers to any location where health care services are delivered. The subject of access points is explored below in relation to the following categories: availability of services, organization of services, structures and agencies, awareness and culture, and translation, interpretation and accompaniment services.

Availability of services

With respect to service availability, a large number of needs and gaps were identified across the South. With a few exceptions, there is a general shortage of primary health care (PHC) services, regardless of language. It was also noted that very few French language PHC services exist, even in designated areas. Where French language services do exist, they are not always visible and are not necessarily offered on a proactive basis.

Participants mentioned specific fields in which they had observed gaps. For example, they pointed out that there is a general lack of social and support services and that these are in even shorter supply in French, that there are very few French language health services (FLHS) in hospitals and clinics, that there is no continuum of FLHS in hospitals, and that lists and waiting times for FLHS are too long. They also expressed the need for more speech-language pathology, audiology, physiotherapy, occupational therapy, home care, palliative care, and support and rehabilitation services in French and for Francophone beds in long-term care centres. They indicated that there are very few community mental health and addiction services in French, especially for children and seniors. Although some professionals are able to provide services, there are very few designated access points for Francophones.

Access to services is made more difficult by the distances involved and by public transportation problems (i.e. dispersion of the Francophone population, concentration of services downtown or in towns). Another factor that reduces access is the lack of French language services at first point of contact (reception, intake, admission, emergency, ambulance), even if there are health professionals to provide FLHS at the next step in the process.

Due to this supply situation, the most vulnerable groups—young families, children and youth, seniors, women, newcomers, people with disabilities, and victims of violence—find themselves at the greatest disadvantage in accessing primary care services in French.

Many ideas were suggested to meet people’s needs and bridge the gaps. Participants argued in favour of a holistic approach to health that includes prevention and promotion as well as social and support services. They saw the need for additional services and programs in French in all parts of the South, including non-designated areas.

Taking the view that the first step is to integrate existing resources and services more effectively, study participants recommended compiling a comprehensive inventory of these resources and services wherever they may

exist—in Anglophone, bilingual and Francophone agencies, both public and private, in urban and rural areas, and in private practice—and to build on the existing infrastructure such as the Francophone and Anglophone CCACs and CHCs. Furthermore, they recommended expanding the range of services and programs offered by the existing Francophone CHCs and increasing the number of points of service (in Greater Toronto, Hamilton/Niagara). They also stressed the importance of creating multidisciplinary teams.

Given the dispersion, makeup and history of Francophone communities in the South, some participants felt it was important that services be bilingual. They also addressed access-related problems. Participants were of the view that a bilingual presence should be available at all access points to the health care system (reception, intake, admission, emergency). To combat access-related problems, they saw a need to establish outreach teams of physicians and nurses (who would see patients on pre-arranged schedules), satellite facilities, and toll-free telephone lines.

Organization of services

All participants were of the view that FLHS could be organized more efficiently. They perceived a lack of coordination in services and resources. In Toronto, for example, there are probably sufficient resources, but services are fragmented, health professionals are dispersed, and there is no mechanism for coordination or sharing. Professionals and the public both lack information on FLHS and how to access them, which makes it difficult to refer patients. Several study participants were of the opinion that the existing resources are poorly utilized and that there is duplication of some services and programs. The organization and coordination that would facilitate access to FLHS is also lacking.

There was much discussion of the need to create service networks. Participants were of the opinion that there are not always enough links between social services and health care services and that the social services available in French are poorly coordinated and largely unknown. Participants indicated that little effort is being made to create service provider networks and there are not enough partnerships among agencies. There are also very few mechanisms for sharing resources.

A final point: agencies and health professionals (both Anglophone and Francophone) are often unfamiliar with the community and do not know how to reach it.

To improve the situation, study participants recommended an integrated and inter-sectoral approach as well as coordinated action and the networking of services. In their view, it is essential to work closely with other sectors (especially education), to forge partnerships with Anglophone agencies (in Durham, for example, with the Durham Health Department and the Oshawa CHC), with existing health care agencies, and with other initiatives such as *Best Start*.

As mentioned above, existing FLHS in Francophone, bilingual and Anglophone agencies, both public and private, including those in rural areas, as well as Francophone professionals in private practice, must be inventoried,



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and this inventory must not be limited to designated areas. To obtain the maximum benefit from these services, a referral system or mechanism matching Francophone patients with Francophone professionals must be created. This system would allow Anglophone and Francophone professionals, including those in schools and daycares as well as case managers, to refer clients to the appropriate professionals.

On several occasions, the idea of seeking out success stories from other jurisdictions (like New Brunswick), benchmarking, examining best practices, and adapting successful models from here and elsewhere was suggested.

Study participants universally recommended the forging of partnerships (regional and inter-regional, often inter-sectoral), among Francophone agencies or with Anglophone, bilingual or multicultural agencies. Such partnerships could include the sharing of resources and professionals between agencies and take the form of either decentralized models, (e.g. the virtual team in London or outreach teams) or centralized models (e.g. the Early Years Centre at the *Centre Francophone de Toronto*). However, agencies' missions as they are currently defined, funding models, collective agreements, and institutional cultures may make it difficult to create partnerships.

Finally, to obtain maximum benefit from existing resources, several participants mentioned that centralized services should be established that also deliver social services, and that designated agencies should receive help in maintaining the progress achieved to date.

Structures and agencies

Most of the comments on access points fall into this section. Participants noted that most municipalities in the region do not have enough family physicians, whether in private practice, group practice or clinics. Participants also underlined the fact that there are very few access points to French language primary health care. There are only two Francophone CHCs operating four service points, with two other CHCs providing some services in French. There are no Francophone or bilingual FHTs. There are not enough family physicians providing FLHS, and very few of those who do are accepting new patients. Many of the CCACs provide very limited services in French, even if they are required to do so (e.g. Toronto). Most addiction and mental health services do not offer service in French. Many public health units do not provide French language services, even in designated areas. There are very few service points for seniors (homes). In some communities, there is no Francophone community centre or central point for accessing information.

Participants indicated that the two existing CHCs, which have long waiting lists, need to broaden the range of services they offer (dental care, chiropody, occupational therapy, physiotherapy, psychology) and open more service points. Agencies that currently offer FLHS feel that the funding models (and allocations) do not reflect the additional costs and challenges involved in delivering FLHS—translation and recruitment costs and the necessity of offering full-time positions. This point is also discussed under *Planning and Management*.

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The preferred solutions? Across the South, there was a desire for access points or service points that are tailored to the particular needs of the region in question and offer a broad range of services, such as primary care, mental health services, social services, employment services, etc. Suggestions with respect to the form that these services could take varied widely—Francophone CHCs and FHTs, walk-in clinics, group practices, Francophone days in Anglophone agencies, regular clinics in community centres, single windows, information centres and so on. The important thing is for such access points to exist and be publicized.

In Toronto, for example, participants were seeking a broader range of programs and services from the *Centre Francophone de Toronto* (CFT) in order to fill certain gaps (e.g. chiropody, physiotherapy, occupational therapy, dental care and psychology). Also mentioned was the opening of additional service points in underserved neighbourhoods in downtown Toronto or Brampton. In Hamilton and Niagara, participants asked for a broader range of programs and services from their CHCs in order to fill certain gaps, such as support and accompaniment services for immigrants and newcomers, while in Niagara, participants asked for a walk-in evening at the CHC for people without a family physician.

Participants also requested designated entry points to make navigating the system easier (“one-stop shopping”). An entry point could, for example, be located in a community centre and provide the services of a bilingual nurse practitioner (employed by an Anglophone CHC) who would deliver certain frontline services and refer clients to other services in French.

Whatever the model, many participants recommended that health professionals and services be bilingual. Over 80% of unions in the South are exogamous, hence the importance of being able to serve families in both official languages.

With respect to funding (and funding models) for care providers, especially community agencies, it was suggested that these be reviewed to ensure that adequate funding is allocated. In the participants’ view, the government should factor in the additional costs associated with delivering FLHS (recruitment, translation, work tools, etc.). FLHS envelopes should be created within provincial programs, and an effort should be made to assist providers in reaching resource-sharing agreements.

Culture and awareness

Study participants noted that gaps and challenges exist related to culture and community awareness. They explained that it is sometimes difficult to convey the importance of French language services to regional decision makers. In some areas, especially non-designated areas, Francophones are not visible. Furthermore, Anglophone agencies and professionals are unaware of Francophones’ history and rights, are not sensitive to their needs, and do not understand how important it is for them to receive health services in French.



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The dynamics specific to different communities must also be considered.

Assimilation is an extremely important issue in the South. It was noted that Francophones do not always ask for French language services. Numerous factors may account for this. They may feel intimidated, may be afraid of having to wait longer or accept lower quality services, may not know they have the right to ask for French language services, may not know that such services are available (or may, on the contrary, know all too well they are not), may speak English fluently and be in the habit of requesting services in English, or may be unaware of the importance of receiving services in their own language.

The dynamics specific to different communities must also be considered. It was pointed out that divisions may exist within communities—between native Francophones and newcomers, Catholic and public school boards, different parts of the same region, and current and emerging leaders. These difficulties have to be managed if communities are to come together around a major societal endeavour such as improving access to French language health services.

The research also revealed a lack of information on existing French language services and the professionals who provide them and, in some cases, on how the system works. It was noted that existing services in French are not sufficiently promoted to the public, to agencies, and to Francophone and Anglophone professionals.

Study participants proposed public awareness programs to counter some of these trends. In their view, there should be programs to make decision makers and employees in Anglophone agencies, Anglophone and Francophone professionals, and the general public more aware of Francophone culture in all its diversity. There is a need to make the LHINs and professional colleges and associations aware of Francophones' needs. It was also recommended that Anglophone agencies be made aware of the Francophone resources they already have and of the importance of providing FLHS. In addition, they should be supported in further developing these services and in networking to share resources.

As for Francophones, participants stated that it is necessary to institute, in partnership with other sectors such as education and social services, a program designed not only to make Francophones aware of their right to receive French language services but also to foster their sense of pride and belonging. It is particularly important to convince Francophones of the added value of bilingualism.

Finally, a marketing campaign is needed to inform the population and professionals about existing French language services and programs in their region and to encourage people to request these. Such a campaign should also involve the Anglophone media and provide Francophones with French language flyers, forms and brochures distributed through clinics, hospitals, schools, chambers of commerce and other meeting places.

Translation, interpretation and accompaniment services

The issue of translation and interpretation was raised across the South. Study participants indicated that many information documents for patients and their families do not exist in French. Often, the French versions of documents are simply translations that do not factor in the Francophone frame of reference. Participants recognized the need for translation services and complained about limited access to the services and a lack of money for translation. As for interpretation and medical accompaniment, no formal cultural interpretation or official medical accompaniment services are available outside Toronto. Usually, family members or volunteers supply these services.

With respect to potential solutions, in addition to seeking culturally sensitive translations and French versions of core documents such as consent forms and medication or examination information sheets, many study participants want improved access to translation services. With respect to interpretation, although it is not the ideal solution (the presence of an interpreter can bias information or breach confidentiality), participants stressed the necessity of having satisfactory and official interpretation and accompaniment services that are both recognized and adequately funded.

4.2.2. Human resources

Access points can operate only with competent human resources to support them. The following section looks at some human resources issues—numbers, access, recruitment and retention, and training.

Numbers

A widespread shortage of health and social service human resources was noted. The shortage is widespread but the situation is even worse for Francophones and in rural areas. The most pressing shortages are for physicians, nurse practitioners, nurses, speech-language pathologists, dietitians, occupational therapists and social workers. In certain locations such as Toronto, the shortage is partially attributable to poor knowledge and use of the existing human resources.

Participants spoke at some length about the lack of family physicians. In their view, people sign up with the physicians who are prepared to accept them, regardless of language. Many people have no family physician. Specialists of all sorts, such as pediatricians, psychiatrists (especially for children and seniors), gerontologists, oncologists, gynecologists and emergency physicians are also lacking. Other health professionals, namely nurse practitioners and nurses, speech-language pathologists, audiologists, occupational therapists, physiotherapists, pharmacists, dentists, midwives and social workers are also in short supply.

To address these shortages, participants proposed incentive programs to attract and retain professionals (recruitment tool kit), measures to facilitate the integration of foreign-trained health professionals, and regional and provincial (Ontario government) recruitment strategies. They suggested recruitment and



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retention strategies tailored to the needs and priorities of different communities, and mentioned longer-term solutions such as the “Careers in Health” program. However, the first step must be to identify professionals who are able to provide FLHS.

Access

People encounter certain difficulties in accessing health professionals able to provide services in French. In some cases, professionals able to provide such services serve primarily Anglophone clients and have no time available for Francophone ones. In other situations, Francophone professionals do not advertise themselves as such or hesitate to offer the service for lack of confidence in their language skills. And too often, the lack of a bilingual presence at first point of contact (reception) constitutes a barrier, even if the professional at the next step in the process does speak French.

People frequently lack information on the health care system and existing French language services. This is true of both health professionals and the general public. The invisibility of services in French is another barrier. Agencies do not post much signage in French, and health professionals able to deliver French language services are not clearly identified.

Waiting lists constitute another difficulty. Generally speaking, people complain about being referred to English language services due to long waiting lists and the lack of knowledge of existing French language services and resources. It was also pointed out that both Francophone CHCs have long waiting lists.

It was frequently mentioned that professionals able to deliver French language services must be identified. Many Francophones in health agencies or private practice do not deliver French language services on an official and recognized basis. These professionals represent a potential pool of under-utilized resources that could help fill the needs and gaps noted by study and discussion group participants. At the same time, it was pointed out how useful a directory of services and professionals, accompanied by a mechanism for referring Francophone patients to French-speaking health professionals, would be. The virtual team in London is an example of such a mechanism.

Study participants strongly encouraged the establishment of multidisciplinary teams and the increased use of nurse practitioners as well as other allied health and social service professionals. In particular, nurse practitioners were seen as professionals who could play a very important role and bridge certain gaps in family medicine. It was also noted that service models must be established that encourage Francophone professionals to accept Francophone patients, whether through virtual teams, incentive programs, reserved times for Francophone patients, or other approaches. Finally, participants pointed out the importance of increasing the number of positions allocated to CHCs (nurse practitioners, physicians, psychologists, physiotherapists, occupational therapists and dental professionals).

Study participants strongly encouraged the establishment of multidisciplinary teams.

Recruitment and retention

According to study participants, most regions are having difficulty recruiting and retaining health professionals, and these difficulties are more severe when recruiting for bilingual positions. There are few strategies for recruiting and retaining French-speaking professionals. Competition among service providers to hire bilingual professionals can create “revolving doors” that leave gaps in the continuum. Furthermore, in some areas, especially non-designated areas, no effort is even being made to seek bilingual staff.

Many participants mentioned the challenges faced by practitioners who provide French language services, which make retaining these professionals all the more difficult. Many French-speaking health professionals hesitate to offer services in French because of compensation and working conditions. These include additional workload, lack of recognition and support from their employer, lack of work tools, lack of support services in French, and the undervaluing of their contribution. Health professionals who provide services in French often feel isolated. They have neither the work tools needed to deliver FLHS (e.g. assessment tools, diagnostic tools, reference materials and information for patients and their families) nor the budget to purchase these tools.

The issue of integrating foreign-trained French-speaking health professionals into the Ontario health care system and the lack of French language programs to help them meet Canadian requirements was repeatedly raised in the South. As well, to work in Southern Ontario, French-speaking health professionals need to be bilingual.

As previously mentioned, provincial, regional and community recruitment and retention strategies are needed to meet these challenges. More specifically, people in Toronto and the Hamilton, Halton, Waterloo and York regions were looking for strategies and incentive programs to attract French-speaking physicians. Many participants brought up the need for a joint recruitment strategy and for agencies to work together. In the Simcoe region, the idea of adding a Francophone community representative to the existing recruitment committee was proposed, while in the York region, there was a desire to add a Francophone component to existing job fairs. Where the issue of FLHS is not yet on Anglophone decision makers’ and agencies’ radar screens, awareness-raising efforts are needed.

Some study participants were looking for other approaches, such as the creation of term positions and an emphasis on partnerships and resource sharing. For example, the three school boards could share a speech-language pathologist on a regional basis.

To combat isolation, there is a need to create regional and inter-regional networks of health professionals and health agencies, networks by field of practice, and meeting places that allow professionals to provide mutual support and share resources (meetings, conferences, workshops, etc.). Such networks should be created through partnerships. Workplace issues must also be



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acknowledged and addressed (working conditions and workload, compensation, bilingualism bonuses, support, work tools, full-time positions and other incentives). As for work tools, there is a need to compile and distribute an inventory of existing work tools, to identify needs (in partnership), and to work together on researching, importing and developing these tools.

Finally, there is a need for training programs delivered in French to help integrate international graduates; existing programs need to be better publicized and made more accessible.

Training

With respect to the training of human resources, it was noted that very few core training programs are delivered in French in Southern Ontario. Although some professionals, such as physicians, do not feel a need for professional development delivered in French, other professionals are looking for this and such training is in very short supply in the South. Furthermore, most agencies do not have the budget to send French-speaking health professionals to other cities to attend professional development delivered in French. As a result, French-speaking health professionals often feel isolated. A number of professionals also indicated the need to polish their grasp of the French terminology in their field and become more familiar with their clients' cultures (cultural competencies).

Study participants frequently raised the subject of young people and how difficult it is to retain them. They pointed out that several areas lack French language secondary schools and that young people must often leave the region to pursue their postsecondary studies in French; many do not return. The lack of clinical placements, especially in French, for students in the region was also noted.

Many ideas to improve the situation were suggested. On the subject of professional development, it was recommended that needs and ways of meeting them be identified in partnership with the professional colleges, Anglophone and Francophone associations, the *Consortium national de formation en santé* (CNFS) and RIFSSSO. The necessity of working with postsecondary institutions and regional networks of professionals was also mentioned. Some participants expressed the desire to see French language core training and professional development programs established for physicians and other health professionals in the South, whether at Glendon College, *Collège Boréal*, McMaster University or other educational institutions in the region. Other participants recommended that agreements be negotiated among Laurentian University, McMaster University and *Collège Boréal* on the training of professionals and that spaces be reserved for Francophones in institutions delivering training in the health professions (even Anglophone institutions). It was also suggested that a larger number of spaces be reserved for Francophones in the Northern Ontario School of Medicine, and that *Collège Boréal* provide core training programs in the South (in early childhood education and nursing, for example).

The development of a long-term strategy to improve population health must be based on health promotion and disease prevention.

In order to assist Francophone professionals, the region’s secondary and tertiary care providers could join forces to create support and mentorship systems that would allow primary care providers to deliver more specialized services (e.g. the Centre for Addiction and Mental Health could make more resources and support available to family physicians/general practitioners). Participants also requested French language training that is better tailored to professionals’ needs, such as language upgrading and maintenance and specialized terminology courses, along with support materials such as guides and glossaries.

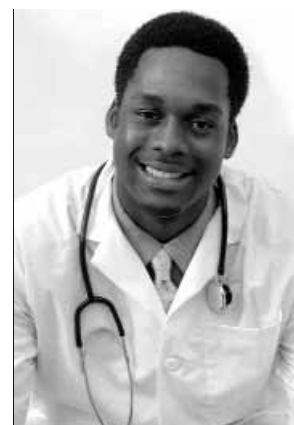
On the subject of young people, participants stressed the importance of continuing to encourage Francophones to study in health fields, preferably in French. It was also suggested that the delivery of programs designed to raise young people’s awareness of health care careers be extended to non-designated areas and elementary schools, as well as parents. For this to occur, support would need to be provided for the work currently being done by RIFSSSO, the CNFS and MOHLTC. Finally, participants mentioned the possibility of creating programs that send young people to university and then bring them back to the region (scholarships, placements, support) and the need to make existing scholarship programs better known.

4.2.3. Health promotion and disease prevention

Study participants agreed that the development of a long-term strategy to improve population health must be based on health promotion and disease prevention. However, it was also clear to them that, to be effective, promotion and prevention programs must be tailored to the characteristics of the target population. They pointed out the lack of bilingual services, resources and staff devoted to health promotion and disease prevention in the South. Most regions lack the promotion and prevention services and resources required to influence determinants of health. In areas such as Toronto and the Durham region, participants stated that resources tailored to the cultures of the various Francophone communities were not available. It was also noted that the public is not provided with information in French on certain important subjects such as menopause, breastfeeding, obesity, heart disease, and sexual health.

The fact that public health units are not subject to the FLSA triggered many comments. Some regions such as Waterloo and York have practically no bilingual services, resources or staff in prevention and promotion. In York, there are no French language services in French language schools. Study participants expressed the view that public health units must be made aware of the need to deliver services in French.

Overall, a holistic approach to health was recommended in which promotion and prevention are integral to improving Francophones’ health status. Any efforts in this area must factor in the South’s diversity and utilize resources tailored to its many cultures. Greater emphasis must be placed on this approach so as to encourage Francophones to take greater responsibility for their health.



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4.2.4. **Planning and management**

Service planning is key to improving resource, service, and coordination of professionals. This section discusses the planning and management of FLHS in relation to the following areas: data, planning, legislative framework, and governance and management.

Data

Gaps in the concrete data available on Francophones and their health status were noted, which make FLHS and French-speaking health human resources (HHR) planning more difficult. Few data are available on FLS utilization or the supply of, and demand for, these services. Similarly, very little information is available on professionals and their geographic distribution and on communities' capacity to deliver FLHS.

To fill these gaps, a detailed profile of the Francophone community of Southern Ontario by LHIN would be required. This profile should map the community, describe its demographic characteristics, and objectively evaluate its needs, gaps, health behaviours and health status. A study that accurately maps and profiles the community's service delivery capacity and describes medium- and long-term trends would also be required.

Planning

FLHS planning was of considerable interest to study participants. They indicated that medium- and long-term needs with respect to French-speaking HHR are unknown. They pointed out that there is no continuum of FLHS, that the programs and services available in English are not necessarily available in French, and that many regions have no up-to-date FLHS implementation plan. They were also of the opinion that the Ministry should align its priorities with those of the community.

With respect to HHR, participants recommended long-term planning (5, 10, 15 years) of French-speaking HHR by region based on the community's needs and characteristics. They also noted that this planning must take Francophones' needs into account from the outset. Integrated service plans must be developed which indicate current status, identify gaps and potential solutions, and define specific priorities along with accountability measures and required resources—in other words, a road map must be developed for meeting Francophone needs. Participants also mentioned that Francophone communities must be consulted about health priorities and that an effort must be made to work in partnership with the French Language Health Services (FLHS) Office and to set priorities that align with MOHLTC and LHIN priorities.

The whole issue of funding models and allocations was raised on many occasions. Most agencies want the government to acknowledge the true costs of delivering services in French, and some recommended that it create Francophone funding envelopes (as is done in some federal programs).

All Francophones should have access to services in French wherever they live.

Legislative framework

Study participants often mentioned the *French Language Services Act* (FLSA) and, more specifically, its limitations. While acknowledging the efforts deployed by the FLHS regional consultants, they pointed out that specific criteria, clear guidelines for agencies, and concrete accountability measures are lacking. Many participants had witnessed a lack of willingness among decision makers to implement the Act in a proactive fashion. Although French is an official language, government policies accord it no precedence. The concept of designation was also criticized. Public health units are not subject to the Act and, for this reason, they offer few French language services. Almost half of Francophones in the South live in non-designated areas. Since there is no obligation to provide French language services in these areas, none are provided. On the other hand, the *Local Health System Integration Act, 2006* (Bill 36) was seen as a golden opportunity to improve access to French language health services.

Many suggestions were put forward. For instance, it was recommended that FLS committees be created where they no longer exist and that regional FLHS implementation plans be updated. A more proactive application of the FLSA was suggested, with clear and precise guidelines and with accountability measures involving penalties for non-compliance. Some participants recommended a more prescriptive approach, with measures that would require health units and agencies to provide services in French and with more proactive regulations for some professions. Finally, it was suggested that the whole concept of designated areas should be reviewed. All Francophones should have access to services in French wherever they live. This is why it is important that regulations under Bill 36 accommodate Francophones and ensure they have the same access to services as Anglophones.

Governance and management

The importance of participating in decision making was also frequently raised. Francophones are absent from the boards of directors and senior management levels of service providers, professional colleges and associations, and decision-making bodies such as LHINs. Since decision makers are unaware of Francophones' concerns and needs, there is little chance these will be taken into account. It was also pointed out that the *Réseau du Sud* has little contact with LHINs, health agencies and communities. However, the *Réseau* would have an important role to play in communicating Francophones' point of view.

Participants proposed several potential solutions. One consisted of joining forces to mount a recruitment program that encourages Francophones to fill positions on boards of directors and committees and in senior management and that makes Anglophones aware of the importance of including Francophones. Another consisted of engaging with the LHINs; this was judged essential. In this regard, the *Réseau du Sud* must develop a LHIN strategy and position that targets these agencies' boards of directors as well as their staff. Contact with the LHINs must be established and maintained, both individually and collectively, and ways must be found to participate in the LHINs' planning and community engagement process. In short, the *Réseau* must become the LHINs' key



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Francophone stakeholder. The *Réseau* must also develop a strategy and position in relation to service providers and communities.

It must be noted that, while participants preferred Francophone governance for certain service models (such as CHCs and FHTs) in regions with the critical mass of Francophones needed to support such models, in other cases they envisioned mixed service models, often in non-institutional settings, delivering services in both English and French. Many saw it as important to provide quality health care services in both languages.

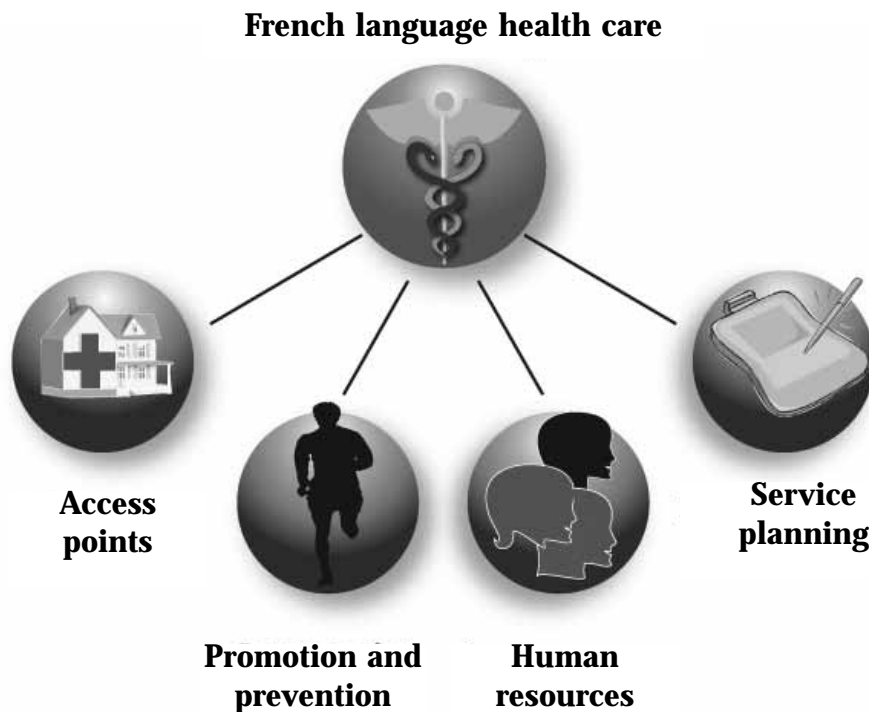
*The development
of French language
health services
should be guided
by four strategic
priorities*

CHAPTER 5 : Recommendations

5.1 The strategic priorities: a starting point for primary health care in French

As its name suggests, *Setting the Stage* represents a starting point for the process of reflecting on the issue of quality French language services in Ontario and seeking potential solutions that will improve access to these services. The following pages contain the results of this reflection to date. The development of French language health services should be guided by four strategic priorities that constitute the key facets of service delivery.

The four proposed strategic priorities are access points, human resources, promotion and prevention, and planning and management of services.



These priorities are explained in detail in the *Provincial Report*. However, they are repeated here to provide more background to the recommendations of the *Réseau franco-santé du Sud de l'Ontario*.



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Access points

By access points, we mean any place where health care services are delivered. The findings of our field research clearly showed that, whatever form it takes, the availability of French language health services falls far short of meeting the Francophone population's needs. The studies also showed that access points that provide quality services in French are, to varying degrees, governed by Francophones and/or managed by a primarily Francophone team. It was also evident that the active participation of the Francophone community is a guarantee of greater success. Access points are the cornerstones of any primary health care delivery strategy. Organizational models may vary from region to region—a model that meets the needs of a Northern Ontario community may be unsuited to circumstances in the South. What is important is that an access point meet certain conditions that are essential to its success.

1st recommendation:

Create, maintain and develop primary health care service access points that are linguistically and culturally appropriate for Ontario's Francophone population.

These access points must be designed to:

- create an entirely Francophone environment as the patient progresses through all phases of the care continuum;
- promote a multidisciplinary and interdisciplinary approach;
- fully integrate leading-edge technologies into both service delivery and information management;
- deliver primary care services that truly factor in geographic realities;
- take a comprehensive approach to health, which integrates promotion and prevention with curative services; and
- take a population approach that specifically targets Francophones.

For this recommendation to achieve the desired results, including those proposed in the regional reports, the following conditions for success must be met.

Conditions for success

These access points must be:

- governed by Francophones;
- managed by Francophones; and
- supported by strong community engagement.

Access points are the cornerstones of any primary health care delivery strategy.

Human resources

Access points obviously require physical infrastructure. However, qualified human resources are an even more important component, and the research findings identified a shortage of French-speaking human resources as a major problem. The chronic lack of French-speaking professionals and the related recruitment and retention problems are emblematic of the major challenges facing the Francophone community. This shortage is also evident at all levels of health care management and administration. Proposed solutions include expanded postsecondary and continuing education opportunities, combined with improved organization and medium-term planning of health human resources.

Among the other factors that affect health human resource planning are: lack of French language treatment and evaluation tools; lack of formal and informal training in French; an aging population; the strain on providers due to overwork; inadequate long-term planning of French-speaking human resources; and disparities between professionals working in rural and urban areas. In addition, the shift to ambulatory care has reduced institutionalization and shifted the burden on to families. Lastly, there is a pressing need for more networking and sharing of information, expertise and experience among French-speaking health professionals.

2nd recommandation:

Ensure the availability of qualified French-speaking human resources where they are needed. This involves a training component and a human resources planning component.

Conditions for success

Human resources training must:

- include a full range of health-related college and university programs in French, to train both professionals and managers in response to needs;
- include French language professional development for targeted provider groups;
- involve cooperation with the CNFS;
- be supported by a coordinated approach to delivery of continuing education programs in French for targeted provider groups;
- be supported by ongoing assessment of basic training and professional development needs for Francophones;
- include cultural competence training for health human resources; and
- provide for a new generation of caregivers by delivering programs to promote careers in health among Francophone youth.



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Human resource organization must be supported by:

- a thorough assessment of human resource needs, including identification of French-speaking health professionals;
- effective medium- and long-term human resource planning; and
- strategies for recruiting and retaining French-speaking professionals in agencies and communities.

Promotion and prevention

All players agree that a long-term strategy for improving population health must incorporate health promotion and disease prevention initiatives. But it is evident that, to be effective, these initiatives must be developed and delivered by professionals with the necessary cultural competence. Too often, promotion and prevention programs for the French-speaking population are simply translations of programs developed by and for Anglophones. Finally, there must be a form of coordination among all such programs to ensure their effectiveness.

3rd recommendation:

Develop and implement linguistically and culturally appropriate health promotion programs focused on determinants of health and designed to improve the health status of the Francophone population.

Conditions for success

Health promotion and disease prevention programs must:

- be based on a comprehensive vision of health;
- be developed and delivered in partnership with communities and key players;
- be developed and delivered with improved coordination among key players;
- be developed for Francophone minority populations; and
- be adequately resourced.

Service planning

French language services, where they exist, are often isolated, and there is often little or no coordination among the agencies delivering them. Effective service planning makes it possible to optimize resource utilization and integrate and coordinate providers and their services, as long as the planners have a full grasp of Francophone reality. Studies have shown that when a population assumes responsibility for its own health and health care, the system is more effective. In fact, one of the guiding principles of Ontario's health care transformation agenda is to shift decision-making power to the regions, ultimately empowering communities. This principle is particularly significant for minority communities, which often have fewer resources at their disposal to attain the same outcomes as majority communities.

Government policies and strategies must take into account the specific realities facing Ontario's Francophone population.

Government policies and strategies must take into account the specific realities facing Ontario's Francophone population. This requires strong, sustained support from the Francophone community. The main goal of the following recommendation is to foster community engagement.

4th recommandation:

Ensure effective planning and coordination of French language resources and services by creating a structure governed and managed by Francophones, taking into account individual and community needs as well as resource availability.

Conditions for success

Planning of French language health services must:

- be based on government policies and regulations that take into account Francophone reality;
- be supported by access to pertinent data on health status and service utilization;
- be built on a partnership among governments, providers and the community;
- derive from a comprehensive provincial French language services plan that accommodates regional circumstances and needs;
- incorporate accountability measures for agencies required to provide services in French; and
- be carried out in partnership with other planning agencies in the province

The four strategic priorities outlined above are essential building blocks for a long-term vision of the development of primary health care services in French. These priorities cannot be addressed in isolation; rather, advances must be made on all four fronts simultaneously, with due regard to the conditions for success, in order to provide Francophones with better access to health care.



**Chapter 5:
Recommendations**

5.1 The strategic priorities:
a starting point for
primary health care in
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5.2 Recommendations of
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The possibility of forging partnerships and negotiating service sharing agreements ... should explored.

5.2 Recommendations of the *Réseau franco-santé du Sud de l'Ontario*

The recommendations of the Réseau franco-santé du Sud de l'Ontario address the four strategic priorities identified at the provincial level.

1st recommandation:

That the government develop the policies and mechanisms needed to implement the recommendations set out below and that the government see to their implementation in all health structures.

Access points

In the course of the project team's research, the issue of the availability and accessibility of primary health care services in French was raised across the South. Of the twelve regions studied in greater detail, nine are considered to be underserved. Access to health care is thus a widespread problem that is even more acute in the case of French language services and services in rural areas. In fact, access to French language health services proved problematic even in designated areas and regions with enough providers of primary health care services. The priority needs that emerged from the research included family medicine and mental health and addiction services as well as services for children and seniors. Francophones in the South also face long waiting lists and difficulties obtaining referrals to French language services. These findings reflect existing shortages, people's lack of knowledge of the system and its current French language resources, and the extent to which these resources are insufficiently integrated and coordinated.

2nd recommandation:

That support be provided for an integrated and inter-sectoral approach to French language health services and the networking of services.

3rd recommandation:

That the creation, expansion and maintenance of access or entry points to French language primary health care services that are tailored to the needs and capacities in each region be supported and that some priority be given to the establishment of Francophone governance structures.

In the Erie St. Clair, South West, Mississauga Halton and North Simcoe Muskoka LHINs, the establishment of access points to French language health services governed by the Francophone community should be supported. These access points could include community health centres, family health teams, group practices or other structures such as additional service points for existing Francophone, bilingual, Anglophone or multi-cultural structures. These new access points must be innovative, put a premium on partnerships and resource sharing, build on existing resources, take a holistic approach to health, and promote multidisciplinary.

In the Central, Toronto Central and Hamilton Niagara Haldimand Brant LHINs, expansion of the existing services delivered by the two Francophone CHCs and the establishment of satellite centres within their respective LHINs and even beyond should be supported.

In the other LHINs, the establishment of French language entry points into the health care system should be supported. These access points, tailored to the communities' needs and capacities, would be developed through partnerships involving Anglophone, Francophone, multicultural and bilingual agencies and make it easier to navigate the health care system. For example, certain frontline services could be provided in a Francophone community centre by a bilingual nurse practitioner from an Anglophone CHC, and clients could also be referred to other French language services. This entry point would be equipped with a database on services and professionals providing French language services.

In all the LHINs in Southern Ontario, the possibility of forging partnerships and negotiating service sharing agreements involving Anglophone, bilingual, multicultural and Francophone agencies should be explored. Such initiatives would support the improved utilization and coordination of resources and increased concentration of French language services. Services could take different forms depending on regional needs and capacities—virtual teams, outreach teams, satellite clinics, sharing of professional services among agencies, etc. with designated entry points.

4th recommendation:

That ongoing awareness campaigns be instituted to:

- a) **increase the visibility of the French language services available in the health care system;**
- b) **inform Francophones about their rights, convince them of the added value of French, and encourage them to request services;**
- c) **make Anglophone agencies as well as Anglophone and Francophone professionals aware of Francophone culture in all its diversity and of the importance to Francophones of being served in their own language.**

The research revealed extensive gaps in knowledge with respect to existing French language services and the demand for, and utilization of, the services by Francophones. It also shed light on health agencies' and professionals' profound lack of awareness of Francophone communities in the South in all their diversity.



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5th recommandation:

That support be provided for the establishment of adequately funded cultural interpretation and medical accompaniment services.

Many people took the view that setting up professional cultural interpretation and medical accompaniment services would facilitate access to health care services. This would be an interim measure that would address certain concerns about quality and confidentiality. Such services are now offered on an informal basis, often by volunteers, staff or family members. This way of doing things can affect people's willingness to use certain services of a more sensitive nature. As well, professional interpretation and accompaniment services could have long-term usefulness in facilitating access to specialists.

Human resources

This study revealed the existence of a shortage of health and social service professionals providing French language services in Southern Ontario. The most frequently cited shortages were for family physicians, nurse practitioners, nurses, speech-language pathologists, occupational therapists and mental health professionals, including social workers. At the same time, however, existing Francophone human resources are little known and poorly utilized. In some regions, there would appear to be enough professionals to meet the demand if they were working in a coordinated fashion. Furthermore, no formal coordination, referral or matching mechanism exists to bring Francophone patients and Francophone professionals together.

Significant difficulties in recruiting and retaining Francophone professionals also exist. The research indicated that it is difficult to find and keep French-speaking professionals.

6th recommandation:

That a permanent inventory of services and of health and social service professionals able to provide quality services in French be compiled and maintained.

Such a survey should target professionals in all Anglophone, Francophone, multicultural and bilingual health care agencies as well as those in private practice. It should also catalogue services that are available in French. A database containing this information would be made available to the public and professionals, which would facilitate referrals. This project would have to be carried out in collaboration with other agencies building databases of services and professionals.

Almost no core programs are offered in French, and the professional development available in French is minimal.

7th recommendation:

That support be provided for the development of recruitment and retention strategies for professionals able to provide quality French language services, so as to meet regional priorities and needs.

Implementation of this recommendation will involve close cooperation among Francophone communities and agencies, Anglophone communities and agencies, and existing resources and programs. For example, a Francophone component could be added to recruitment plans and existing career fairs.

8th recommendation:

That support be provided for the integration of French-speaking health professionals from abroad.

The integration of international graduates into Ontario’s health care system, through French training and upgrading programs and skills assessment programs, is another aspect of the recruitment issue not to be neglected. Southern Ontario has the highest percentage of newcomers.

9th recommendation:

That stakeholders work together to assess needs in the area of core training and professional development programs delivered in French in Southern Ontario, and that support be provided for the establishment of training programs to meet those needs.

Another important issue in Southern Ontario is core professional training and professional development. Almost no core programs are offered in French, and the professional development available in French is minimal. This isolates professionals (which in turn affects their retention rates) and forces young people to pursue their studies in other regions; many do not return after they graduate.

Efforts to address these issues must be undertaken jointly with the CNFS, *Collège Boréal*, RIFSSSO, the Ministry of Training, Colleges and Universities, and the *Réseau*. Possible cooperation and partnerships with Anglophone and bilingual postsecondary institutions such as McMaster University, the University of Toronto, the Northern Ontario School of Medicine in Sudbury, and Glendon College must also be explored.



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10th recommandation

That networking among health and social service professionals, by region and profession, be supported through the provision of virtual and physical meeting places.

This networking should occur through the *Portail franco-santé du Sud* project and in partnership with agencies such as RIFSSSO and the *Réseau CORPS*. Health professionals could, for example:

- a) take advantage of opportunities to take training in French;
- b) discuss best practices;
- c) build ties with other health professionals;
- d) provide mutual assistance.

Such networking would help support professionals and recognize their efforts to deliver French language services.

11th recommandation:

That efforts by RIFSSSO, the CNFS and the French Language Health Services (FLHS) Office of the Ministry of Health and Long-Term Care to raise young people's awareness of careers in health and social services continue to be supported.

These career programs should be extended to the non-designated areas of Southern Ontario and to elementary schools.

12th recommandation:

That young Francophones be made aware of the financial support available to students in health and social service programs and that Francophone communities be mobilized to create new programs and strategies encouraging young Francophones to return to their home regions following their studies.

The efforts by community and health agencies and government authorities to create programs that assist students in health programs from a region (through opportunities for mentorship and the provision of financial aid and other forms of assistance) should be supported, in order to make working in French more attractive and encourage students to return to their home regions.

To reach Francophones in Southern Ontario effectively, it will be necessary to look beyond the designated areas.

Promotion and prevention

It was noted that French language resources in promotion and prevention are in generally short supply and resources tailored to the needs of Francophone communities in the South in all their diversity are in especially short supply. Participants also raised the issue of the availability of French language services in French language schools and of services to new mothers and young families, to newcomers, and to seniors except in certain centres. It is important to view disease prevention and health promotion as the cornerstones of primary health care.

13th recommendation:

That health promotion and disease prevention form the cornerstones of Francophones' effort to take responsibility for their health, and that these approaches be based on a holistic vision of health and an emphasis on health determinants, while also taking vulnerable groups into account.

It is important to offer French language programs that are tailored to the diverse cultures of the Francophone communities in the South and to the needs of target groups such as children, adolescents, young mothers and seniors. The contributions made by allied health professionals such as pharmacists and optometrists, who are often an important source of health advice, must not be neglected.

14th recommendation:

That necessary measures be taken to ensure that public health units plan and deliver their programs in French, after tailoring them to Francophone communities.

Since public health units fall under municipal jurisdiction, they are not subject to the *French Language Services Act*. Therefore, most offer little in the way of French language services, despite the fact that the Ministry encourages those in designated areas to deliver mandatory programs in both languages. The public health units play a very important role in health promotion and disease prevention through the services they deliver in settings such as French language and immersion schools.

Given the limited resources available in French and the rarity of bilingual staff, it would be necessary to encourage partnerships among different health units and other agencies and the sharing of resources. To reach Francophones in Southern Ontario effectively, it will be necessary to look beyond the designated areas.



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Planning and management

15th recommendation:

That programs be established which are designed to encourage Francophones to volunteer for positions on the board of directors and working committees of health agencies, professional colleges and associations, and decision-making bodies such as LHINs

Participation in decision making has often been identified as a key element in the delivery of quality primary care services in French. A Francophone presence is therefore required in middle and senior management positions in service provider agencies and on the boards of directors and working committees of these agencies (especially the LHINs).

16th recommendation:

That integrated French language health service plans be developed that identify clear priorities, propose concrete action, and define accountability measures.

This planning must be conducted jointly by the Réseau, the LHINs, government authorities and community agencies. The plans should reflect communities' health priorities as well as those of MOHLTC and the LHINs; they should address the whole range of health care services (including those offered in non-institutional settings) and cover all areas of the South.

17th recommendation:

That support be provided for research designed to produce a detailed profile of the Francophone communities in Southern Ontario, by LHIN, based on objective data.

Planning must be based on thorough knowledge of communities and their needs, of existing resources, of best practices and of effective models. It must also be supported by relevant and reliable quantitative and qualitative data. A lack of quantitative data on Francophones and services in French, on the utilization of services, on health professionals, and on Francophones' health status and health behaviours was noted in the South.

Such a profile should map the community, examine its demographic characteristics, define and evaluate the population's needs, behaviours and health status, and document the supply of, and demand for, French language health services.

Participation in decision making has often been identified as a key element in the delivery of quality primary care services in French.

Conclusion

Setting the Stage has drawn a fairly detailed portrait of the current state of the primary health care services available in French in Southern Ontario. However, this is only the starting point on the road to improved access to services.

The *Réseau franco-santé du Sud de l'Ontario* has already started taking steps to implement some of the recommendations in this report. For instance, it has developed a new project, "Santé primaire en action" [primary health care in action], which, if funded, will create conditions favourable to increasing the accessibility of primary health care and services and improving Francophones' health status.

The *Réseau* will pursue its work with government authorities so that, together, we may find ways of implementing some of these recommendations. The *Réseau* will also continue working with its partners to improve our knowledge of the health status of Francophones in minority communities. Success will hinge on people's willingness to work together to improve the health of Francophones in Southern Ontario.



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