Health Canada and the Public Health Agency of Canada
Santé Canada et l'Agence de la Santé publique du Canada

Evaluation of the Official Languages Health Contribution Program 2008-2012

Prepared by
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List of acronyms

CCHS	Canadian Community Health Survey
CIRLM	Canadian Institute for Research on Linguistic Minorities
CHN	Community Health Networks
CHSSN	Community Health and Social Services Network
CNFS	Consortium national de formation en santé
CPIAHS	Contribution Program to Improve Access to Health Services
FOLS	First Official Language Spoken
OLA	*Official Languages Act*
OLCDB	Official Language Community Development Bureau
OLHCP	Official Languages Health Contribution Program
OLMC	Official Language Minority Communities
OLSP	Official Languages Support Program
QCGN	Quebec Community Groups Network
SSF	Société Santé en français
SVOLM	Survey on the Vitality of Official Language Minorities

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Executive Summary

Evaluation Purpose, Scope and Design

The purpose of the Official Languages Health Contribution Program (OLHCP) evaluation was to assess the relevance and performance of the Program in fulfillment of the requirements of the *Financial Administration Act* and the Treasury Board *Policy on Evaluation (2009)*. The evaluation covered the period from April 2008 to June 2012.

The evaluation methodology included a literature review, document review, review of census and other surveys, key informant interviews, case studies, and a panel of experts.

Description of the Official Languages Health Contribution Program

The *Roadmap for Canada's Linguistic Duality* 2008–2013: *Acting for the Future* committed $1.1 billion over five years to 15 departments and agencies in the areas of justice, health, immigration, economic development, and arts and culture. Health Canada received $174.3 million to carry out the OLHCP, as well as to undertake Program management, strategic planning, and performance measurement activities over the five-year period.

The two main objectives of the Program were to: (1) improve access to health services in the minority official language, and (2) increase the use of both official languages in the provision of health services. The Program included three components delivered by primary and secondary funding recipients:

1. Community health networking ($22M - delivered by the Community Health Social Services Network (CHSSN) and the Société santé en francais (SSF));
2. Training and retention of health professionals ($114.5M - delivered by the Consortium national de formation en santé (CNFS) and McGill University); and
3. Official language health projects ($33.5M - coordinated by the SSF and CHSSN and sponsored by communities receiving funding).

Evaluation Conclusions and Recommendations

Key conclusions and recommendations are presented below.

CONCLUSIONS

Continued Need

Official language minority communities (OLMCs) are concentrated in specific regions of Canada, and thus the need for minority language health services varies across the country. OLMCs represent 6.4% of the Canadian population (Census 2006) and are more concentrated in specific regions of Canada, including the northern parts of New Brunswick, the Montreal census metropolitan area, and eastern parts of Ontario. In such regions of concentration, the language

affiliation of health professionals is more in line with the linguistic composition of the population and so English and French-speaking persons can more easily choose health care providers who are fluent in their language. Language mismatches between patients and health care providers are more likely to occur in regions, provinces and territories where OLMCs are less concentrated.

According to available data, the health care needs of OLMCs do not appear to differ significantly from those of the majority language and difficulties in accessing health services seem to be more associated with barriers unrelated to language (e.g. geographic location and overall availability of health care professionals). Despite this, most OLMC members (77% for Canada in 2006 as reported by Statistics Canada SVOLM) believe it is important to receive health services in the minority official language.

Alignment with Government Priorities

The OLHCP is aligned with the Government of Canada's priorities as articulated in the *Roadmap for Canada's Linguistic Duality* which reaffirms the Government of Canada's commitment to linguistic duality and is based on two pillars: the participation of all Canadians in linguistic duality, and the support for OLMCs.

Alignment with Federal Roles and Responsibilities

The OLHCP has been implemented to fulfill federal roles and responsibilities articulated in the *Official Languages Act* which commits the federal government to "enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development." Also, the most recent amendment to the Act confirms the duty of each federal institution to "ensure that positive measures are taken" for the implementation of that commitment.

There is a clear obligation on the part of departments such as Health Canada to implement specific initiatives such as the OLHCP. As the Act specifies, these initiatives must "be carried out while respecting the jurisdiction and powers of the provinces." This, clearly, applies to the area of health and the professional training in which the OLHCP participates.

The OLHCP is also aligned with Health Canada's Strategic Outcome: "A Health System Responsive to the Needs of Canadians" which includes Program Activity 1.3 "Official Language Minority Community Development".

Achievement of Expected Outcomes

Progress has been made towards achieving the immediate outcomes which include: increasing the number of health professionals available to provide services in OLMCs; increasing coordination and integration of health services for OLMCs; increasing partnerships with health systems; increasing the awareness of Community Health Networks (CHNs) as focal points for health concerns; and, increasing knowledge of strategies and best practices to address health concerns of OLMCs.

In particular, primarily through the training component, progress has been made, in increasing the number of health professionals available and able to provide health care services in OLMCs in Ontario, Quebec and New Brunswick. For other regions where OLMCs are more dispersed or smaller, the training of health professionals was not as significant. It is still unclear whether the health professionals being trained represent the needed combinations of health disciplines and regional distribution.

Community Health Networks are seen as a focal point for addressing health concerns of OLMCs in many provinces and territories and anecdotal evidence indicates that the networks seem to be contributing to improving access to and the use of minority language health care services through collaborations and partnerships with regional health authorities, local facilities and provincial/territorial governments. The projects component of the Program has provided more flexibility for networks by increasing funding in specific areas to pursue priorities often related to vulnerable populations. However, there is limited evidence systematically documenting the outcomes and impact of many CHNs activities.

Assessment of Economy and Efficiency

A number of external factors appear to be influencing the effective and efficient achievement of outcomes, as Community Health Networks rely on collaboration with external partners (e.g., provincial governments, health authorities) in the planning and delivery of health services. For example, the ability of these Networks to achieve outcomes depends on the extent to which priorities for action are shared with their provincial partners and the degree of influence they have with these partners.

The evaluation was unable to fully assess the efficiency and economy of the OLHCP due to a lack of concrete data on achievement of outcomes with respect to cost. However, the evaluation did note that there were no other comprehensive alternatives to the OLHCP and that the Program was able to leverage funding from other sources.

RECOMMENDATIONS

The majority of training is currently taking place in areas of OLMC concentration (i.e. Ontario, Quebec and New Brunswick) where the trained health service providers tend to remain, and where there already seems to be a sufficient base of minority language health professionals. Therefore, it is important to consider alternative ways to reach other OLMC populations. Given that training is a resource intensive approach, more cost effective methods that also focus on recruitment and retention in smaller OLMC population areas, should be examined.

Recommendation 1:

It is recommended that the Official Language Community Development Bureau (OLCDB) identify approaches, in addition to professional training, to increase access to health care services in the minority language in regions where the OLMC populations are small and/or dispersed.

Community Health Networks are increasingly seen as the focal point for addressing health concerns of OLMCs and understanding OLMC needs, and have been successful in developing partnerships with health authorities to meet these needs. As such, they are well positioned to work with post-secondary institutions who are already delivering training Programs. Such collaborations can ensure that training offerings are well aligned with an identified shortage or need and that internships and permanent employment opportunities are available in the appropriate communities.

Recommendation 2:

It is recommended that the OLCDB ensure that the Community Health Networks and post-secondary institutions collaborate, where appropriate, to develop training aligned to OLMC health needs and jointly engage with health authorities and facilities to develop internship positions for bilingual students, so as to increase their retention in OLMCs after graduation.

A number of performance data gaps and limitations were found as part of this evaluation that affected the ability to fully assess Program impact, economy and efficiency. For example, due to different interpretations of "access" or Program outputs such as "recruitment strategy" or "information tool", data collected was inconsistent and not comparable. As such, it would be beneficial to have standard definitions that funding recipients can use to support the collection of reliable performance data and ensure validation and roll-up (aggregation) of performance data at the provincial/territorial level.

It would also be helpful to identify mechanisms that can increase the systematic collection of data related to the intermediate outcomes (e.g., build on past collaborations with Statistics Canada regarding the ratio of health professionals and add more disciplines; track students who have graduated from post-secondary institutions by cohort and Program to determine where they end up working and what minority language health services result).

As well, to strengthen financial information in support of assessing efficiency and economy, it may be worthwhile to ask funding recipients to track funding leveraged, cost per key output/outcome and overhead expenses.

Recommendation 3:

It is recommended that the OLCDB standardize the collection of performance information so that it can be aggregated and used to report on the achievement of outcomes and Program economy and efficiency.

Management Response and Action Plan
Official Languages Health Contribution Program 2008-2012

Recommendation	Program Response	Key Tasks	Responsibility Centre	Timeframe
Recommendation 1 It is recommended that the Official Language Community Development Bureau (OLCDB) identify approaches, in addition to, professional training, to increase access to health care services in the minority language in regions where the OLMC populations are small and/or dispersed.	Agreed. Professional training will be maintained as a core component of the renewed Official Languages Health Contribution Program to build upon its track record in improving the number of health professionals available for official language minorities.	To complement (or support) the core training activities of the Official Languages Health Contribution Program, Health Canada will include activities for the labor market retention of health professionals in official language minority communities under the Official Languages Health Projects component of the renewed Program.	Executive Director, OLCDB	March 2014
Recommendation 2 It is recommended that the OLCDB ensure that Community Health Networks and post-secondary institutions collaborate, where appropriate, to develop training aligned to OLMC health needs and jointly engage with health authorities and facilities to develop internship positions for bilingual students, so as to increase their retention in OLMCs after graduation.	Agreed. Collaborative approaches between networks and training institutions such as the partnership between McGill University and the community-based health networks in Quebec for health internship placements will be presented as models for networking and training recipients in other jurisdictions.	Under the renewed Official Languages Health Contribution Program, networking and training recipients will be required to report on the extent to which they have jointly implemented student health internships in relevant health disciplines and target regions in each year of the Program.	Executive Director, OLCDB	March 2015
Recommendation 3 It is recommended that the OLCDB standardize the collection of performance information so that it can be aggregated and used to report on the achievement of outcomes and Program economy and efficiency.	Agreed. Health Canada will improve its Program performance measures and the collection and validation of performance data for assessing the achievement of outcomes under the Program.	To strengthen consistency and facilitate comparison across the Program, an English/French glossary of key terminologies and performance indicators will be included in all calls for proposal.	Executive Director, OLCDB	March 2014
		Program recipients will be required to aggregate performance data, where appropriate, at the provincial and territorial level, and at the level of health and social services administrative regions in Quebec.	Executive Director, OLCDB	March 2015

1.0 Evaluation Purpose

The purpose of the evaluation was to assess the relevance and performance of the three components of the Official Languages Health Contribution Program (OLHCP): Community Health Networking, Training and Retention of Health Professionals, and Official Languages Health Projects for the period of April 2008 to June 2012. .

The evaluation was required by the *Financial Administration Act* and the Treasury Board *Policy on Evaluation (2009).*

2.0 Program Description

This section of the report provides an overview of the Official Languages Health Contribution Program.

2.1 Program Profile

The *Roadmap for Canada's Linguistic Duality* 2008–2013: *Acting for the Future* (the Roadmap) committed $1.1 billion over five years to 15 departments and agencies in the areas of justice, health, immigration, economic development, and arts and culture to implement the *Official Languages Act* which commits the federal government to "enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development". Health Canada received $174.3 million to carry out the OLHCP, as well as to undertake Program management, strategic planning, and performance measurement activities over the five-year period.

The OLHCP falls under the Program Alignment Architecture's strategic outcome 1: "A Health system responsive to the needs of Canadians" and the Program Activity 1.3 "Official Language Minority Community Development". The Official Language Community Development Bureau (OLCDB) within the Strategic Policy Branch of Health Canada is responsible for the management of the OLHCP. To fulfill its roles and responsibilities, it coordinates the activities related to the OLHCP with the following:

- Health Canada's regional offices, who ensure ongoing communication with recipient organizations;
- Other Health Canada Programs, such as the Health Care Policy Contribution Program, the Health Human Resource Strategy, and other initiatives under the First Nations and Inuit Health Branch;
- The Public Health Agency of Canada (PHAC), to ensure that Programs pertaining to the two organizations complement each other (examples of such Programs under PHAC include: Community Action Program for Children, Population Health Fund, and Community Support and Research Program);

- Diversity and Official Languages Programs with regards to the application of Parts IV, V, and VI of the Official Languages Act; and
- The Official Languages Champion, who provides advice to the Bureau when it requires the approval of senior management, and provides advice as a member of the Interdepartmental Committee of Assistant Deputy Ministers for Official Languages (Health Canada, 2008, p.8-9).

The two main objectives of the Program were to: (1) improve access to health services in the minority official language, and (2) increase the use of both official languages in the provision of health services. Building on advice received from two consultative committees[1] (one for Anglophones in Québec and another one for Francophones in the remaining provinces), primary and secondary recipients are responsible for the delivery of the three Program components:

1. Community health networking

The community health networking component of the OLHCP received $22 million over five years to:

- maintain and enhance official language minority community (OLMC) networks in line with provincial/territorial priorities;
- develop strategies to increase and improve OLMCs' access to health services; and
- provide leadership and coordination of activities that span all three components of the OLHCP.

As primary recipients, the Community Health and Social Services Network (CHSSN) and the *Société santé en Français* (SSF) delivered the health networking activities, in collaboration with secondary recipients.

2. Training and retention of health professionals

The training and retention component of the OLHCP received $114.5 million over five years to:

- provide post-secondary training to develop Francophone health professionals outside Quebec to meet the needs of OLMCs;
- promote the recruitment of students with the required prerequisites into Francophone post-secondary health training Programs and their re-integration into OLMCs upon graduation;
- provide training and retention initiatives in Quebec to ensure that health professionals have opportunities to improve their ability to work in both official languages to meet the needs of OLMCs;
- provide cultural and French-language training to bilingual health professionals in communities outside Quebec, or to Francophone health professionals who received their training in English, to improve their ability to provide health services to Francophone minority language communities; and

[1] The Consultative Committee for French-Speaking Minority Communities submitted its last report to Health Canada in February 2007. This Committee was comprised of members of provincial and territorial governments, representatives of the Departments of Canadian Heritage and Health Canada as well as community representatives and representatives of Société santé en français. The Consultative Committee for English-Speaking Minority Communities submitted its last report to Health Canada in August 2007. This Committee was comprised of representatives of Departments of Canadian Heritage and Health Canada as well as community representatives including McGill University.

- undertake research and information-sharing on approaches to improve access to health services and reduce barriers to health care access for OLMCs.

The *Consortium national de formation en santé* (CNFS) and its member institutions, as well as McGill University, oversaw the training and retention-related activities.

3. Official language health projects

The official language health projects component of the OLHCP received $33.5 million over four years to increase public awareness of health care services among OLMCs and to encourage them to take responsibility for their own health. Projects were developed at the community level to respond to immediate community health needs and priorities, while respecting provincial, territorial and local jurisdictions, and focussing on vulnerable populations such as children, youth and seniors. The projects were coordinated by the SSF and the CHSSN.

Additional information on OLHCP funding recipients can be found in Appendix A.

2.2 Program Logic Model and Narrative

The Program logic model was revised in 2008 by the OLCDB in collaboration with the Evaluation Directorate to reflect Program renewal changes and to link outcomes more clearly to those of the Roadmap.

As mentioned previously, the two main objectives (intermediate outcomes) of the OLHCP were to: (1) improve access to health services in the minority official language; and, (2) increase the use of both official languages in the provision of health services. These objectives were to be achieved by focusing on the following immediate outcomes:

1) Increased number of health professionals to provide health services in OLMCs;
2) Increased coordination and integration of health services for OLMCs within institutions and communities;
3) Increased partnership/interaction of networks in provincial and territorial health systems;
4) Increased awareness among stakeholders that networks are a focal point for addressing the health concerns of OLMCs; and
5) Increased dissemination and adoption of knowledge, strategies or best practices to address the health concerns of OLMCs.

The connections between these expected outcomes, and the activities that support them, is depicted in the logic model below.

The Program theory assumes that improved access to health services in the minority official language will be achieved by increasing the number of health professionals available that provide services in OLMCs. This increase will be mainly through recruitment and retention of health professionals speaking the language of the minority, with other activities (e.g. community networking and official language health projects) paving the way by, for example, advocating to service planners (provincial/territorial and regional health administration) for the delivery of more health services in OLMCs.

Table 1: Logic Model

<table>
<tr><th></th><th>Stream 1</th><th>Stream 2</th><th>Stream 3</th><th>Stream 4</th><th>Stream 5</th></tr>
<tr><td rowspan="2">Horizontal outcomes</td><td colspan="5">Canadians enjoy the benefits of linguistic duality; live and work in communities that reflect Canadian values with respect to the use of English and French, and have access to government services in the language of choice.</td></tr>
<tr><td colspan="2">Enhanced capacity of Canadians, English-speaking in Quebec and French-speaking across Canada, to live and work in vibrant communities in the language of choice</td><td colspan="3">Increased proportion of Canadians are aware of the benefits of linguistic duality and have access to the services that support it</td></tr>
<tr><td rowspan="2">Immediate outcomes</td><td colspan="2">Improved access to health services in the minority official language</td><td colspan="3">Increased use of both official languages in the provision of health care services</td></tr>
<tr><td>Increased number of health professionals to provide health services in OLMCs</td><td>Increased coordination and integration of health services for OLMCs within institutions and communities</td><td>Increased partnership/interaction of networks in PT health systems</td><td>Increased awareness among stakeholders that networks are a focal point for addressing health concerns of OLMCs</td><td>Increased dissemination and adoption of knowledge, strategies or best practices to address health concerns of OLMCs</td></tr>
<tr><td>Recipients' outputs</td><td>Recruitment & retention strategies (including support mechanisms); training sessions/seats</td><td colspan="2">Strategies and collaboration between networks, OLMC partners and provincial/territorial/regional health authorities</td><td colspan="2">Information tools, identified barriers and best/promising practices</td></tr>
<tr><td>Recipients' activities</td><td>Health professional recruitment, training, retention and deployment in line with OLMC health services requirements.</td><td colspan="2">Coordination and mobilization of community networks with OLMC partners and provincial/ territorial/regional health organizations</td><td colspan="2">Identify/assess barriers to access and best/promising practices</td></tr>
<tr><td rowspan="2">HC outputs</td><td colspan="5">Policy, planning and performance documents</td></tr>
<tr><td colspan="5">Funding Agreements</td></tr>
<tr><td>HC activities</td><td>Program management, strategic planning and performance measurement</td><td>Fund community health networking</td><td>Fund training and retention of health professionals</td><td colspan="2">Fund official languages health projects</td></tr>
</table>

2.3 Program Resources

Health Canada received $174.3 million under the Roadmap to support the implementation of the Program over the 2008–2009 to 2012–2013 period[2]. As indicated in Table 2, $4.3 million is dedicated to Program management, strategic planning, and performance measurement activities (operating expenditures under Vote 1), and $170 million is dedicated to carrying out the three components of the OLHCP (grants and contributions under Vote 10). Table 2 summarizes the Program resources and provides an overview of planned funding allocations to recipients (Health Canada, 2008).

Table 2: Budget for the OLHCP years 2008–2009 to 2012–2013 ($)

Vote 10 – Grants and Contributions						
	2008–2009	**2009–2010**	**2010–2011**	**2011–2012**	**2012-2013**	**Total**
CHSSN						
Health networking	1,000,000	1,500,000	2,000,000	2,016,757	2,000,000	8,516,757
OLMC health projects	-	3,334,600	3,616,720	3,232,006	3,300,000	13,483,326
Total (CHSSN)	**1,000,000**	**4,834,600**	**5,616,720**	**5,248,763**	**5,300,000**	**22,000,083**
SSF						
Training	-	-	363,252	-		363,252
Networking						
Prince Edward Island	64,501	80,626	96,752	96,752	96,752	435,383
New Brunswick	269,154	336,440	403,730	403,730	403,730	1,816,784
Nova Scotia	97,548	121,935	146,322	146,322	146,322	658,449
Newfoundland Labrador	61,540	76,925	92,310	92,310	92,310	415,395
Ontario	525,511	656,889	788,267	788,267	788,267	3,547,201
Manitoba	109,159	136,449	163,739	163,739	163,739	736,825
Saskatchewan	94,592	118,240	141,888	141,888	141,888	638,496
Alberta	120,078	150,099	180,115	180,115	180,115	810,522
Yukon	57,583	71,979	86,375	86,375	86,375	388,687
NWT	54,859	68,574	82,289	82,289	82,289	370,300
Nunavut	57,125	71,406	85,688	85,688	85,688	385,595
British-Columbia	128,350	160,438	192,525	192,525	192,525	866,363
National	860,000	450,000	540,000	540,000	540,000	2,930,000
Projects	-	5,058,429	5,941,149	5,609,022	5,500,000	22,108,600
Total (SSF)	**2,500,000**	**7,558,429**	**9,304,401**	**8,609,022**	**8,500,000**	**36,471,852**
McGill University						
Total (McGill)	**4,000,000**	**4,500,000**	**4,700,000**	**4,800,000**	**5,000,000**	**23,000,000**

[2] In 2003, the Government of Canada launched the government-wide *Action Plan for Official Languages 2003–2008*. It included "[an] $89 million investment in health services to OLMCs" (Health Canada, 2007, p. iii), $59 million of which was used to establish the Contribution Program to Improve Access to Health Services (CPIAHS) from 2003–2004 to 2007–2008. The *Roadmap for Canada's Linguistic Duality, 2008–2013: Acting for the Future* followed the initial Action Plan. As of 2008-2009, the OLHCP replaced the CPIAHS.

Vote 10 – Grants and Contributions						
	2008–2009	**2009–2010**	**2010–2011**	**2011–2012**	**2012-2013**	**Total**
CNFS						
Université Sainte-Anne (NS)	369,707	384,848	395,999	407,506	407,506	1,965,566
Université de Moncton (NB)	2,209,417	2,493,578	2,584,042	2,657,779	2,658,467	12,603,283
Entente Qc-N.-B.(NB)	2,367,504	2,037,994	2,104,107	2,172,331	2,172,331	10,854,267
Université d'Ottawa (ON)	4,671,225	4,930,957	5,082,811	5,239,511	5,239,511	25,164,015
Université Laurentienne (ON)	1,610,648	1,513,719	1,559,581	1,606,907	1,606,907	7,897,762
Collège universitaire de Saint-Boniface (MB)	767,500	774,426	797,684	821,683	821,683	3,982,976
Université de l'Alberta (Campus Saint-Jean)	691,606	644,861	665,618	687,038	687,038	3,376,161
La Cité collégiale (ON)	1,051,495	1,259,566	1,274,312	1,309,143	1,308,455	6,202,971
Collège Boréal (ON)	668,887	708,182	731,156	754,863	754,863	3,617,951
CCNB (Campbellton, NB)	754,261	703,457	726,278	749,826	749,826	3,683,648
Collège Acadie-Î.-P.-É		155,000	185,000	200,000	200,000	740,000
National Secretariat	837,750	2,393,412	2,030,150	2,143,413	2,143,413	9,548,138
Total (CNFS)	**16,000,000**	**18,000,000**	**18,136,738**	**18,750,000**	**18,750,000**	**89,636,738**
Total Vote 10	**23,500,000**	**34,000,000**	**36,700,000**	**38,000,000**	**38,300,000**	**170,000,000**
Vote 1- Operating Expenditures						
Salaries	20,000	228,000	300,000	310,000	317,000	1,175,000
Other Operating	173,400	496,760	701,000	487,700	878,390	2,737,250
Employee Benefits Plans and Accommodations	6,600	75,240	99,000	102,300	104,610	387,750
Total Vote 1	**200,000**	**800,000**	**1,100,000**	**900,000**	**1,300,000**	**4,300,000**
OLHCP Total	**23,200,000**	**34,800,000**	**37,800,000**	**38,900,000**	**39,600,000**	**174,300,000**

Source: OLCDB, 2011a, p. 4; OLCDB, 2011b; McGill University, 2009a; CNFS, 2009, p. i.; Health Canada, 2008, p. 15.

3.0 Evaluation Description

This section of the report provides a description of the evaluation methodology, including the evaluation objectives and issues, and the approach to data collection, as well as the key limitations that applied to the evaluation methods and findings.

3.1 Evaluation Scope

The Evaluation Framework was based on the Results-based Management and Accountability Framework approved by the Treasury Board Secretariat in 2008, which was adjusted in collaboration with Health Canada to reflect the core issues now mandatory under the *Policy on Evaluation (2009).*

The scope of the evaluation included all OLHCP activities from fiscal year, 2008–2009 to 2012-2013.

The specific evaluation questions used in this evaluation were based on the five core issues outlined in the *Policy on Evaluation (2009*). These are noted in Table 3:

Table 3: Evaluation Core Issues

Evaluation Issues		Evaluation Questions
Relevance		
Issue #1:	Continued Need for Program	Is there a continued need for the OLHCP?
Issue #2:	Alignment with Government Priorities	Is the OLHCP aligned with Government of Canada priorities?
Issue #3:	Alignment with Federal Roles and Responsibilities	Is the OLHCP aligned with Government of Canada roles and responsibilities?
Performance (effectiveness, efficiency and economy)		
Issue #4:	Achievement of Expected Outcomes	Is the OLHCP achieving the outcomes expected as outline in the Logic Model?
Issue #5:	Demonstration of Efficiency and Economy	Has the OLHCP been efficiently and economically implemented?

3.2 Evaluation Approach and Design

A non-experimental design was used for this evaluation. This means that there was neither random assignment of sample groups for inclusion in the evaluation nor a control group to compare with the sample. As a non-experimental design, the evaluation relied on correlation to demonstrate effect. As such, the evaluation was designed to demonstrate the likely contributions of the Program to the expected outcomes, rather than demonstrate direct causal links between the Program and outcomes.

3.3 Data Collection Methods and Limitations

Evaluators collected and analyzed data from multiple sources based on the Evaluation Framework that was developed to guide the collection of data in support of the evaluation.

Sources of information used in this evaluation included the following (further details can be found in Appendices B and C):

1. **Literature review:**
   The literature review focused on the following themes: needs of the official language minorities; knowledge transfer in the health sector; determinants of access to health care; and, accessibility of health care for OLMCs. A total of 50 relevant articles, papers, and reports were used.

2. **Document review:**
   The document review relied primarily on documentation originating from the OLHCP and provided by Health Canada or accessed through the Health Canada website. In total, more than 1,400 documents, in various formats, were reviewed for the purpose of this report. Of that number, close to 100 were retained for in-depth analysis and coding.

3. **Review of census and other survey results:**
   The review of census and other survey results provided information on the state of OLMCs and the evolution of health care needs, factors limiting or increasing health care access, and satisfaction with health care access among OLMCs.

4. **Key informant interviews:**
   A total of 30 interviews were conducted with: representatives of the CHNs; other stakeholders; representatives from post-secondary institutions; Health Canada Program management and operational staff; and provincial and territorial government representatives.

5. **Case studies:**
   Seven case studies were conducted across the country, focussing on CHNs — two in Quebec and five in the rest of Canada. CHNs were selected to achieve regional representation and to include both small and large CHNs. They provided information aiding in the assessment of the achievement of expected outcomes by identifying factors that had influenced CHNs (and associated projects) development and progress.

6. **Panel of experts:**
   A panel of experts (4 academics and researchers) was used to obtain feedback on findings from the lines of evidence that had been collected. The expert opinions were used to analyze and validate evaluation data prior to integration in the report.

The key limitations of the data collection methods are noted in Table 4 below:

Table 4: Limitations of Data Collection Methods

Data Collection Method	Limitation	Mitigation Strategy
Literature Review	Due to the timing of the review, literature did not pertain strictly to the period examined for this evaluation. Also, little information was found pertaining specifically to knowledge transfer that addressed the health concerns of OLMCs. In addition, no academic or grey literature was found on alternatives to the OLHCP. This impacted the evaluation's ability to fully assess Program economy and efficiency.	Limitations were noted and used to qualify findings and conclusions. A Panel of Experts was convened to address some of these limitations.
Document Review	Some of the performance information documented was of limited value since data were not able to be aggregated and/or did not relate to the indicators included in the performance measurement strategy. The baseline study completed in 2008 for the OLHCP was of limited use since it was based on information that dates prior to the evaluation period. This impacted the evaluation's ability to fully assess the impact of the Program (i.e., achievement of outcomes).	Other lines of evidence were used to provide evidence on the effectiveness of the Program, and, where performance data is used in this report, any issues with these data are indicated in a footnote.
Review of Census and Other Survey Results	A consistent definition of members of OLMCs across Canada was not available from sources other than the census. Few data sources provided information that directly indicated the demand for services in the minority language or the ability of suppliers to provide services in that language. Results of the sample surveys cannot be generalized and applied to an entire population given the limitations in geographical coverage associated with some of the various surveys. In addition, for a number of data sources, it was not possible to compare data points over multiple points in time. These factors limited the ability to identify and discuss changes or impacts over the 2008-2012 evaluation period.	Proxy variables were defined and used as necessary, most often by comparing an individual's first official language spoken (FOLS) with the majority language of their province; those whose FOLS is French and who reside in Canada outside Quebec are assumed to represent OLMCs, as are those whose FOLS is English and who reside in Quebec. Data from differing sources were not directly compared in the analysis and key limitations were noted where applicable and kept in mind when interpreting findings.
Key Informant Interviews and Case Studies	Individuals knowledgeable about the Program, and thus interviewed, were likely to have a vested interest in the Program. The evaluation had to rely on funding recipients as key informants. This had the potential impact of positively skewing the findings.	The evaluation attempted to balance interviewee opinions with evidence from the review of literature, document and surveys.
Expert Panel	The findings from the expert panel were limited by the knowledge and expertise of the experts chosen for participation, and reflected their experiences and biases.	Expert opinions were used to assist in validating and analyzing the various findings but other methods were also used to minimize any biases (e.g., Program validation, triangulation of various lines of evidence).

4.0 Findings

This section of the report presents the findings of the evaluation organized according to the main evaluation issues of relevance (section 4.1) and performance of the Program (section 4.2), including its efficiency and economy (section 4.3). For ease of reference, key findings are profiled in text boxes at the start of each section.

4.1 Relevance

4.1.1 Continued need for the Program

OLMCs represent 6.4% of the Canadian population (2006) and are concentrated mainly in New Brunswick, Ontario and Quebec.

The vast majority of OLMC members believe it is important to be able to use their minority language in daily life and consider it important for linguistic rights to be respected and for federal and provincial government services to be provided in the language of the minority.

In terms of the determinants of health and the perceived health needs of OLMCs, the data currently available (which is by no means conclusive) does not indicate that health care needs of OLMCs differ significantly from those of the majority language community. However, the French minority communities tend to be older and therefore are likely to require more medical interventions. Also, the French minority tends to live in rural areas and, in New Brunswick only; the OLMC has lower education and income levels.

While a number of barriers (e.g., language and culture, geographic location, availability of health care professionals) seem to influence OLMCs access to health care services to varying degrees, difficulties in accessing health services seems to be associated more with barriers unrelated to language.

The French minority population outside Quebec was satisfied with their level of access to health services. However, the English minority in Quebec appears significantly less satisfied.

OLMC Description

The primary method used by the Federal Government for measuring official language minority communities is described as "Method I" in the *Official Languages (Communications with and Services to the Public) Regulations*. The approach is taken from Statistics Canada's 1989 *Population Estimates by First Official Language Spoken*, which "gives consideration, firstly, to knowledge of the official languages, secondly, to mother tongue, and thirdly, to language spoken in the home, with any cases in which the available information is not sufficient for Statistics Canada to decide between English and French as the first official language spoken being

distributed equally between English and French." Using this approach, the number of persons who reside in Quebec and have English as their first official language spoken is considered to be the official language minority community population of that jurisdiction. Likewise, the number of persons who reside in all other provinces and territories who have French as their first official language spoken is considered to be the official language minority community population of those jurisdictions.

Based on 2006 Census (Table 5), OLMCs comprise almost 2 million persons and represent about 6.4% of the total population in Canada. These persons are almost evenly split between English-speaking Quebecers and French-speaking Canadians in all other jurisdictions. The OLMC population is more concentrated in some jurisdictions (New Brunswick at 32.7%, Quebec at 13.4%, and Ontario at 4.5%). The lowest concentration is in Newfoundland and Labrador at 0.4%.

Table 5: Official language minority communities by province and territory, 2006

	Total Population	First official language spoken				Official language minority	
		English	French	English and French	Neither English nor French	Number	Percentage
Newfoundland and Labrador	500,605	497,815	1,835	195	755	1,935	0.4
Prince Edward Island	134,205	128,980	5,085	95	40	5,135	3.8
Nova Scotia	903,090	868,850	31,510	1,430	1,300	32,225	3.6
New Brunswick	719,650	482,870	234,155	1,945	680	235,130	32.7
Quebec	7,435,900	885,445	6,263,950	218,555	67,955	994,725	13.4
Ontario	12,028,895	11,189,935	497,150	80,890	260,920	537,595	4.5
Manitoba	1,133,515	1,079,235	42,125	1,985	10,165	43,120	3.8
Saskatchewan	953,850	935,495	14,475	750	3,130	14,850	1.6
Alberta	3,256,360	3,150,175	58,575	8,420	39,185	62,785	1.9
British Columbia	4,074,385	3,883,215	53,060	17,350	120,755	61,735	1.5
Yukon	30,195	28,830	1,125	120	115	1,185	3.9
Northwest Territories	41,055	39,675	950	110	320	1,005	2.5
Nunavut	29,325	26,575	385	80	2,290	425	1.4
Canada	31,241,030	23,197,095	7,204,380	331,925	507,610	1,991,850	6.4
Canada less Quebec	23,805,130	22,311,650	940,430	113,370	439,655	997,125	4.2

A summary of OLMC characteristics is provided below.

New Brunswick

The population with French as their FOLS in New Brunswick is concentrated in specific regions of the province, with approximately 90% residing in six of the province's fifteen census divisions, and mainly located in the north and south-east of New Brunswick.

Highlights of the New Brunswick OLMC population include the following:

- The minority language population has lower educational levels, with 36% of this group having no certificate, diploma, or degree, compared to 22% for the Anglophone majority.
- The OLMC population has lower incomes, on average, with the mean income of the minority population $4000 and $1000 less for men and women, respectively, compared to the majority population. 22% of OLMCs are in the lowest income percentile compared to 16% of Anglophones (Bouchard et al, 2009).
- Francophones are also more likely to live in rural areas than Anglophones (53% vs. 46%) (Bouchard et al, 2009).

Ontario

Francophones of Ontario concentrate in specific regions of the province with approximately 60% of the population with French as their FOLS residing near the border of Quebec. In these areas, they represent a much higher proportion of the population.

Highlights of the Ontario OLMC population include the following:

- Statistics on diplomas, certificates or degrees obtained at the post-secondary level show that education gaps between the groups are small. Data from the 2006 Census shows that 24% of the Francophone population had no certificate, diploma or degree, compared to 21% of the Anglophone population.
- The average income of the minority population is similar to that of the majority according to 2006 statistics (Francophones' median income is $3,500 higher than that of Anglophones). However, the CCHS data indicates that a greater proportion of the minority population is in the lowest income percentile compared to the majority (21% vs. 17%).
- Francophones of Ontario are more likely to live in rural and remote areas compared to Anglophones (19% vs. 14%) (Bouchard et al, 2009) and tend to be older.

Quebec

The English minority population is approximately 13.4% (see Table 5) of the province's population. Three regions of the province account for close to 92% of the English minority with over 80% of Anglophones living in the Montreal census metropolitan area (22% of the overall population in that region). The Outaouais as well as the Estrie and southern regions of Quebec respectively account for 6% and 5% of Quebec's English population; their relative weight within the population was 17% and 9% respectively.

Highlights of the Quebec OLMC population include the following:

- According to Census 2006, statistics on diplomas, certificates or degrees obtained at the postsecondary level reveal that there is a sizable gap in university degrees or diplomas in favour of Anglophones: almost 25% of the latter have such a degree or diploma, compared to slightly more than 15% of Francophones.

- While the income gap between Anglophones and Francophones has gotten narrower over time, the 2006 census data shows that while the mean income of persons with English as their FOLS is $3,080 higher than that of persons with French as their FOLS, the median income of Anglophones is actually $1,806 lower than that of Francophone. These findings suggest that Anglophones have a wider range of incomes than do Francophones.
- Fewer Anglophones lived in rural areas as compared to Francophones (10% vs. 21%) according to Bouchard et al (2009).
- A majority of English-speaking persons in Quebec (87%) believe it is important to receive health services in English (Statistics Canada, SVOLM). They are also generally comfortable requesting services in English (74%).

Elsewhere in the country

Based on the FOLS definition, the size of the Francophone minority population in other provinces or territories varies from 425 individuals in Nunavut to 62,785 in Alberta, which represents 0.04% and 6.2% of the territorial/provincial population, respectively. In all provinces/territories, OLMCs tend to live in rural areas.

Highlights of OLMCs residing in other provinces include the following:

- Educational attainment varies depending on regions, sometimes favouring the minority and sometimes favouring the majority. Other variables such as immigration (i.e., immigrants tend to integrate to the majority) may be also influencing statistics on educational attainment.
- French minority communities tend to be older than the majority population and therefore are more likely to use health services regularly.
- In the four western provinces and three territories combined, 49% of French-speaking persons believe it is important to receive health services in French. Only 51% are comfortable requesting services in French and 59% indicated that it would be difficult for them to access services in French.
- In the three provinces of Newfoundland and Labrador, Prince Edward Island and Nova Scotia combined, 63% of French-speaking persons believe it is important to receive health services in French. Forty four per cents are comfortable requesting services in French and 54% indicated that it would be difficult for them to access services in French.

Health Status

Stakeholders who took part in the evaluation indicated that **the health care needs are similar between the minority and majority official language groups, in similar circumstances (e.g., age, rurality and/or remoteness)**. The majority of key informants noted that the health care needs of OLMCs remained relatively stable between 2008 and 2012, and some pointed out that progress has been made towards meeting those needs. Case studies confirmed that the needs are basically the same between the official language minority and majority in several provinces and territories (with the exception of the Francophone minorities which tend to be older than the majority population).

As noted earlier, **the official language minority populations show some regional variations in the prevalence of disadvantaged determinants of health across Canada** (e.g., disadvantaged determinants include lower income, lower education levels, rural living). As well, OLMC populations in Canada outside Quebec are, on average, older than the majority population. However, comparative distributions within Quebec are not as consistently distinct. While elderly members of OLMCs represent a small number of individuals in most provinces and territories (see Table 5), they are more likely to be unilingual and thus experience a language barrier. They may also be less familiar with specialized medical terminology, and may have more contact with the health care system (Bernier, 2009; Corbeil et al., 2006; Kischuck, 2010).

When language barriers exist to receiving health care services in the minority language, it is usually the vulnerable populations (e.g. the elderly and children) who are the most affected. There have been a number of studies that illustrate the negative impact on health that can arise when health information is not communicated and received effectively.

Data regarding the health status of OLMCs is limited or inconsistent. For the purposes of a study conducted for the CNFS, Bouchard and Paulin (2010) reviewed a comprehensive inventory of Canadian databases containing information regarding the health of the Francophone minority population outside Quebec. They noted that information regarding actual or perceived health status was available in only 60% of the databases; furthermore, few data sources contained any information regarding social support, cultural, financial, or physical environmental factors known to be determinants of health. Information pertaining to key determinants of health, such as education and literacy, were not included in almost half of the data sources reviewed (42.9%). While 20 % of the data sources contained individual health survey results, there were many gaps, including data relative to morbidity and the occurrence of major disease, such as cancer.

A recent comparative study of the "Health and Healthcare Utilization of Francophones in Manitoba" francophone population that was funded by the Manitoba Department of Health (Chartier 2012) found that "older Franco–Manitobans (those born before 1958) are less healthy than other Manitobans born during this time period, those born between 1958 and 1987 have similar health, and those born after 1982 are in better health than their matched Manitobans."

One synthesis report notes that results pertaining to the health status of Francophone minorities outside Quebec vary across studies, as authors differently perceive the status of health for minority Francophone communities. For example, some feel that the level of health is as good as that of the English majority, while others claim that Francophones have poorer overall health (Women's Health Network Fact Sheet). Various methods for self-rated assessments of health suffer from an assortment of limitations, and, as Bélanger et al. (2011) noted, the measurement of self-rated health remains subjective and varying interpretations of health, primarily due to cultural background, could play a role in the individual assessment of health.

The absence of language variables in provincial health administrative databases was also underlined as an issue during interviews and case studies conducted in Quebec, as was the absence of mechanisms by which to assess the demand and supply of health services in English based on administrative databases.

Similarly, the limited self-reported information on health related indicators seems to be pointing in different directions. Therefore, it is difficult to say conclusively that there is a difference in health status given the data limitations. It may be that minority communities are disadvantaged in terms of their health status but the evidence cannot conclude this.

Specific Health Needs

The most common health care needs identified by stakeholders are related to overall availability, as well as to the recruitment and retention of health care professionals. A number of key informants identified the need for specific services (e.g., general and specialized physicians, pharmacists, nurses and psychologists) in the minority language while others pointed out the need for services targeted at specific segments of the population (e.g., the elderly).

One source reviewed noted that the CNFS conducted an environmental scan (Brynaert, 2011) which suggested the most pressing needs in terms of access to health services for French-speaking communities outside Quebec is mental health services (Brynaert, 2011). The study also underlined the significance of the aging of the population among French-speaking Canadians outside Quebec.

Although the Statistics Canada study on health care professionals (2009) suggests that social workers and the psychologist workforce appeared sufficient in provinces where most of the OLMC resides (i.e., New Brunswick, Quebec and Ontario) as well as in few other provinces (i.e., Prince Edward Island, Nova Scotia and British Columbia[3]), the need for more mental health services was nonetheless echoed by a number of key informants. A few of them also noted the need for more primary care, specialty care, and health promotion and prevention activities, as well as the need for more points of services.

Sense of belonging and importance of being able to use a minority language in daily life

The Survey on the Vitality of Official Language Minorities (SVOLM – Statistics Canada, 2007) enquired about the 'linguistic group to which members of official language minorities were most likely to identify with' as an indication of the population's sense of belonging to a linguistic group. Data collected as part of this survey show that the proportion of French speaking adults identifying with only or mainly to the Francophone group ranged from 61% in New Brunswick, to 31% in Ontario to 12% Saskatchewan. In western provinces, the proportion of French-speaking adults identifying mainly or only with the Anglophone group exceeded those identifying with the Francophone group. In Atlantic Provinces (with the exception of New Brunswick), the proportion of French-speaking adults identifying only or mainly with the Francophone group was similar to the proportion identifying only or mainly with the Anglophone group. In Quebec, nearly one in two adults of the Anglophone minority identified primarily with the Anglophone group, compared to 37% who identified with both groups.

[3] In most other provinces or territories, the sample size was not sufficient to provide accurate estimate on the use of the minority language by social workers and psychologists.

While the sense of belonging appeared to vary greatly across the country, **a large proportion of French-speaking adults outside Quebec reported that being able to use French in daily life was important,** ranging from 93% in New Brunswick to slightly above 50% in Saskatchewan, Alberta and British Columbia. However, this response appeared linked to the proportional weight of the minority group in the municipality where they tend to reside. **As it pertains to the English minority of Quebec, the vast majority of Anglophones (88%) indicated that it was important or very important for them to be able to use English in their daily life**. Of those who were able to conduct a conversation in French, 76% still considered it to be important or very important to be able to use English in their daily life.

Importance for government services to be provided in the language of the minority

The proportion of French speaking adults considering it important for federal government services to be provided in French and for linguistic rights to be respected when receiving federal government services in their province remained over 66% for both in any province. As well, 94% of Quebec Anglophones considered it important or very important for government services to be provided in English, and 96% assigned importance to linguistic rights being respected when receiving federal government services in their province. According to the SVOLM, the perceptions of the French speaking population on the importance of linguistic rights being respected are related to the language in which they report being most at ease in. Outside Quebec and New Brunswick, approximately 46% of French-speakers report feeling more at ease in English than in French, compared to 38% feeling more at ease in French and 16% being as at ease in one language as in the other.

When OLMC members were asked specifically about the importance of receiving health services in the minority languages, responses varied widely by province. New Brunswick stands out with 80% of French-speaking adults reporting that it is 'very important' or 'important', while in other provinces, the proportions range between 23% in Saskatchewan and 54% in Ontario (Statistics Canada, 2007).

The influence of access barriers

While a number of barriers (e.g., language and culture, geographic location, availability of health care professionals) seem to influence OLMCs access to health care services to varying degrees, difficulties in accessing health services seems to be associated more with barriers unrelated to language. When examining the factors that influence access to health care services, it is evident that some factors are present in the general population and others are specific to language minority communities. This evaluation examined five main factors: socio-economic factors, language and culture, geographic distribution and distance from services, the availability of health care professionals, and, the proactive offer of services in the language of the minority. The key findings include the following (see Appendix C for details):

- While language proficiency can impact access to quality health care, the majority of French-speakers outside Quebec and New Brunswick reported being more at ease in English than in French or equally at ease in both official languages.

- Distance from health care services and low population densities seem to be barriers to health care access, although it remains unclear whether these barriers are more intense for the official minority population compared to the majority living in similar circumstances (e.g., rural or remote living).
- In provinces with higher concentrations of OLMCs, access to language-appropriate health care services was generally available.
- Although shortages in health professionals are felt in communities across Canada, stakeholders seemed to suggest it is more problematic for OLMCs. Literature suggests that shortages in health professionals providing services to OLMCs are apparent in several professions, including general practitioners, medical specialists, nurses, and orderlies and attendants (Dufour and Fontaine, 2008). Brynaert (2011) further underlined the significance of the aging of the official language minority population.

The 2009 Statistics Canada study entitled ***Health Care Professionals and Official Language Minorities in Canada*** provides a portrait of certain groups of health care professionals who serve or who may be able to serve official language minority communities. The report analyses linguistic data from the 2006 Census to produce statistics on the number of doctors, nurses, psychologists, social workers and other health care professionals in each province and territory who belong to the minority population, use the minority language at work, or report being able to conduct a conversation in that language. Table 6 presents information on the distribution of health professionals in different regions of Canada based on these three language competencies.

A general observation emerges from a study of the different regions and occupations presented in Table 6 and in the Statistics Canada study. In regions where OLMCs are more highly concentrated, there is also a very significant presence of minority first official language health professionals. This trend repeats itself in the three regions of high OLMC concentration, namely, Northern New Brunswick, the Montreal region, and Eastern Ontario which is denoted here as the Champlain Health Region.

Conversely, in regions where OLMC concentrations are lower, there is an increased reliance on health professionals who have a working knowledge of the minority official language and who use their minority language on a regular basis but who do not identify that language as their first official language.

Table 6: Health care professionals by use of the minority language at work, by knowledge of minority official language and region of residence, 2006

Region	% of doctors using the minority language at least regularly at work	% of doctors with knowledge of minority OL	% of nurses using the minority language at least regularly at work	% of nurses with knowledge of minority OL	% of social workers and psychologists using the minority language at least regularly at work	% of social workers and psychologists with knowledge of minority OL	FOLS: French only, English only in Quebec (general population)
Newfoundland and Labrador	4.4%	19.7%	1.2%	4.0%	0.0%	6.7%	0.4%
Prince Edward Island	0.0%	11.5%	3.7%	8.0%	6.1%	27.3%	3.8%
Nova Scotia	5.4%	20.3%	3.2%	9.5%	4.4%	15.0%	3.6%

Region	% of doctors using the minority language at least regularly at work	% of doctors with knowledge of minority OL	% of nurses using the minority language at least regularly at work	% of nurses with knowledge of minority OL	% of social workers and psychologists using the minority language at least regularly at work	% of social workers and psychologists with knowledge of minority OL	FOLS: French only, English only in Quebec (general population)
New Brunswick	45.8%	53.0%	44.3%	48.8%	56.5%	60.2%	32.7%
Quebec	51.1%	85.5%	36.8%	44.9%	29.4%	55.5%	13.4%
Ontario	7.0%	23.0%	6.9%	11.8%	8.2%	18.6%	4.5%
Manitoba	2.9%	15.0%	3.6%	8.5%	2.9%	10.1%	3.8%
Saskatchewan	0.9%	12.0%	0.7%	4.6%	0.9%	6.2%	1.6%
Alberta	2.5%	14.9%	1.0%	7.2%	1.2%	7.7%	1.9%
British Columbia	2.7%	19.3%	0.7%	6.7%	1.6%	10.7%	1.5%
Yukon	10.0%	35.0%	0.0%	14.9%	0.0%	17.4%	3.9%
Northwest Territories	0.0%	25.0%	2.3%	8.1%	0.0%	23.8%	2.5%
Nunavut	0.0%	40.0%	10.5%	21.1%	0.0%	13.3%	1.4%
Canada outside Quebec	6.1%	21.1%	5.6%	10.8%	6.9%	16.0%	4.2%

Source : Statistics Canada (2006).
In some provinces (shaded cells) samples were sometimes too small to provide accurate estimates and results are to be interpretated with caution.

Overall, the SVOLM suggested that the **OLMC population seems generally satisfied with the level of access to health services in the minority official language** with roughly half of Anglophones in Quebec and Francophones in the rest of Canada reporting that it would be 'easy' or 'very easy' for them to get health care services in the minority language. The use of the minority language does not seem to be as frequent in western provinces.

While Census information suggested that that the language of the OLMC seems to be used in the delivery of health care services by doctors, nurses, social workers and psychologists, at least in provinces where OLMCs tend to concentrate, Blaser suggested (2009) that the actual capacity of health care professionals to deliver services in the minority language was not necessarily well-represented by linguistic ability as reported by census variables (such as "official languages known" or "language of work"). Professionals who speak conversational French may still not be well-equipped to provide services in French; conversely, doctors who rarely use English at work in practice might still be sufficiently fluent to provide services in English if there was demand.

In addition, beyond the shortage of health care professionals in OLMCs, the increased workload for bilingual health care providers is a key consideration, and can be a source of tension between health care providers and the community (Bouchard, L., 2011). A 2008 survey of students and new health care professionals from CNFS institutions revealed that workload was the number one concern (Bouchard et al, 2009), although this survey did not assess the extent to which workload concerns were similar or worse than those perceived by English-speaking students. Other studies indicated that outside Quebec, French-speaking health professionals do not always disclose their ability to speak French for the same reasons as patients (e.g., acquired behaviour), or for fear of getting swamped by patients and being expected to act as interpreters or translators (Bouchard et al, 2010; OFLSCO, 2009). Stakeholders who took part in the evaluation confirmed

this is a key concern, and indicated that bilingual health care providers are also often relied upon to provide translation and interpretation services, regardless of their role and other responsibilities.

There are inherent difficulties in identifying health professionals who are sufficiently proficient and are comfortable being identified as able to provide services in the minority language. While several directories of such professionals have been created by CHNs in various provinces, they are difficult to establish and maintain. Stakeholders indicate that it is challenging or even impossible for individuals to find health professionals who can provide services in the minority language on their own, especially outside urban areas. Where word of mouth is often the main source of information to identify a health professional who is proficient in the minority OL, they can quickly be overwhelmed by demand.

4.1.2 Alignment of the Program with government priorities

> The OLHCP fits within the priorities related to the federal Roadmap for Canada's Linguistic Duality.

The federal priority for linguistic duality was demonstrated through the development and implementation of the Roadmap and was highlighted in the 2007 and 2010 Speeches from the Throne, as noted below:

- The Government of Canada reaffirmed its ongoing commitment to linguistic duality in the 2007 Speech from the Throne, in which the Governor General of Canada indicated that "government supports Canada's linguistic duality. It will renew its commitment to official languages in Canada by developing a strategy for the next phase of the Action Plan for Official Languages" (Government of Canada, 2007). The government also reiterated its commitment in the Speech from the Throne in 2010.
- In this context, the federal government established the Roadmap (2008–2013), which represents a $1.1 billion investment in linguistic duality and was formalized in the 2008 Budget[4]. As indicated previously, the Roadmap includes major investments through 15 federal departments and agencies. Health Canada received 16% of the funding allocated under the Roadmap to implement the OLHCP from 2008–2009 to 2012–2013. The funding allocated to the OLHCP ($174.3 million) represented an increase in funding compared to the former CPIAHS ($89 million).

4.1.3 Alignment of the Program with government roles and responsibilities

> The OLHCP fits within the federal government's role defined in the Official Languages Act and Health Canada's strategic outcome to have "a health system responsive to the needs of Canadians".

4 This information comes from OLCDB personnel.

The OLHCP operates in a remarkably challenging policy environment, combining the intrinsically complex health care system with official language considerations, all of which unfolds in a system where both the federal and provincial/territorial orders of government play significant yet different roles.

Provincial and territorial ministries of health are generally concerned with maintaining, improving, and restoring the health of their citizens, and do so by ensuring the delivery of high-quality health and social services. Depending on provincial and territorial government priorities at any given time, the interest in and focus on services to OLMCs has historically varied. Each jurisdiction in Canada may establish legislated provisions or policies that would, in principle, allow its citizens to receive a designated number of health care services in either English or French. As it currently stands, a number of provinces and territories have, in fact, enacted legislation or policies that specifically cover the issue of health care services in both official languages. This includes constitutional provisions on official languages applicable to New Brunswick; government-wide laws and regulations on the provision of French-language services such as those in Ontario, Nova Scotia, Prince Edward Island, and the territories; policies on French-language services in Manitoba and, to a lesser degree, in Saskatchewan; and specific provisions such as the one applicable in Quebec that deals specifically with the provision of health care services in English.

While considerable attention is given to the roles and responsibilities of provincial and territorial governments in providing health care services in both official languages, it must be acknowledged that the federal government also plays a role. For many years, stakeholders in the realm of official languages have struggled to fully understand the scope of Section 41 of **the *Official Languages Act* (*OLA*) that commits the federal government to "enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development." With the most recent amendment to the Act confirming the duty of each federal institution to "ensure that positive measures are taken" for the implementation of that commitment, there is a clear obligation on the part of departments such as Health Canada to implement specific initiatives such as the OLHCP. As the Act specifies, these initiatives must "be carried out while respecting the jurisdiction and powers of the provinces." This, clearly, applies to the area of health**.

In addition, the Government of Canada's investment in the area of official languages, specifically the investments under the Action Plan (2003–2008) and the Roadmap (2008–2013), combined with those of other levels of government, reaffirm a concept first introduced by the *Royal Commission on Bilingualism and Biculturalism* (1967) that the provision of Programs and services in both official languages systematically implies additional costs, and that it is in the interest of the Government of Canada to contribute toward those costs.

The Official Languages Support Programs (OLSP) of Canadian Heritage remain the federal government's key tool in meeting its obligations under Part VII of the *Official Languages Act*, specifically Articles 41 to 43. The Official Languages Support Programs represent one of very few tools the federal government has to support provincial and territorial governments' efforts in the provision of education in the language of the minority, second language training, and services

in the language of the minority. Official Languages Support Programs play a unique role in supporting second language training which, unlike education in the language of the minority, is not guaranteed by the Constitution in all areas and which triggers additional costs. Similarly, the OLHCP plays a unique role in supporting access to health services in both official languages. Specifically, the OLHCP contributes toward the additional costs and efforts related to increasing the number of health professionals available to provide services to OLMCs with its Training and Retention component. In fact, the CNFS was initially created in 1999 under Canadian Heritage's Official Languages in Education Program — which now forms part of the OLSPs — to provide health training to Francophones outside Quebec (Health Canada, 2008, p. 4). It also contributes toward additional costs and efforts to support access to services in both official languages in a variety of other ways with its Networking component, which supports collaboration between communities and provincial/territorial health systems.

With its focus on access, **the OLHCP is also aligned with the overall principles of the *Canada Health Act* and the Canadian health care policy**. Specifically, Health Canada "administers the *Canada Health Act*, which embodies national principles to ensure a universal and equitable publicly-funded health care system" across all provinces and territories. "The Act [also] sets out the primary objective of Canadian health care policy, which is 'to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers'".

In addition, the Program corresponds to one of the department's strategic outcomes: "A Health System Responsive to the Needs of Canadians". In the department's Program Alignment Architecture, under this strategic outcome, the **OLHCP is associated with and funded through the "Official Language Minority Community Development" Program activity, which aims to increase the number of health professionals available to provide health services in OLMCs and improve the integration of OLMC health needs into the health system**.

4.2 Performance — Achievement of Expected Outcomes

As indicated in the logic model, the Program funds activities that contribute to the achievement of the following five immediate expected outcomes (listed in order of presentation in subsequent sections):

1. Increased number of health professionals available to provide health services in OLMCs;
2. Increased coordination and integration of health services for OLMCs within institutions and communities (increased number of institutions and communities providing health services in the language of the minority);
3. Increased partnerships or interaction of networks in provincial/territorial health systems;
4. Increased awareness among stakeholders that networks are a focal point for addressing health concerns of OLMCs; and
5. Increased dissemination and adoption of knowledge, strategies, or best practices to address health concerns of OLMCs.

According to Program theory, these immediate outcomes are anticipated to contribute to the achievement of the following two intermediate outcomes:

1. Increased use of both official languages in the provision of health care services; and
2. Improved access to health services in the minority official language.

This section presents findings pertaining to the performance of the Program organized according to the five expected immediate outcomes over the evaluation period (2008 to 2012).

4.2.1 Expected Immediate Outcome: Increased number of health professionals to provide health services in OLMCs

> The number of health professionals available and able to provide health care services in OLMCs seems to have increased.

The capacity of post-secondary institutions (receiving funding pursuant to the OLHCP) to deliver training in the minority language to students in health Programs and to health professionals seems to have increased since 2008. Ontario and New Brunswick offer the most training Programs.

The CNFS receives funding through the OLHCP to provide educational Programs in the health professions in French outside Quebec. The overall number of Programs has remained fairly stable since 2008-2009 with a total of 94 Programs delivered in 2011–2012 (CNFS, 2012, p.6). *La Cité collégiale* and the *Université de Moncton* are the two institutions offering the most Programs (Appendix D). CNFS institutions also offer non-credit, continuing education courses to health professionals. As of 2011–2012, the *Collège universitaire* (now *Université*) de *Saint-Boniface*, *Centre de formation médicale* (*Entente Québec/Nouveau-Brunswick*) and *Université de Moncton* have provided continuing education sessions to the largest number of health professionals.

For four years of data, there was a 17% increase in enrolment in 2009-2010, followed by a 7% increase in 2010–2011, and 0.7% increase in 2011–2012. Overall, there have been 3,860 registrations to CNFS-funded post-secondary institutions since 2008, which exceeds expected results by the CNFS. It should be noted that there is no documentation pertaining to the number of seats added to the Programs since the creation of the OLHCP or its predecessor.

The CNFS also compiled the number of students per institution, per Program and according to province of origin for the academic year 2008–2009 (CNFS, 2008-2009). It indicated that institutions draw the vast majority of their clientele from their own province, with the exception of Ontario institutions such as the University of Ottawa, the *Cité collégiale* and *Université Laurentienne*, which draw students from Quebec, and to a lesser extent, from New Brunswick. The *Université de Moncton* also draws students from Quebec and Nova Scotia.

A variety of new recruitment and retention strategies/activities have been implemented. These were targeted either at potential students (e.g., promotional activities in high schools), students (e.g., field placements, bursaries), or health professionals (e.g., online resources in the minority official languages). The multiple recruitment and retentions strategies aimed at increasing the number of students, graduates, and eventually, health professionals working in OLMCs are summarized below. They emerged from individual recipient organization performance reports, interviews, and case studies, and may not be comprehensive.

Strategies aimed at potential and actual students included the following:

- As of 2009–2010, the CNFS has developed tools that facilitate the exchange of learning and best practices among the member institutions, including an online portal that makes all the tools available to member institutions, in order to assist with Program development, recruitment and retention of students.
- The CNFS and its four regional partners visited high schools to promote the Programs offered, produced videos of testimonials on health professions, and produced promotional equipment (e.g., pens, T-shirts) with the logo of the CNFS.
- Networks indicated that they conducted health information sessions in schools, which often included information about health professions.
- The SSF also collaborated with the CNFS to attract existing students to information sessions so they could raise their awareness about the provision of health services in French.
- Some CHNs awarded bursaries to students in order to attract them to minority language health profession Programs, specifically in professions where the lack of service providers is more pronounced (e.g., speech therapy). There is anecdotal evidence of such cases in recent years, but no compilation of the number and dollar amounts of bursaries was available for this evaluation. This is not directly addressed in performance reports.
- A few post-secondary institutions provided academic support to help students succeed in their minority language health Program and remain in the Program. For example, additional help in math was provided for nursing students who struggled in that field.
- Some networks collaborated with post-secondary institutions and health care institutions in an attempt to strengthen the ties between the students and the OLMCs so that students would consider staying or returning to OLMCs upon graduation. It is often possible for the networks to keep track of the limited number of students from their province or region that are enrolled in health-related Programs in the minority language, and seek out a suitable field supervisor in a local health care facility.

Strategies aimed at health care professionals included the following:

- The National Secretariat of the CNFS managed two initiatives that targeted newcomers to Canada, aimed at helping them in their professional integration in the health professions. For example, it helped nurses who have been trained abroad to take the necessary test in order to get their licence to practice in Canada (CNFS, 2011a, pp. 13-14).
- In 2008–2009, McGill posted professional development activities for English-speaking professionals on the website of the nursing therapeutic plan. It reported 976 hits on the website.

Some networks collaborated with health care institutions in order to post-employment opportunities for bilingual individuals on the network's website and promote opportunities at job fairs.

Graduations from CNFS institutions have increased overall. Table 7 indicates the number of Francophone students who graduated from CNFS institutions from 2008–2009 to 2010–2011. Having the highest number of Programs offered and the highest enrolment, it is no surprise that *La Cité collégiale* has the highest number of students who graduated. There has been an increase of 47.5% in graduations over the first three years, and there were a total of 596 CNFS graduates in 2010–2011.

Table 7: Numbers of students who graduated from member institutions of the CNFS

Institutions	2008–2009	2009–2010	2010–2011
Collège Acadie Î.-P.-É.	0	6	6
Collège Boréal	76	79	58
Collège communautaire du Nouveau-Brunswick – Campus de Campbellton	50	31	72
Collège universitaire (Université) de Saint-Boniface	13	40	44
La Cité collégiale	106	121	165
Entente Québec/Nouveau-Brunswick	6	8	7
Université de l'Alberta – Campus Saint-Jean	14	8	18
Université Laurentienne	44	35	35
Université de Moncton	47	85	76
Université d'Ottawa	47	102	100
Université Sainte-Anne	1	3	15
Total	**404**	**518**	**596**

Source: 2008–2009 data, Health Canada, 2010, p. 13; 2009–2010 data, CNFS, 2011a, p.3; 2010–2011 data, CNFS, 2012, p.6, 17-35.

See Appendix D for detailed information on Programs offered, enrolment, and graduation rates.

Placement rates for OLMC graduates are high. Based on the compilation of results of institutional surveys of graduates by the CNFS in 2005–2006 and again in 2008–2009, approximately 18 months after graduation, 86% of CNFS graduates seem to be working in health care institutions or community health organizations providing services to Francophone minority communities outside Quebec[5]. While results have varied among institutions over time, the

[5] CNFS graduates" are defined as graduates of programs in the health sciences which are offered in French, and which benefit from funding under the Training and Research program component, while graduates of programs that existed prior to that funding are not included as CNFS graduates. CNFS graduates also include graduates of programs that predated this funding, but where the funding served to increase the number of seats. Only the graduates from these additional seats are included in the data presented in the CNFS study. The response rate was 50% of CNFS graduates, excluding those who have pursued further studies in health sciences. Five and 10 institutions (not listed) participated to the survey in 2005-2006 and 2008-2009, respectively.

overall proportion has remained the same. Furthermore, **the rate of graduates returning to their home province is also high**, at 79% in 2008–2009 (LeBlanc, 2011). These high proportions are not surprising because prospective students choose the institution they wish to attend based on where they wish to work following graduation (LeBlanc, 2011). Statistics regarding province of origin confirm that the vast majority of students study in their home province (see Appendix D). The availability of more Programs and higher enrollment in provinces where OLMCs are more concentrated, coupled with the finding that graduates are returning to their home province, suggests that a high proportion of OLHCP graduates are returning to provinces where the level of services available was already higher (compared to provinces with lower concentration of the official language population).

While many stakeholders who participated in the evaluation indicated that the rate of graduates returning to work in OLMCs is high, almost all quote the CNFS study referenced above which is the only post-graduation follow-up study available for this evaluation. Based on post-graduation follow-up statistics from individual post-secondary institutions (which were not made available for this evaluation), stakeholders noted that the vast majority of CNFS graduates in their region were placed in positions where they provide services in French. They also indicated that in smaller OLMCs, it is often possible for the community networks to keep track of the number of returning graduates because of the limited number of students involved (e.g., Nunavut, Saskatchewan, rural Quebec), and they have noted an increase in French-speaking individuals in the health care system in recent years in some OLMCs (e.g., in St. Boniface).

As mentioned in the section pertaining to limitations, it is important to note at this point that **a number of factors influenced the reliability of Program performance data**, such as the changes made to Program terms and conditions in 2009 and the third-party delivery which prevents the Official Language Community Development Bureau from having direct access to performance data collected by secondary funding recipients for validation purposes.

Several stakeholders also underlined that it is too early to assess whether the new educational Programs and recruitment and retention mechanisms implemented in recent years actually improve the proportion of health professionals who remain, return to, or choose to work in OLMCs. It may be too early to assess the effect of these interventions because some Programs have been in place only for a few years, and graduating and completing an internship may take several years in some of the longer university-level Programs. Furthermore, it is difficult to distinguish the effect since there are only a small number of graduates in some Programs and graduates may not work in OLMCs at first and may instead gravitate to wherever positions are open.

Participation has fluctuated, but remained fairly high, in language training Programs for health professionals. McGill University delivered the language training component in Quebec to Francophone health professionals in English and to Anglophone health professionals in French. While McGill University coordinated this component, the regional health authorities decided how many and who would be sent for language training which is delivered by CÉGEPs, colleges, school boards, universities, and private organizations. Participation varied over the years. For example, the McGill University led component trained 1,781 professionals in 2008–2009 in the other official language, followed by only 1,152 in 2009–2010, and an increase to

1,534 in 2010–2011. In addition, the CNFS who delivered French language training and cultural adaptation[6] sessions outside Quebec, trained 281 participants in language training sessions in 2009–2010, 276 2010–2011(BACLO, 2010a, p. 7), and 258 in 2011–2012 (CNFS, 2012, p.6).

While there are numerous incentives for registering (e.g., personal interest) or for completing the training (e.g., promotion or change in position), there are also many reasons for not completing it (e.g., the trainee position may no longer be back-filled). Since language training is aimed at health care professionals already in a position to provide services to OLMCs, it is assumed that they can make use of their increased proficiency in the other official language upon their return to work. However, there is no source of information as to whether or not they apply their training once they return.

Stakeholders indicated that language training Programs have helped increase the number of professionals available to provide care in the minority language. A majority of stakeholders interviewed for this evaluation indicated that the number of health professionals available to provide services in OLMCs has increased since 2008. However, there is no source of information in this regard as provincial and territorial authorities do not have such data. Notwithstanding the lack of quantitative data, they attribute the positive change that they perceive to the various recruitment and retention strategies and support mechanisms put in place in the context of the OLHCP. Some stakeholders indicate that language training Programs have helped many health professionals increase their proficiency in the minority language, thereby increasing the number of professionals available to provide care in that language.

Others attribute improvements to the identification of these professionals. For example, online directories which identify health care professionals who can provide services in the minority language have been developed by several CHNs across the country. In some cases, they are developed and maintained in collaboration with professional associations and provincial/territorial government departments.

On the other hand, case studies confirm that positions in health services which should be occupied by a bilingual individual often are not, as individuals are not interested, or they go unfilled — as much as 50% in New Brunswick and Manitoba according to key informants — and must eventually be filled by unilingual individuals. Stakeholders recognize that bilingual individuals may accept unilingual positions for various reasons. For example, young physicians may seek the diversity of urban emergency rooms versus rural long-term care institutions, and bilingual positions may not be available at the time they graduate, or in the region they wish to work in.

Stakeholders stressed that there is a lack of information on the language used during consultations because the health care system does not collect sufficient information, if any, on language use and on the language preference of users. However, they did provide specific examples of positions, facilities, or health authorities in minority settings that were designated as bilingual. Notwithstanding the CHSSN-CROP surveys (2005 and 2010), the Statistics Canada study on health care professionals (2009) (see key information discussed under 4.1.1, section entitled

6 There is no definition of cultural adaptation in the documentation available for this evaluation.

'Availability of health care professionals') provides useful information on the use of minority language in the provision of health services although, unlike the CHSSN-CROP survey, the study conducted by Statistics Canada was not repeated.

The 2011 SSF survey of Francophones outside Quebec indicates that 81% of the French official language minority population outside Quebec seems satisfied with the level of access, with the overall availability of services in French being identified as the most important factor determining satisfaction with access. As it pertains to the Quebec English minority, the survey conducted in 2010 by CHSSN suggests that only 48% of them are satisfied with the level of access. There is, however, a whole host of factors that could play a role in the different survey results, such as the point in time, the effect of the different sampling strategies and geographical coverage, and the formulation of questions.

In Quebec, the 2010 CHSSN-CROP survey revealed a statistically significant increase over 2005 in the use of private health offices or clinics and CLSCs, and the Info Santé/Info Health information lines by OLMC populations, but also a significant decrease in the use of English as the language of service in CLSCs (from 65% to 56%) and private offices and clinics (from 86% to 80%), as seen in Table 8. There was only a reported increase (from 60% to 65%) in the use of English for Anglophones receiving those services for emergency room and out-patient clinic services outside the Montreal/Laval area.

Table 8: Members of OLMCs receiving specific services in English, Quebec, 2005 and 2010

Type of service	Quebec total			Montreal and Laval			Rest of Quebec		
	2005	2010	Change	2005	2010	Change	2005	2010	Change
Private office or clinic	86%	80%	-6%	90%	83%	-7%	78%	75%	-3%
CLSC	65%	56%	-9%	66%	58%	-8%	64%	52%	-12%
Info Santé	61%	59%	-2%	65%	63%	-2%	51%	50%	-1%
ER or out-patient clinic	69%	68%	-1%	73%	70%	-3%	60%	65%	+5%
Hospital stay (1+ nights)	72%	71%	-1%	76%	75%	-1%	63%	60%	-3%

Source: CHSSN-CROP (2010).

According to the 2011 SSF survey of Francophones outside Quebec, between 74.8% and 88.0% of respondents indicate that the ten main categories of services in Table 9 are perceived as either available exclusively or mostly in French, or in both French and English. Results vary widely across service categories. The authors note that the proportion of respondents who indicate that services are available in French is much lower for those who live in areas where Francophones make up less than 10% of the population (Forgues & Landry, 2012, p.45). The proportions of respondents who are satisfied may appear relatively high. A breakdown by region is not available, and as indicated previously, this survey included eight provinces and none of the territories. Also, according to the authors, the results represent perceptions, and the perception that a service is or should be available in French may not reflect the extent to which it is actually offered.

Table 9: Perception of availability of health services in French, 2011

	Not available in my region	Available exclusively or mostly in English	Available in English and French	Available exclusively or mostly in French	Total
Health prevention and promotion	1.1%	14.1%	76.2%	8.5%	100%
Information and referral	0.7%	11.3%	80.1%	7.9%	100%
Family doctor/nurse/medical clinic	0.5%	20.0%	64.4%	15.1%	100%
Pharmacy	0.2%	24.9%	62.2%	12.6%	100%
Community health centre	2.4%	14.0%	68.1%	15.5%	100%
Hospital emergency room	0.7%	22.0%	66.3%	10.9%	100%
Social services (youth or adult)	0.8%	15.2%	72.4%	11.5%	100%
Hospital services other than emergencies	0.7%	23.0%	66.5%	9.8%	100%
At-home care	1.3%	16.5%	67.2%	15.0%	100%
Long-term care	0.7%	16.3%	69.1%	13.9%	100%

Source: Forgues & Landry (2012) p.44.

4.2.2 Expected Immediate Outcome: Increased coordination and integration of health services for OLMCs within institutions and communities

Coordination and integration of health services for OLMCs within institutions and communities have improved, although based on anecdotal evidence.

Opinions concerning collaboration between stakeholders are generally favorable. Some of the key advantages are that it allows partners to develop projects and offer services that would not have been possible otherwise, and it contributes to a climate of trust among partners in health services.

Collaboration, particularly between CHNs and other stakeholders has improved. Stakeholders report an overall increase in the amount of collaboration between the various stakeholders of the OLHCP, and, more specifically, between the CHNs and the other stakeholders. CHNs seem to have been able to create substantial links and partnerships with organizations serving their communities, and to have built credibility with provincial/territorial and regional health authorities, health promotion organizations, health care institutions, and post-secondary institutions. Stakeholders indicate that networks form an important liaison between the health care system and the OLMCs, acting as the voice of the minority community when it comes to health matters. Furthermore, there is a dedicated resource and a specific organization to lead each network, which is essential to ensure prioritization, planning, and coordination of health services for OLMCs. They also provide information to decision-makers and generally work in collaboration to find solutions to unmet needs or gaps in health services.

The networks also collaborate with health care professional associations in various ways, for instance: to benefit from their insights into health and health care delivery, to disseminate information to health care professionals, and to promote health care provider directories that they have developed. Stakeholders also report increased collaboration between post-secondary institutions and networks in order to develop various Programs, projects, and internship opportunities in OLMCs. Since the recruitment of bilingual staff to areas of need is a key challenge, the case studies found that **the networks' main contributions to recruitment are through collaboration with post-secondary institutions and health care institutions in order to place students for field placements** (in the hope that they will stay or return to that community), as well as collaborating with health care institutions in order to post employment opportunities for bilingual individuals on the network's website and by promoting opportunities at job fairs.

Funding for Health Projects flowed to 217 distinct activities in all provinces and territories. Some of this funding was to strengthen specific activities planned by the community health networks, such as service organisation initiatives, knowledge and information-sharing initiatives, and health promotion initiatives. Additional resources were directed to health service authorities through CHNs, to improve collaboration with particular organisations and increase awareness of vulnerable populations of the availability of minority services by leveraging the relationships already developed by CHNs. For example, there has been an increase in collaboration in order to disseminate information regarding services in the minority official language (e.g., between CHNs and seniors' groups), and in health promotion and education of the minority due to multi-partner health fairs (e.g., Carrefour Santé in Ottawa) and using tools like telehealth.

The CHSSN organizes retreats twice a year and asks the nine older networks to share their experiences with the nine newest members. The SSF organizes a similar event once a year as well as three mini-conferences per year and a general meeting. Information is also shared by the SSF via the meetings of the directors of the networks, and through various networks and roundtables across the country.

In addition to increased collaboration**, a number of institutions have integrated services in the minority official language**. New institutions integrating services in the minority official language include new care facilities and services, as well as new units within existing facilities. New institutions include a hospital mental health unit in Nunavut; a seniors' residence and an intermediate care facility in Quebec; a community health centre and a designated French hospital in Nova Scotia; two community health centres in New Brunswick; two new community health centres and several telehealth centres in rural Francophone communities in Manitoba with plans for more currently underway; and, a new bilingual birthing facility in Winnipeg (in addition to an increase in the number of public health care institutions that are designated as bilingual in that province). Other new services integrated in facilities include: health promotion and prevention Programming for youth and families in English in Îles-de-la-Madeleine and in Quebec, and new province-wide translation services implemented in Alberta. In Nunavut, language indicators were introduced in the medical records of patients.

The SSF reported data on the number of health services maintained or developed in the different provinces and territories over 2010–2011. **New Brunswick and Ontario are the provinces where most health services were developed or maintained** (see Table 10 below).

Table 10: Number of health services developed or maintained over 2010–2011 by the SSF

Province or territory	Developed	Developed or maintained
Alberta	-	1
British Columbia	4	4
Prince Edward Island	-	-
Manitoba	2	8
New Brunswick	4	32
Nova Scotia	1	7
Nunavut	4	1
Ontario East	6	10
Ontario MN	-	-
Ontario North	1	3
Ontario South	2	13
Saskatchewan	-	-
Newfoundland and Labrador	-	1
Northwest Territories	2	4
Yukon	-	-
Total	**26**	**84**

Source: SSF, 2011a, p. 17

Stakeholders also offered a few other examples of specific communities that provided health services in French outside Quebec (these did not until recently provide such services); for example: Argyle, New Brunswick; Isle Madame, Nova Scotia; and, a number of communities in Saskatchewan.

4.2.3 Expected Immediate Outcome: Increased partnerships or interaction of networks in provincial/territorial health systems

Partnerships/interactions of networks in provincial/territorial health systems have been developed and/or maintained. However, little is known about the nature, implementation and results of these changes.

Although it varies from one CHN to the next, there has been a greater number and variety of members/partners over the years. The composition of networks has evolved over time to include some health care professionals, as well as representatives from the provincial and territorial government, health authorities, professional associations, educational institutions,

health care organizations, community organizations, and health promotion organizations/foundations. As networks develop and mature, they are generally becoming more inclusive. For example, in Nunavut, community organizations, health professionals, as well as elementary/secondary schools and daycares are members of the CHN in order to improve service delivery and inform French-speaking parents and families about what French services are offered in their area. SSF also has working agreements with many professional associations, some of which have representatives on their national board (e.g., representatives of French-speaking nurses).

Opinions vary concerning the representativeness of the CHNs. Some wish to have every partner at the table (i.e., Nova Scotia) while others wish for greater representation from health care institutions (i.e., Saskatchewan). More developed networks in Manitoba and New Brunswick recently made a conscious effort to move from larger boards of directors to smaller, more operational boards, while transitioning to a greater number of committees. For example, in New Brunswick, instead of having one network responsible for all the activities, three separate networks have a province-wide mandate with a specific focus: one focuses on research, one on organization, and the other on service delivery. In Manitoba, the network also managed several health projects funded by the OLHCP, the provincial government, or health authorities.

In Manitoba and in Quebec, the composition of the networks has been or is being affected by the restructuring and merger of regional and local health authorities. The perception at this time is that there may be fewer health authority representatives at the table, but they may cover the same geographic areas.

CHN activities with partners are generally broader than in earlier years, but some networks have existed longer than others. The activities of the relatively less established networks are perceived to have evolved the most over the last five years. For instance, network activities in Nunavut and Saskatchewan are perceived to be broader than before, building on earlier activities. A fairly recent addition for some networks is the contribution to student placement through collaboration with post-secondary institutions and the recruitment of personnel for health care institutions (e.g., posting employment opportunities).

Partnerships have been formed (e.g., service agreements, collaborative agreements and networking, joint committees) to deliver Programs like language training and influence or develop policy regarding the provision of minority language health care delivery. These partnerships are assumed to have contributed to some changes in legislation, regulations, and public policies as well as provincial/territorial or regional health authority decisions considering the health needs of OLMCs. However, there is limited information about the nature, implementation and results of these changes.

Most CHNs have created regional and/or province-wide committees in order to more systematically consult OLMC members, and some have done so in collaboration with regional health authorities (e.g., in Manitoba and New Brunswick). Feedback from the health authorities indicates that working with the CHNs enables them to identify gaps in their services for the linguistic minority and to tap into a whole network of partners which can help them fill gaps (e.g., help them recruit health care professionals).

As well, health promotion organizations (e.g., cancer agencies) collaborated with CHNs in order to advertise, organize, and attract the official language minority population to their events and activities. Also, some provincial, territorial, and regional health authorities interacted with CHNs in the following ways:

- Provide information to the CHNs in order to disseminate it to the official language minority population (e.g., bulletins), and rely on them to promote health information sessions or other activities;
- Consult with CHNs on adapting written material and/or asking for assistance in translating it;
- Consult with CHNs regarding the needs of the minority language population, and on how the network and its partners can help them fill gaps; and
- Consult with CHNs when hiring bilingual health care professionals.

Also in this case, there is limited information about the nature and results of these activities.

4.2.4 Expected Immediate Outcome: Increased awareness among stakeholders that networks are a focal point for addressing health concerns of OLMCs

Awareness among stakeholders that CHNs are a focal point for addressing the health concerns of OLMCs has increased.

Provinces and territories now officially recognize CHNs as components of the health system. Based on available documents, formal recognition of networks by provinces and territories increased among the Francophone community networks (i.e., from 8 to 13, since 2008), but decreased among Anglophone networks (i.e., from 10 regional networks and 1 provincial network to 8, since 2008). In total, 21 out of 37 networks are officially recognized as components of the health system (Health Canada, pp. 8–9)**.**

Aside from the funding provided to CHNs through the networking stream and for specific projects through the health projects stream of the OLHCP, **CHNs also received funding from their provincial/territorial government and some have been assigned various roles and responsibilities by their government**. Funding has been provided, for example, to assist in the planning of services in the minority official language (in Ontario), or to act as consultants for government bodies (in New Brunswick and Manitoba). The provincial/territorial governments sit on all 17 of the boards within the SSF networks. In many cases, representatives of the provincial or regional health authorities are also members of the networks (Health Canada, 2010, p. 10). The CHSSN indicates that they are recognized by the Quebec government and health authorities in the province, with which they have a formal agreement in regard to service planning, and as of 2009–2010, they reported that 140 board members and/or staff members of their community networks sat on 101 health authority committees (regional *Tables de concertation*) (OLCDB, 2011a, p. 9). The participation of CHNs on regional health authority committees is also present in New Brunswick and Manitoba.

CHNs are increasingly being invited to participate in consultations as they are seen as a mechanism to reach the official language minority population. The number of formal invitations for networks to participate in consultations has been increased by 32.6% among the SSF networks from 2008–2009 to 2009–2010, and by 5.3% among the CHSSN over the same period. However, data reported by these two organizations differ slightly from what is reported by Health Canada (Health Canada, p. 10). Both organizations report that the majority of the invitations in 2010-2011 came from community partners, government departments or health agencies, and research and educational institutions (OLCDB, 2011a). **Although there is no evidence systematically collected / available documenting the results of involvement in P / T consultations**, stakeholders provided many examples of networks being invited to participate in such consultations, for example:

- In Saskatchewan, the number of consultations to which the network has been invited has increased in the last two years. Examples include consultations with the Ministry of Health on projects about weight management and the management of chronic conditions.
- The network in Nunavut has been invited to some consultations with the territorial government. For example, the network has participated in consultations with the Ministry of Health for a reform project of the *Public Health Act*. Also, the public health unit in Iqaluit consults the network when they are developing activities to reach Francophones (e.g., family health information sessions, vaccination campaigns).
- The network in Alberta was invited to take part in consultations with the health directors from the provincial government, one of which was for the French health services coordination Program.
- When there are consultations on health issues, the government of Nova Scotia also holds consultations in French; generally, the Acadian population is consulted as well as the network, because it is part of the Acadian community.
- In Manitoba, in recent years the *Conseil communauté en santé* has been invited to attend and occasionally present issues to the provincial Health Executive Committee (senior executives of the Ministry of Health and health authorities). A representative of Francophone affairs with the provincial government is also a member of the board of directors of CCS.

In Quebec specifically, stakeholders from the communities, the networks, and the provincial government view the networks as helping to address the health concerns in OLMCs in that province. They report that sustainable relationships have been developed with numerous partners (mainly health service delivery organizations), and that partners now depend on the networks for the dissemination of information, to help seek new sources of funding, and overall as a support system. The networking component of the OLHCP has allowed communities to organize themselves and to have representation and participate in regional health committees in Quebec.

Stakeholders in New Brunswick and Manitoba also underscore the importance of the networks in enabling the OLMCs to organize themselves, call attention to the needs of their communities, and have a role in the planning and organization of services that meet their needs, especially as they have gained much credibility since their creation. In Ontario, they are perceived as a partner by the provincial government in planning health services alongside health authorities.

4.2.5 Expected Immediate Outcome: Increased dissemination and adoption of knowledge, strategies, or best practices to address health concerns of OLMCs

Dissemination of knowledge, strategies or best practices to address the health concerns of OLMCs has increased, although the extent to which they have been adopted is generally unknown.

Funding recipient organizations have developed, implemented and/or disseminated a large number of information tools, approaches, strategies and best practices to address health concerns of OLMCs. Training and Retention funds are used in multiple ways to promote research, information sharing, and networking. To give an order of magnitude, in 2010–2011 — the latest year for which information is available — the CNFS funded 29 research projects on Francophone health issues, supporting a total of 44 students across 21 teams[7]. Other post-secondary institutions have started participating as partners in research projects. The CNFS also has a forum on knowledge exchange and fosters links between researchers so that they can collaborate, and, in some cases, make joint funding applications. The National Secretariat of the CNFS also undertook the following:

- Worked with the SSF on a joint committee in order to develop capacity in health research;
- Organized meetings in universities with the goal of better aligning the research done at the CNFS and within universities; and
- Mandated the Canadian Institute for Research on Linguistic Minorities to undertake a research project on the factors of integration of the Francophone health professionals trained abroad (CNFS, 2011a, pp. 8, 14).

It also launched two other studies in 2010-2011 (CNFS, 2011b, p. 6):

- An environmental scan of factors that can affect training and research in health in French; and
- A comparative analysis of the training in health professions offered in English and in French.

McGill University had a more limited budget ($250,000 for research and $75,000 for dissemination) and funded nine research products or strategies and eight evaluations, impact analyses, or significant research reports in 2009–2010 (OLCDB, 2011b, p. 8).

In addition, both CHSSN and SSF hold annual meetings of their networks, with a view to share information pertaining to challenges and strategies developed, and to foster development of joint solutions to common challenges. The CHSSN also created community profiles for networks to use and share with other stakeholders.

7 Based on the documentation available for this evaluation, it is not possible to determine what portion of the funding awarded to the CNFS was allocated to the research projects.

In terms of dissemination, there have been numerous materials produced and distributed. For example, McGill University produced and disseminated a variety of materials (see Table 11). The SSF produced and disseminated 468 information tools in 2009-10 for community partners, government departments, health professionals and health institutions and managers. The CHSSN produced 61 tools, products, strategies or best practices in 2009-2010.

Table 11: Materials disseminated by McGill University

Dissemination method	Number	Geographic coverage
Conferences/Symposia	4	Across Canada
Digital Video Disc (DVD)	1	Quebec
Electronic mail	5,000	Across Canada
Print media	9,001	Across Canada
Direct mail	5,502	Across Canada
Poster	1	Across Canada
Video-conference	3	Quebec
Tele-conference	1	Quebec
Broadcast	2	International
Website	4,502	Across Canada
Meetings	1	Across Canada

Source: McGill's reporting template
Note: Some items were disseminated through more than one method; they are double-counted.

Funding has been used to promote research and projects to better understand the challenges and barriers affecting access to health care in OLMCs and the strategies to overcome them.

There are multiple ways in which CHNs and specific health projects have contributed to the identification of obstacles and strategies to overcome them. They are summarized below:

- To overcome the lack of information about OLMCs, the CHSSN and Quebec Vitality Network have conducted surveys and developed socio-economic profiles for health authorities, and taught the networks how to use these data. The *Conseil communauté en santé* in Manitoba was a partner in a large-scale survey of the population recently published by the Manitoba Centre on Health Policy. However, based on interviews and case studies, most networks do not have the capacity to participate in research and depend on the census, academic research, and provincial/territorial authorities for data.
- To ensure the availability of information in the minority official language, many networks have created their own websites and continue to help health authorities translate written material.

- There are still challenges in identifying health care professionals who can provide services in the minority official language. Due to the reluctance of professional associations to collect information on language proficiency, most networks have developed their own directories of professionals who are proficient in the minority official language.[8]
- It is more challenging to meet the needs of certain segments of the population, such as individuals with mental health issues, immigrants, and the elderly. Some networks attempted to address the needs of these groups by collaborating with community organizations in a "bottom-up" approach. Others worked with institutions providing services for these groups in the majority official language in order to expand and adapt them for the minority language group.
- As the SSF encourages the integration of minority services into established structures serving the majority (over the development of stand-alone establishments serving the minority), certain CHNs in smaller or more dispersed minority communities work with organizations providing services to the majority to include some services for the minority – e.g., designating bilingual days or French days of the week at English clinics.
- To account for the dispersion of the minority language population in more remote locations, many networks collaborate with school boards or specific schools and early childhood centres that serve their community in order to help fund positions for health professionals, who then distribute their time across several institutions (e.g., Nunavut, Manitoba, and Quebec).
- To promote adaptability and prevent working in silos, some networks have developed various "horizontal" solutions for rural OLMCs, such as community health centres in New Brunswick, and telehealth centres in Manitoba.
- All representatives of provincial and local networks that participated in the evaluation indicated that they continue to raise awareness and work with unions, health authorities, and health care institutions in order to overcome the resistance to put linguistic ability ahead of seniority — everything else being equal — since the latter has traditionally trumped all other factors in recruitment, selection, and promotion in the health care sector.

While the examples above illustrate the range of knowledge and strategies developed to address minority language health care needs, their degree of success, adoption or uptake has not yet been reported/measured.

4.3 Performance — Efficiency and Economy

This section presents data on the efficiency and economy of the OLHCP and, more specifically, focuses on the outputs produced, alternatives approaches available, and the management of Program resources.

[8] The networks that have developed directories of professionals include Newfoundland and Labrador, Prince Edward Island, Quebec — some local networks, Nova Scotia, Ontario — through local networks or *RLISS*, Manitoba, Saskatchewan and British Columbia.

The efficiency and economy of delivering OLHCP outcomes, particularly regarding networks and training seem to be influenced by the priorities and needs of different levels of government, and the relationship of the networks with their partners.

CHNs are affected by external factors and the policies and practices of the provincial/territorial and federal governments with whom they collaborate. CHNs can be affected by the complexity of negotiations at the different levels of government, which can affect the pace of activities. As well, changes in government and turnover in government officials result in networks having to rebuild relationships and re-educate officials about OLMC needs. They can also result in a change in priorities or create instability, which can make other organizations less willing to get involved in projects. These influences are unavoidable, and are mainly due to the complex relationships around federal intervention in health services, which is an area of provincial jurisdiction.

There are also external influences that impact training activities and the capacity of educational institutions to contribute to OLHCP outcomes. These include shortages in clinical training settings, a limited pool of potential students, the difficulty associated with recruiting and retaining professors, and the lack of access to training in more remote, under-serviced regions, all of which are also likely to be influenced to some extent by the policies and priorities of each province and territory in the area of postsecondary education.

Finally, a number of additional factors may also affect the various outcomes of the OLHCP, including the following:

- The policies and practices of health care institutions (e.g., a health care institution's hiring practices which could favour the majority population or require health care professionals to speak only the majority official language within the institution).
- Demographic changes, such as the continued out-migration of younger members of OLMCs or the influx of newcomers to Canada in some OLMCs.
- High turnover rates and mobility in the health care community as well as the shortage in health care professionals.
- Information and data gaps relating to members of OLMCs and their needs, health care professionals and their language proficiency.
- A complex regulatory environment and the web of organizations advocating for improved access to services for the minority language population, for ethno cultural groups, and for the quality of health care overall.

Several important changes in legislation or public policies in many jurisdictions appear to foster greater access to health services in the minority official language. While it is not possible to establish direct linkages, a number of changes in legislation or public policies have potentially been contributing to addressing some issues relating to access to health services in both official languages. As such, they may have had a positive effect on the environment that the OLHCP, particularly the environment in which CHNs operate. Some of the key changes include the following provincial/territorial initiatives:

- **New Brunswick:** With the recent restructuring in 2009 from eight health authorities to two, one health authority was designated as bilingual, and there was no longer a guarantee that the Francophone community would be represented on administration committees as members were to be appointed by the Minister. After a legal challenge and a special commission (*Commission Leblanc*), one of the two health authorities (*Vitalité*) was designated as Francophone (not bilingual). The Premier also commissioned a report "to recommend improvements in health-care delivery for Francophone provincial residents" (Health Canada, p. 6), which was released in 2010.
- **Québec:** The provincial government renewed the Programme d'accès aux services de santé et aux services Sociaux en langue anglaise pour les personnes d'expression anglaise de la Région de la Chaudière-Appalaches for 2011–2014 and for various other health and social services regions of Québec (Health Canada, p. 6).
- **Ontario:** "On January 1, 2010, a new regulation under Section 16 of the Local Health System Integration Act, 2006 came into effect to support coordinated and effective engagement of Francophone communities on French Language Health Services issues" (Health Canada, p. 6). Ontario has shifted the responsibility for service planning and delivery to the three CHNs, which are now recognized formally as service planning entities for French health services.
- **Manitoba:** A more recent development in 2012 is the collaboration between Conseil communauté en santé and the Manitoba government over a renewed bilingual designation policy for health institutions in that province, which will be enshrined in regulation for the first time.
- **Northwest Territories:** The Supreme Court of the Northwest Territories ruled in favour of the Fédération Franco-ténoise in 2006, indicating that the government of the territories was infringing on the federal Official Languages Act. A commission was then created to develop a strategic plan for the provision of services in French in the territories (Health Canada, p. 6). The creation of a Secretariat for Francophone affairs and a one-stop Services TNO followed in 2012, which include all services provided by the government of the territories.

Networks depend on the resources, support and decision-making ability of their partners. The networking component relies to a greater extent on provincial and territorial governments. In their advisory capacity, the CHNs have a limited capacity to bring about changes and thus depend on the priorities, resources, and decision-making ability of their main partners (i.e., provincial/territorial and regional health authorities). As a consequence, their ability to contribute to expected outcomes is often negatively impacted by the resource limitations of these partners and their priorities.

There were no comprehensive alternatives to the OLHCP identified.

No alternatives or comparable approaches to the OLHCP were identified in this evaluation. Evidence gathered from stakeholders suggests that other Programs or initiatives are not of the same magnitude as the OLHCP and cannot affect the same level of change. In fact, when prompted for examples of Programs using a similar approach or structure, very few stakeholders could identify any, and those who did only mentioned Canadian Heritage's Official Languages Support Programs. Specifically, it was reported by stakeholders that the OLHCP is the only Program targeting health care professionals' training, and also that the Program, namely by supporting the development of a network of CHNs, lays the groundwork for other Programs and interventions, at various levels (institutional, community, local, provincial or federal government). Complementary sources of funding exist, mainly through other Health Canada or Public Health Agency of Canada Programs (e.g., initiatives under the Health Care Policy Contribution Program like the Internationally Educated Health Professionals Initiative), but the OLHCP is perceived as essential.

It is not possible to determine if the OLHCP optimized products, services and resource used to achieve expected outcomes.

The OLHCP did track overall Program spending and reported on the delivery of outputs. For this evaluation, the number of outputs produced, as reported by OLHCP recipients, was compiled from a number of documents submitted by the recipient organizations to Health Canada or prepared by Health Canada. These data reflect a wide breadth and number of outputs, and an overall high level of activity by the Program and its recipients, and certainly point toward contributions in many outcome areas as per the Program logic.
However, **the data remains incomplete, and limitations make it impossible to compare or aggregate**. It is only available for certain years, thus limiting the ability to provide a complete picture of the outputs produced throughout the four-year period for this evaluation. In addition, in certain cases, the figures regarding the number of outputs produced are not consistent across various reports and the output descriptions are not consistent across institutions. For example, the CNFS produced various "promotion and recruitment strategies/products", whereas McGill and the CHSSN produced various "recruitment activities". Even after a close read of the source documents, it is not possible to compare these categories directly. Finally, where certain outputs were produced based on the contribution of more than one institution, it is not possible to sum up the number of outputs produced across institutions without double counting.

Table 12 illustrates the amount budgeted and spent, for each fiscal year, for Vote 1 (Internal Federal Spending), Vote 10 (Contributions to External Funding Recipients), and Accommodation costs (internal federal spending). The amount spent during 2008–2009 was 20.3% more than budgeted; the amount spent during 2009–2010 was 4.3% more than budgeted; and the amount spent during 2010–2011 was equal to the amount budgeted. Information is not yet available for 2011–2012. The overspending in the first year maybe due to having additional funds from the previous Program (CPIAHS) which transitioned in 2007-2008 and may not have spent its full allocation in that year (so it was available for 2008-2009).

Table 12: Program budget versus expenditures, by category, 2008-2009 to 2012-2013

Category	2008–2009	2009–2010	2010–2011	2011–2012	2012–2013
Vote 1 budget (spent)	$197,400 ($194,400)	$770,360 ($770,360)	$1,061,000 ($1,061,000)	$859,700 (N/A)	$1,258,790 (N/A)
Vote 10 budget (spent)	$23,000,000 ($27,699,800)	$34,000,000 ($35,500,000)	$36,700,000 ($36,700,000)	$38,000,000 (N/A)	$38,300,000 (N/A)
Accommodation budget (spent)	$2,600 ($2,600)	$29,640 ($29,640)	$39,000 ($39,000)	$40,300 (N/A)	$41,210 (N/A)
Total budget (spent)	$23,200,000 ($27,896,800)	$34,800,000 ($36,300,000)	$37,800,000 ($37,800,000)	$38,900,000 (N/A)	$39,600,000 (N/A)

Source: Health Canada, p. 13

With the data available for the evaluation, it is not possible to conclude whether the OLHCP has been managed so as to minimize resource use. As previously demonstrated, the cost of grants and contributions is known, as are the operational costs and the number of outputs per type of output (at least for some fiscal years). However, with such a diverse set of components and outputs, it is not practical to use a conventional expense to output ratio. It would not yield meaningful results. There is also a lack of information on cost per output and/or administrative/overhead cost ratios to indicate efficiencies.

There was no source of evidence to examine if the management of Program resources was appropriate relative to the achievement of expected outcomes given that most of the Program delivery and management was done by primary and secondary recipients. Perceptions of management and reporting requirements are generally positive among stakeholders; however, they made comments regarding efficiencies and expectations:

- Reporting requirements could be simplified. They are too time-consuming, especially for organizations with multiple projects. For example, recipients could be permitted to combine various projects in a single report.
- Funding decisions and receipt of funds take too long, which can have negative consequences for the recipient organizations (e.g., project timeline may be compressed, organizations may be forced to take out loans and pay interest until project funding is obtained).
- The expectations of CHNs and what they can do to achieve outcomes is high, and not commensurate with their limited human and financial resources.

While there is little information about leveraging, per se, **the evaluation confirmed through interviews and case studies that OLHCP funding helps recipient organizations secure funds from other sources, especially project-specific funding** (e.g., from health authorities, community organizations, PHAC). Network managers and partners indicate that CHNs often contribute a portion of the activity funding in order to encourage partners and other organizations to contribute as well. They also note that OLHCP funding helps establish the credibility of the CHNs, and other agencies and government bodies are more willing to contribute to specific activities once they have been approved for funding by Health Canada under this Program. In

addition, they mention that networking activities help secure funding through the creation of partnerships, which lead to joint funding applications for various activities, including research — for example, the CNFS brings together researchers who make joint applications for Canadian Institutes for Health Research (CIHR) funding.

Overall, as noted throughout the evaluation, **sufficient performance information was not available to measure against baseline levels or to quantify the degree to which outcomes have been achieved**.

5.0 Conclusions

This section of the report provides the key conclusions of the evaluation, based on the findings.

5.1 Relevance Conclusions

Continued Need

Official language minority communities (OLMCs) are concentrated in specific regions of Canada, and thus the need for minority language health services varies across the country. Official language minority communities (OLMCs) represent 6.4% of the Canadian population (2006) and are more concentrated in specific regions of Canada, including the northern parts of New Brunswick, the Montreal census metropolitan area, and eastern parts of Ontario. In such regions of concentration, the language affiliation of health professionals is more in line with the linguistic composition of the population and so English and French-speaking persons can more easily choose health care providers who are fluent in their language. Language mismatches between patients and health care providers are more likely to occur in regions, provinces and territories where OLMCs are less concentrated.

While the health care needs of OLMCs do not appear to differ significantly from those of the majority language community, according to available data, and while difficulties in accessing health services seem more associated with barriers unrelated to language (such as geographic location and overall availability of health care professionals), most OLMC members (77% for Canada in 2006 as reported by Statistics Canada SVOLM) believe it is important to receive health services in the minority official language.

Alignment with Government Priorities

The OLHCP is aligned with the Government of Canada’s priorities as articulated in the *Roadmap for Canada’s Linguistic Duality* which reaffirms the Government of Canada's commitment to linguistic duality and is based on two pillars: the participation of all Canadians in linguistic duality, and the support for OLMCs.

Alignment with Federal Roles and Responsibilities

The OLHCP has been implemented to fulfill federal roles and responsibilities articulated in the Official Languages Act which commits the federal government to "enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development." Also, the most recent amendment to the Act confirms the duty of each federal institution to "ensure that positive measures are taken" for the implementation of that commitment.

There is a clear obligation on the part of departments, such as Health Canada, to implement specific initiatives such as the OLHCP. As the Act specifies, these initiatives must "be carried out while respecting the jurisdiction and powers of the provinces." This, clearly, applies to the area of health and the professional training in which the OLHCP participates.

The OLHCP is also aligned within Health Canada's Strategic Outcome: "A Health System Responsive to the Needs of Canadians" which includes Program Activity 1.3 "Official Language Minority Community Development".

5.2 Performance Conclusions

Achievement of Expected Outcomes

Progress has been made towards achieving the immediate outcomes which include: increasing the number of health professionals available to provide services in OLMCs; increasing coordination and integration of health services for OLMCs; increasing partnerships with health systems; increasing the awareness of Community Health Networks as focal points for health concerns; and, increasing knowledge of strategies and best practices to address health concerns of OLMCs.

In particular, progress has been made, primarily through the training component, in increasing the number of health professionals available and able to provide health care services in OLMCs in Ontario, Quebec and New Brunswick. For other regions where OLMCs are more dispersed or smaller, the training of health professionals was not as significant. It is still unclear whether the health professionals being trained represent the needed combinations of health disciplines and regional distribution.

Community Health Networks are seen as a focal point for addressing health concerns of OLMCs in many provinces and territories and anecdotal evidence indicates that the networks seem to be contributing to improving access to and the use of minority language health care services through collaborations and partnerships with regional health authorities, local facilities and provincial/territorial governments. The projects component of the Program has provided more flexibility for networks by increasing funding in specific areas to pursue priorities often related to vulnerable populations. However, there is limited evidence systematically documenting the outcomes and impact of many CHNs activities.

Assessment of Economy and Efficiency

A number of external factors appear to be influencing the effective and efficient achievement of outcomes, as Community Health Networks rely on collaboration with external partners (e.g., provincial government, health authorities) in the planning and delivery of health services. For example, the ability of these Networks to achieve outcomes depends on the extent to which priorities for action are shared with their provincial partners and the degree of influence they have with these partners.

The evaluation was unable to fully assess the efficiency and economy of the OLHCP due to lack of concrete data on outcomes of achievements with respect to cost. However, the evaluation did note that there were no other comprehensive alternatives to the OLHCP and the Program was able to leverage funding from other sources.

6.0 Recommendations

The majority of training is currently taking place in areas of OLMC concentration (Ontario, Quebec and New Brunswick) where the trained health service providers tend to remain, and where there already seems to be a sufficient base of minority language health professionals. Therefore, it is important to consider alternative ways to reach other OLMC populations. Given that training is a resource intensive approach, more cost effective methods may be better with a focus not only on training but also on recruitment and retention approaches to service smaller OLMC population areas.

Recommendation 1:

It is recommended that the Official Language Community Development Bureau (OLCDB) identify approaches, in addition to, professional training, to increase access to health care services in the minority language in regions where the OLMC populations are small and/or dispersed.

Community Health Networks are increasingly seen as the focal point for addressing health concerns of OLMCs, understanding OLMC needs, and have been successful in developing partnerships with health authorities to meet these needs. As such, they are well positioned to work with post-secondary institutions who are already delivering training Programs. Such collaborations can ensure that training offerings are well aligned with an identified shortage or need and that internships and permanent employment opportunities are available in the appropriate communities.

Recommendation 2:

It is recommended that the OLCDB ensures that Community Health Networks and post-secondary institutions collaborate, where appropriate, to develop training aligned to OLMC health needs and jointly engage with health authorities and facilities to develop internship positions for bilingual students, so as to increase their retention in OLMCs after graduation.

A number of performance data gaps and limitations were found as part of this evaluation that affected the ability to fully assess Program impact, economy and efficiency. For example, due to different interpretations of "access" or Program outputs like "recruitment strategy" or "information tool", data collected was inconsistent and not comparable. As such, it would be beneficial to have standard definitions that funding recipients can use to support the collection of reliable performance data and ensure validation and roll-up (aggregation) of performance data at the provincial/territorial level.

It would also be helpful to identify mechanisms that can increase the systematic collection of data related to the intermediate outcomes (e.g., build on past collaborations with Statistics Canada regarding the ratio of health professionals and add more disciplines; track students who have graduated from post-secondary institutions by cohort and Program to determine where they end up working and what minority language health services result).

As well, to strengthen financial information in support of assessing efficiency and economy, it may be worthwhile to ask funding recipients to track funding leveraged, cost per key output/outcome and overhead expenses.

Recommendation 3:

It is recommended that the OLCDB standardize the collection of performance information so that it can be aggregated and be used to report on the achievement of outcomes and Program economy and efficiency.

Appendix A Recipient Organizations

COMMUNITY HEALTH AND SOCIAL SERVICES NETWORK (CHSSN)

The CHSSN was formed in 2000, and consisted of ten regional and local networks located throughout Quebec. In 2012, more networks were added, for a total of 18 member networks[9]. The CHSSN develops projects and partnerships at the local, regional, and provincial levels to address health determinants, influence public policy, and develop services to improve access to health care services (CHSSN, 2012).

SOCIÉTÉ SANTÉ EN FRANÇAIS (SSF)

The SSF was created in 2002 in response to the recommendations made in the report entitled: "*Pour un meilleur accès à des services de santé en français*" (SSF, 2009, p. 4). The SSF:

- establishes a collaborative network between provincial and territorial networks;
- encourages groupings and partnerships at the national level, and facilitates information sharing and coordination of efforts;
- offers technical and professional services that respond to the needs of members of the networks; and
- represents the interest of the networks, sectors, or groupings and supports them in their representation (SSF, 2012).

The SSF established the following 17 French language networks in the twelve provinces and territories outside Quebec:

- Réseau de santé en français de Terre-Neuve et Labrador
- Réseau TNO Santé en français
- Réseau Santé en français de la Saskatchewan
- Partenariat communauté en santé (Yukon)
- Réseau santé Albertain
- RésoSanté Colombie-Britannique
- Réseau des services de santé en français de l'Île-du-Prince-Édouard
- Conseil communauté en santé du Manitoba
- Réseau Santé Nouvelle-Écosse
- Résefan (Nunavut)
- Réseau des services de santé en français de l'Est de l'Ontario, Réseau francophone de santé du Nord de l'Ontario, Réseau franco-santé du Sud de l'Ontario, and Réseau santé en français du Moyen-Nord de l'Ontario
- Société Santé et Mieux-être en français du Nouveau-Brunswick, which includes Réseau-action Organisation des services, Réseau-action formation et recherche, and Réseau-action communautaire

9 Council for Anglophone Magdelen Islanders; Committee for Anglophone Social Action (Gaspé Peninsula); Coasters Association (Lower North Shore); East Island Network for English-Language Services (Montreal East); Catholic Community Services (Montreal); CSSS Vaudreuil-Soulanges (Montérégie); The Youth and Parents AGAPE Association Inc. (Laval); African Canadian Development and Prevention Network (Montreal); 4 Korners Family Resource Centre (Laurentians); Megantic English-Speaking Community Development Corporation (Chaudière-Appalaches and l'Érable); Neighbours Regional Association of Rouyn-Noranda; Outaouais Health and Social Services Network; Townshippers' Association (Estrie and Montérégie); Jeffrey Hale Community Partners (Quebec); North Shore Community Association; Heritage Lower Saint-Lawrence (Gaspésie Îles-de- la Madeleine); Vision Gaspé-Percé Now.

CONSORTIUM NATIONAL DE FORMATION EN SANTÉ (CNFS)

The CNFS was created in 1999 under Canadian Heritage's Official Languages in Education Program (Health Canada, 2008, p. 4) to provide health training to Francophones outside Quebec. The CNFS has the following objectives:

- "gain knowledge about the specific needs of communities and promote the integration of trained professionals into their home region
- maximise the contribution of existing institutions by deploying their training capacities
- foster access to new training in communities lacking these opportunities
- promote partnerships and collaboration
- facilitate and maintain liaison and concerted efforts within the network and with complementary networks"[10]

The CNFS provides health training through the following 11 Francophone, bilingual Francophone, and Acadian colleges and universities. The health training offered by the CNFS and its member institutions includes college and university training Programs, distance training, linguistic and cultural adaptation training, and clinical training. The OLHCP funding allowed the CNFS to add seats to existing Programs and to create new Programs.

MCGILL UNIVERSITY

McGill University provides "English-language training to Francophone health care professionals so that they can offer services in the minority language, and French language training to Anglophone health care professionals so that they can effectively work within the Quebec health care system" (Health Canada, 2010, p. 2).

[10] http://www.cnfs.ca/english

Appendix B Literature, Documents and Surveys Reviewed

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Appendix C The Influence of Access Barriers

There are a number of factors influencing access to health care services - some of these factors may be present in the general population, others may be specific to language minority communities. This appendix details on how access is influenced by five main factors identified over the course of this evaluation: socio-economic factors, language and culture, geographic distribution and distance from services, the availability of health care professionals, and, the proactive offer of services in the language of the minority.

Socio-economic factors

In the general population, a number of socio-economic variables have been associated with access to different types of health care service. For instance, lower income, education, and employment has been associated with less preventive care, less contact with specialists, as well as more hospitalizations and unmet need (Asada and Kephart, 2007; Blackwell, Martinez, Gentleman, Sanmartin and Berthelot, 2009; Curtis & MacWinn, 2008; Sibley & Weiner, 2011). There are very few studies regarding the OLMC population specifically, and results are not conclusive in terms of the influence of socio-economic factors on OLMC access to health care services.

Language and culture

While some individuals who function well in both official languages may turn to the services that are provided in the majority language, as underlined by the Commissioner of French-language services in Ontario, for those who are not proficient in that language, "failure to offer appropriate services in the minority language may put their health at risk" (OFLSCO, 2009). Stakeholders who participated in the evaluation explained that language proficiency can impact access to quality care in various ways by influencing patient's understanding, and add to already complex, emotional, or stressful situations. Stakeholders further suggest that language proficiency can also impact the choice of services and health care facilities — e.g., minorities may only want to access language-appropriate services, due to difficulties in communication and comprehension that arise when they must rely on their second official language. Although it should be noted that language proficiency seems to vary across the country, with approximately 62% of French-speakers outside Quebec and New Brunswick reporting feeling either more at ease in English than in French (46%) or in both official language equally (16%), compared to 38% feeling more at ease in French (SVOLM, 2007).

As indicated by several stakeholders, as well as the literature, unilingual patients from OLMCs may have to rely on a family member or other health professionals in order to communicate with a health care provider; however, these individuals may not be suitable to take responsibility for a patient's health. Alternatively, some service providers turn to trained interpreters who seem to contribute to the improvement of communication, utilization clinical outcomes and satisfaction with care (Jacobs, Chen, Karliner and Mutha, 2007).

Culture can also influence the access to quality service, even when the patient and provider speak the same language. It can have an impact on whether individuals feel confident enough to request services in their preferred language, and whether they will ask questions or admit when they do not fully understand the information they receive. Finally, stakeholders who took part in the evaluation stressed that both language and culture may be particularly important for certain services such as psychosocial interventions and other language-based treatment.

While language is being described as a potential barrier to access, information from the 2010 CCHS indicated that the proportion of OLMCs having difficulty receiving health information due to language is low. Francophones in Ontario reported having difficulties accessing health services due to language in a lesser proportion than Ontario Anglophones, across the different types of health services (Health Canada, 2012). The proportions for both populations are almost always below 1% across the types of services; at the highest, 2.4% of surveyed Anglophones reported having difficulty receiving health information due to language, compared to 0.6% of Francophones. Much greater proportions of both surveyed populations reported difficulties accessing health services for other reasons, including: socio-economic inequalities and distance from the health care facility (e.g., type of community (rural vs. urban) and province of residence).

Geographic location and minority concentration

Some stakeholders and the literature indicated that minority communities — especially rural and remote communities — have less access to language-appropriate health care services, especially specialized services, and report more unmet needs for health services. A number of studies indicated that, although circumstances of OLMCs are far from homogeneous, Francophones living in rural and remote communities are more disadvantaged with regards to their access to health services. French services are practically non-existent in certain regions because the small size of the Francophone community, while in other areas, primary care is available in French, but individuals must travel a great distance to obtain specialized services, which are concentrated in larger cities (Bouchard, L. and Desmeules, 2011; Bouchard et al., 2010).

According to stakeholders who participated in the evaluation, distance from services and low population density are barriers to health care access in OLMCs. More specifically, a recent survey conducted by the Manitoba Centre for Health Policy (2011) considered the issue of distance, and indicates that the distance between the residence and the place where health care services are delivered is an issue for 25% of the users of French health services in that province, and for 53% of that population in rural Manitoba. In Quebec, a consultation undertaken by the Quebec Community Groups Network (QCGN) considered the issue of urban versus rural location, and it showed that it is more difficult for the English-speaking population living in semi-urban and rural regions in Quebec to access some health services, mainly due to a scarcity of health professionals servicing those regions. For example, care for youth with special needs, mental health services, and services for addictions and dependencies are limited or non-existent in those regions (QCGN, 2011, p. 4). It should be noted that these studies did not allow for the assessment of the extent to which the issue of distance is more or less important for the minority population compared to the majority population living in similar circumstances.

Stakeholders also indicated that low concentrations of the minority population present a challenge. New Brunswick and Quebec specifically have regional hospitals, each with specific areas of specialization (cardiac care, oncology, etc.), and their minority clientele may come from various parts of a large region, or another region of the province altogether, depending on the specialized care they need. This can affect the ability of a facility to plan for services for OLMCs. According to results of the SVOLM, the lower the concentration of the minority population, the greater the proportion of that population that indicated it would be difficult for them to get services in the minority official language. Outside Quebec, in municipalities where French-speaking adults constitute less than 10% of the population, two-thirds of them stated that it would be difficult or very difficult for them to get services in French, while only a third indicated as much in municipalities where French-speaking adults constitute between 10% and 30% of the population. A similar pattern is found among English-speaking adults in Quebec (Corbeil, Grenier & Lafrenière, 2006).

Availability of health care professionals

Although shortages in health professionals are felt in communities across Canada, stakeholders seemed to suggest it is more problematic for OLMCs. Literature suggests that shortages in health professionals providing services to OKMCs are apparent in several professions, including GPs, medical specialists, nurses, and orderlies and attendants (Dufour and Fontaine, 2008). Further, the environmental scan conducted recently for the CNFS (Brynaert, 2011) underlined the significance of the aging of the official language minority population, be it in terms of the lack of renewal of human resources in the health care sector, or the change in the distribution of the French-speaking client population, which may trigger a reorganization of health services toward those required by this aging population. It also pointed to a shortage in the years to come, specifically in the medical and nursing professions, as well as in technical health services.

The general shortage can be partly explained by the insufficient amount of French-speaking health professionals willing or able to work in OLMCs, particularly where there is low population density (Dufour and Fontaine, 2008). Although it should be noted that despite the fact that data of the Health Care Professionals and Official-Language Minorities in Canada study[11] dates back to 2006, it nonetheless provides a more precise assessment of the language use and linguistic skills of specific health professionals (Table 13) – i.e. doctors (including GPs and family doctors), nurses as well as social workers and psychologists. According to this study, the percentage of health professionals using the minority language at work at least regularly exceeded the percentage of the population with the minority language as their FOLS in many areas, including New Brunswick, Ontario and Quebec. The SVOLM also suggested that 47% of adults living outside New Brunswick, and for whom French is the main language, reported using only that language with their regular doctor while this proportion reached 87% in New Brunswick and 54% in Ontario. The same source suggested that OLMCs seem generally satisfied with the level of access to health services in the minority official language with roughly half of Anglophones in Quebec and Francophones in the rest of Canada reporting that it would be 'easy' or 'very easy' for them to get health care services in the minority language. The use of the minority language does not seem to be as frequent in western provinces.

The use of the minority language appeared to be well spread in provinces where OLMCs are more concentrated. According to Statistics Canada, the measure of use "provides a 'realistic' portrait to the extent it focuses on the presence of a given language in the work environment". While not being a direct measure of distribution, the use of the minority language at work may give some indication that distribution of health professionals is reasonably aligned to the one of official language minority. Additionally, in each province, the pool of health care professionals with knowledge of the minority language exceeded the proportions of the official language minority.

The main limitation of Statistic Canada study on health care professionals is that only it was limited to the few key health disciplines at the front-line of the system.

[11] This study was also covered under relevance given it build on 2001 and 2006 Census data.

Table 13: Health care professionals by use of the minority language at work, by knowledge of minority official language and region of residence, 2006

Region	% of doctors using the minority language at least regularly at work	% of doctors with knowledge of minority OL	% of nurses using the minority language at least regularly at work	% of nurses with knowledge of minority OL	% of social workers and psychologists using the minority language at least regularly at work	% of social workers and psychologists with knowledge of minority OL	FOLS: French only, English only in Quebec (general population)
Newfoundland and Labrador	4.4%	19.7%	1.2%	4.0%	0.0%	6.7%	0.4%
Prince Edward Island	0.0%	11.5%	3.7%	8.0%	6.1%	27.3%	3.8%
Nova Scotia	5.4%	20.3%	3.2%	9.5%	4.4%	15.0%	3.6%
New Brunswick	45.8%	53.0%	44.3%	48.8%	56.5%	60.2%	32.7%
Quebec	51.1%	85.5%	36.8%	44.9%	29.4%	55.5%	13.4%
Ontario	7.0%	23.0%	6.9%	11.8%	8.2%	18.6%	4.5%
Manitoba	2.9%	15.0%	3.6%	8.5%	2.9%	10.1%	3.8%
Saskatchewan	0.9%	12.0%	0.7%	4.6%	0.9%	6.2%	1.6%
Alberta	2.5%	14.9%	1.0%	7.2%	1.2%	7.7%	1.9%
British Columbia	2.7%	19.3%	0.7%	6.7%	1.6%	10.7%	1.5%
Yukon	10.0%	35.0%	0.0%	14.9%	0.0%	17.4%	3.9%
Northwest Territories	0.0%	25.0%	2.3%	8.1%	0.0%	23.8%	2.5%
Nunavut	0.0%	40.0%	10.5%	21.1%	0.0%	13.3%	1.4%
Canada outside Quebec	6.1%	21.1%	5.6%	10.8%	6.9%	16.0%	4.2%

Source : Statistics Canada (2006).
In some provinces (shaded cells) samples were sometimes too small to provide accurate estimates and results are to be interpretated with caution.

While Census information suggested that that the language of the OLMCs seems to be used in the delivery of health care services by doctors, nurses social workers and psychologists, at least in provinces where OLMCs tend to concentrate, Blaser suggested in 2009 that the actual capacity of health care professionals to deliver services in the minority language was not necessarily well-represented by linguistic ability as reported by census variables (such as “official languages known” or “language of work”). Professionals who speak conversational French may still not be well-equipped to provide services in French; conversely, doctors who rarely use English at work in practice might still be sufficiently fluent to provide services in English if there was demand.

In addition, beyond the shortage of health care professionals in OLMCs, the increased workload for bilingual health care providers is a key consideration, and can be a source of tension between health care providers and the community (Bouchard, L. 2011). A 2008 survey of students and new health care professionals from CNFS institutions revealed that workload was the number one concern (Bouchard, P., Vézina, Paulin, and Provencher, 2009), although this survey did not assess the extent to which workload concerns were similar or worse than those perceived by english-speaking students. Other studies indicated that outside Quebec, French-speaking health professionals do not always disclose their ability to speak French; for the same reasons as patients (e.g., acquired behaviour), or for fear of getting swamped by patients and being expected to act as interpreters or translators (Bouchard, P., Vézina, Savoie, & Robinson, 2010; OFLSCO, 2009). Stakeholders who took part in the evaluation confirmed this is a key concern, and indicated that bilingual health care providers are also often relied upon to provide translation and interpretation services, regardless of their role and other responsibilities.

There are inherent difficulties in identifying health professionals who are sufficiently proficient and are comfortable being identified as able to provide services in the minority language. While several directories of such professionals have been created by CHNs in various provinces, they are difficult to establish and maintain. Stakeholders indicate that it is challenging or even impossible for individuals to find health professionals who can provide services in the minority language on their own, especially outside urban areas. Where word of mouth is often the main source of information to identify a health professional who is proficient in the minority OL, they can quickly be overwhelmed by demand.

Proactive offer

Recent survey results seem to show a link between a proactive offer of service and the concentration of the official language minority population. First, according to the 2011 SSF survey of Francophones outside Quebec, among the respondents who reported receiving services in French, the vast majority (86.2%) indicated that these services were proactively offered in French. Secondly, this study confirms that services are more likely to be proactively offered in French where there is a greater geographical concentration of Francophones (Forgues & Landry, 2012).

Appendix D Postsecondary Programs, Enrolment and Graduations

The CNFS receives funding through the OLHCP to provide educational Programs in the health professions in French outside Quebec. 14 shows the new and continuing Programs offered by the 11 member institutions of the CNFS. The overall number of Programs has remained fairly stable. It reached a total of 94 Programs in 2011–2012 (CNFS, 2012, p.6). *La Cité collégiale* and the *Université de Moncton* are the two institutions offering the most Programs.

Table 14: Programs offered by member institutions of the CNFS

Institution	2008–2009	2009–2010	2010–2011	2011–2012
Collège Acadie Î.-P.-É. (PE)	2	2	2	3
Collège Boréal (ON)	11	11	11	13
Collège communautaire du Nouveau-Brunswick - Campus de Campbellton (NB)	6	8	8	10
Collège universitaire (Université) de Saint-Boniface (MB)	3	3	3	
La Cité collégiale (ON)	18	19	19	19
Entente Québec/Nouveau-Brunswick (NB)	3	3	3	3
Université de l'Albert – Campus Saint-Jean	2	2	2	
Université Laurentienne (ON)	13	12	12	11
Université de Moncton (NB)	14	14	14	14
Université d'Ottawa (ON)	13	13	13	13
Université Sainte-Anne (NS)	2	3	3	3
Total	**87**	**90**	**90**	**94**

Source: 2008–2008 and 2009–2010 data: Health Canada, 2010, pp. 4-5; 2010–2011 data: CNFS, 2011a, p. 2; 2011-2012 data, CNFS, 2012, pp. 6, 17-35.

Note: Some of the Programs offered by member institutions have been dropped or replaced, and some other Programs have been created. The member institutions can drop a Program because it is not viable. New Programs are created to better reflect the demand in health professions.

Again, with a view to increase the number of health professionals who can provide health services in OLMCs, the CNFS institutions also offer non-credit, continuing education courses to health professionals, as shown in Table 15. As of 2011–2012, the *Collège universitaire* (now *Université*) de *Saint-Boniface*, *Centre de formation médicale* (*Entente Québec/Nouveau-Brunswick*) and *Université de Moncton* have provided continuing education sessions to the largest numbers of health professionals.

Table 15: Number of sessions completed and number of registrants to CNFS training Programs, 2011–2012

Institutions	Number of sessions completed	Number of registrants
Collège Acadie Î.-P.-É.	2	15
Collège Boréal	33	62
Collège communautaire du Nouveau-Brunswick – Campus de Campbellton	14	29
Collège universitaire (Université) de Saint-Boniface	52	435
La Cité collégiale	17	132
Entente Québec/Nouveau-Brunswick	2	275

Institutions	Number of sessions completed	Number of registrants
Université de l'Alberta – Campus Saint-Jean	2	71
Université Laurentienne	11	20
Université de Moncton	10	218
Université d'Ottawa	21	176
Université Sainte-Anne	8	20
Total	**231**	**1,835**

Source: CNFS, 2012, pp. 6, 17-35

Table 16 illustrates the student enrolment in post-secondary health Programs at member institutions of the CNFS from 2008–2009 to 2011–2012. There was a 17% increase in enrolment in 2009-2010, followed by 7% increase 2010-2011, and 0.7% increase in 2011–2012. Table 16 below is a detailed table of enrolment by Program and institution for 2010–2011 — the latest data available from the CNFS. Overall, there have been 3,860 registrations to CNFS-funded post-secondary institutions since 2008, which exceeds expected results by the CNFS. There is no documentation pertaining to the number of seats in the Programs that existed prior to the creation of the OLHCP or the CPIAHS.

Table 16: Student enrolment in health Programs at member institutions of the CNFS

Institutions	2008-2009	2009–2010	2010–2011	2011–2012
Collège Acadie Î.-P.-É.	0	8	9	10
Collège Boréal	126	118	180	149
Collège communautaire du Nouveau-Brunswick – Campus de Campbellton	39	57	48	107
Collège universitaire (Université) de Saint-Boniface	47	65	70	54
La Cité collégiale	153	233	260	313
Entente Québec/Nouveau-Brunswick	8	8	7	8
Université de l'Alberta – Campus Saint-Jean	21	18	17	19
Université Laurentienne	152	150	110	61
Université de Moncton	107	124	99	130
Université d'Ottawa	159	170	188	163
Université Sainte-Anne	10	14	45	26
Total	**822**	**965**	**1,033**	**1,040**

Source: 2009–2010 data, Health Canada, 2010, pp. 5-6; 2010–2011 data, CNFS, 2011a, p. 3; 2011–2012 data, CNFS, 2012, pp. 6, 17-35.

Note 1: The document reviewed indicate that the 965 students were getting training for 26 different health professions in 2009–2010, whereas it also indicates 31 health professions.

Note 2: The documents reviewed for this table and Table 17 indicates different enrolment numbers for Collège communautaire du Nouveau-Brunswick, Campus St-Jean (Université de l'Alberta) and Université Laurentienne.

Stakeholders have also indicated that enrolment has been increasing in some college-level Programs and some universities and that, in some cases, demand exceeds the number of seats available. Here are specific cases:

- Although the number of enrolments has fluctuated in the last few years, Collège Boréal in Ontario has seen an overall increase in enrolment, which has exceeded the expected number by 27% between 2008 and 2012 (573 instead of 450).

- Although the nursing Program at Campus St-Jean of the University of Alberta has experienced a decrease in applications, it still receives more applications than the number of seats available. The decrease in 2011 was attributed to a problem with the application system. Conversely, the number of seats available for the speech therapy Program has been steadily increasing over the past few years.
- There are three times as many applicants than spaces available in medicine in New Brunswick (the Program is offered through Université de Sherbrooke in Quebec).
- There are fewer applications to the pharmacy Program in New Brunswick because a master's degree is required to work in that field in that province. Nova Scotia has more success in getting applications to its pharmacy Program, as it only requires a bachelor's degree.

However, it is not uncommon for postsecondary institutions to impose quotas on enrolment in specific health professions, based namely on projected demand in these professions. Without data pertaining to the number of eligible applicants and any quotas that may be in place, it is not possible to fully assess any excess demand that may exist for these Programs.

The CNFS also compiled the number of students per institution, per Program and according to province of origin for the academic year 2008–2009 (CNFS, 2008-2009). It indicates that institutions draw the vast majority of their clientele from their own province, with the exception of Ontario institutions such as the University of Ottawa, the *Cité collégiale* and *Université Laurentienne*, which draw students from Quebec and to a lesser extent from New Brunswick. The *Université de Moncton* also draws students from Quebec and Nova Scotia.

Table 17: Enrolment at CNFS institutions, by Program and institution, 2010-2011

Programs by institution	Enrolment by Program and institution
Collège Acadie Î.-P.-É.	**9**
Aide en soins de santé	9
Collège Boréal	**180**
Ergothérapie	11
Sciences infirmières	78
Service social	40
Techniques pharmaceutiques	2
Aide en soins de santé	21
Soins dentaires	6
Soins ambulanciers	7
Échographie et radiologie	15
Collège communautaire du Nouveau-Brunswick - Campus de Campbellton	**48**
Thérapie respiratoire	6
Techniques pharmaceutiques	5
Aide en soins de santé	22
Échographie et radiologie	3
Gérontologie	9
Laboratoire médical	3
Collège Universitaire de Saint-Boniface	**70**
Sciences infirmières	35
Service social	5
Aide en soins de santé	30
La Cité collégiale	**260**

Programs by institution	Enrolment by Program and institution
Ergothérapie	8
Sciences infirmières	31
Service social	19
Thérapie respiratoire	19
Techniques pharmaceutiques	10
Aide en soins de santé	41
Électrophysiologie	4
Soins dentaires	40
Autisme	14
Commis – milieu de santé	4
Soins palliatifs	2
Soins ambulanciers	26
Science mentale et toxicomanie	2
Gérontologie	20
Soins aux personnes handicapées	20
Centre de formation médicale du N.-B., Accord, Gouvernement du N.-B.	**7**
Médecine	7
Université de l'Alberta (Campus Saint-Jean)	**17**
Sciences infirmières	11
Orthophonie	6
Université Laurentienne	**110**
Médecine	13
Orthophonie	19
Psychologie	2
Sciences infirmières	42
Service social	21
Santé publique	4
Kinésiologie	5
Sage femme	4
Université de Moncton	**99**
Nutrition	25
Psychologie	12
Sciences infirmières	21
Service social	19
Thérapie respiratoire	6
Gestion des services de santé	10
Échographie et radiologie	3
Laboratoire médical	3
Université d'Ottawa	**188**
Audiologie	1
Ergothérapie	20
Médecine	8
Nutrition	33
Orthophonie	7
Physiothérapie	20
Psychologie	3
Sciences infirmières	38

Programs by institution	Enrolment by Program and institution
Service social	58
Université Sainte-Anne	**45**
Service social	12
Santé publique	10
Aide en soins de santé	23
TOTAL	**1,033**

Source: Performance report, CNFS, 2010-2011, Question 5A.2.

Graduations

Table 18 indicates the number of Francophone students who graduated from CNFS institutions from 2008–2009 to 2010–2011. Having the highest number of Programs offered and the highest enrolment, it is no surprise that *La Cité collégiale* has the highest number of students who graduated. There has been an increase of 47.5% in graduations over the first three years, and there are a total of 596 CNFS graduates by 2010–2011, which are directly related to OLHCP funding under the Training and Retention component.

Table 18: Numbers of students who graduated from member institutions of the CNFS

Institutions	2008–2009	2009–2010	2010–2011
Collège Acadie Î.-P.-É.	0	6	6
Collège Boréal	76	79	58
Collège communautaire du Nouveau-Brunswick - Campus de Campbellton	50	31	72
Collège universitaire (Université) de Saint-Boniface	13	40	44
La Cité collégiale	106	121	165
Entente Québec/Nouveau-Brunswick	6	8	7
Université de l'Alberta (Campus Saint-Jean)	14	8	18
Université Laurentienne	44	35	35
Université de Moncton	47	85	76
Université d'Ottawa	47	102	100
Université Sainte-Anne	1	3	15
Total	**404**	**518**	**596**

Source: 2008–2009 data, Health Canada, 2010, p. 13; 2009–2010 data, CNFS, 2011a, p.3; 2010–2011 data, CNFS, 2012, p.6, 17-35.