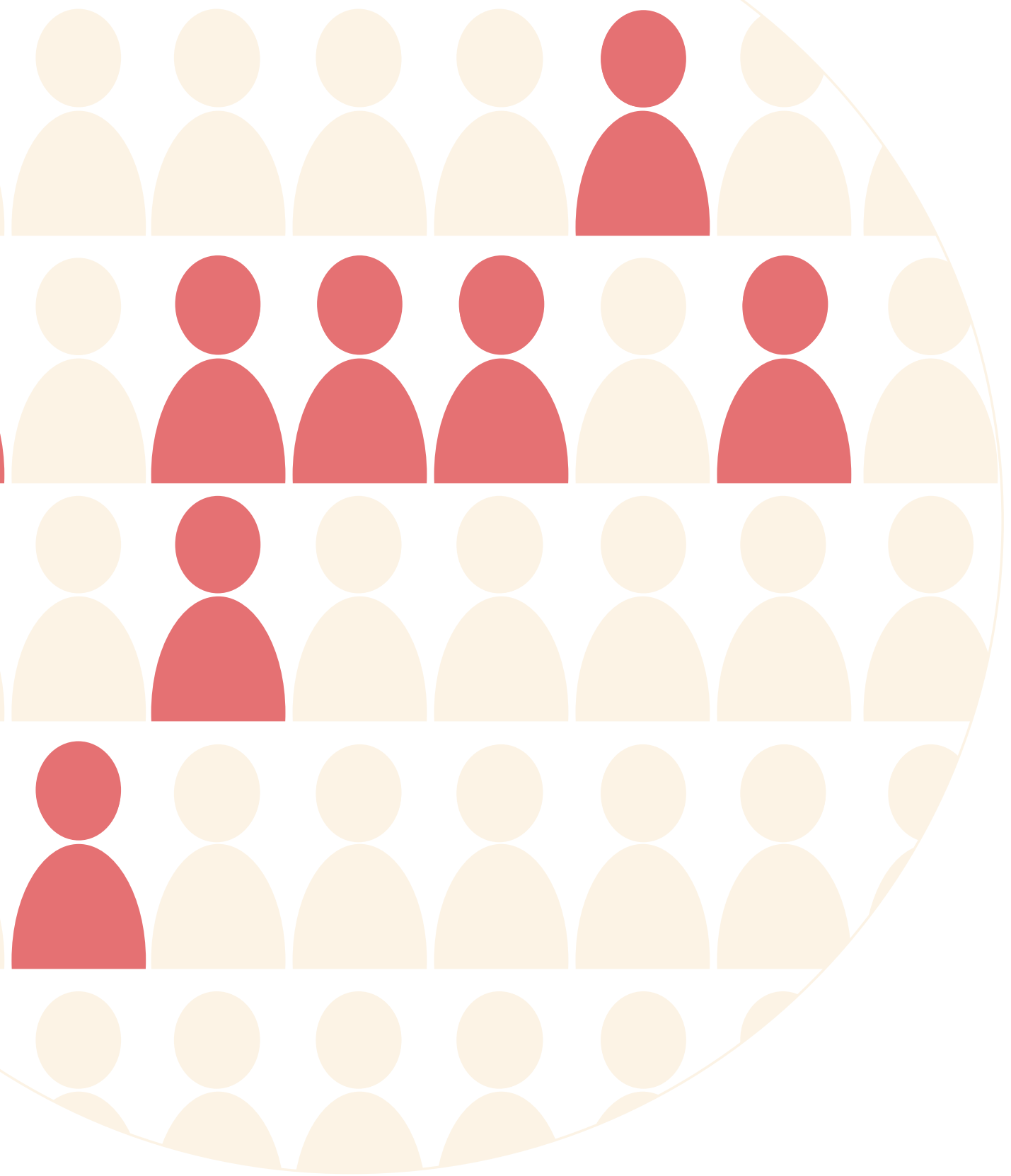


**A SCAN AND STUDY OF PRIMARY HEALTH CARE
MODELS FOR FRANCOPHONE COMMUNITIES IN
MINORITY SETTINGS ACROSS CANADA**

February 2016



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ASSOCIATION CANADIENNE DES
CENTRES DE SANTE COMMUNAUTAIRE



CANADIAN ASSOCIATION OF
COMMUNITY HEALTH CENTRES



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REPORT PRODUCED FOR THE CANADIAN ASSOCIATION OF COMMUNITY HEALTH CENTRES (CACHC) AND SOCIÉTÉ SANTÉ EN FRANÇAIS (SSF)

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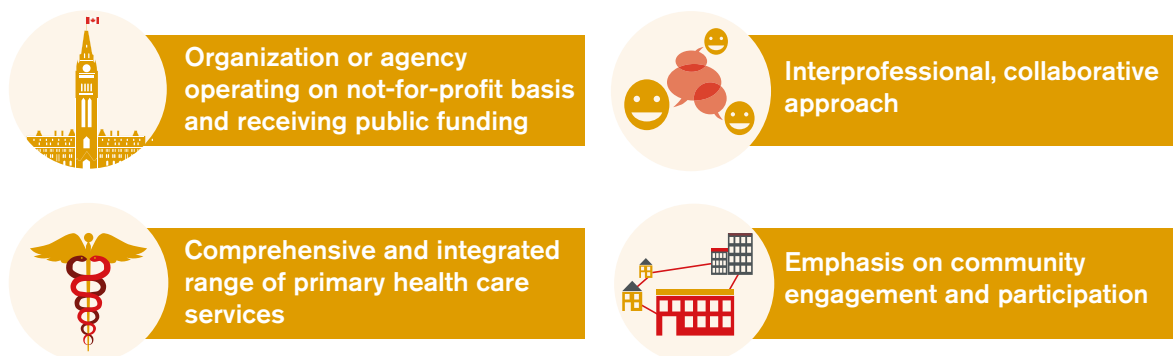
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I SUMMARY

Francophones living in minority settings across Canada have highly variable access to primary care and primary health care services depending on their province or territory of residence. Every jurisdiction has some limited forms of primary care or primary health care services for Francophone community members, but these are highly-dispersed and they vary considerably across the country. They also vary greatly within provinces and territories themselves, from one community to the next. The spectrum of such services ranges from basic primary care clinics that offer a limited number of French-language services, on the one hand, to Francophone Community Health Centres (CHCs) on the other hand – centres that offer a comprehensive range of primary health care programs and services primarily or exclusively in French.

Many studies have shown the benefits of integrated primary health care services and programs, delivered by collaborative, interprofessional teams. These benefits include producing better outcomes in the areas of disease prevention, health promotion and chronic disease management, while also reducing the use of services, including hospital and emergency services. The model of primary health care that this study prioritizes, therefore, and also promotes as key to improving health and health services for Francophone communities includes the following core attributes:



This study focuses on the governance, service delivery, and operational models that prevail across Canada for Francophones living in minority contexts. It also examines some of the challenges and barriers facing communities in making appropriate services available and identifies opportunities for growth and development. Major trends in primary health care in Canada are considered, as are the impacts of these trends on health service delivery for Francophone community members.

The goal of this study is not to provide an exhaustive analysis but to gain a better understanding of certain trends and models in the area of primary care and primary health care, as well as to identify strategies that can effectively address the needs of Francophones living in a minority context with respect to culturally-appropriate, French-language health services.

Saskatchewan, Newfoundland and Labrador, the Northwest Territories and Nunavut are not included in the current study as no health centres serving Francophones could be identified and no representative from Société Santé en français from those provinces and territories was available for consultation.

HEALTH CARE TRENDS IN CANADA

Health Canada has defined a range of social determinants that are known to play a significant role in the health of Canadians, including income and social status; social support systems; education; employment and working conditions; social and physical environments; personal health practices; coping skills; healthy child development; gender; and culture. According to the report entitled *Community Health Centres: An Integrated Approach to Strengthening Communities, and Improving the Health and Wellbeing of Vulnerable Canadians and Their Families*, Canada's Community Health Centres serve the most vulnerable populations, providing assistance through a variety of programs that target most of the social determinants of health defined by Health Canada.

Several provinces have developed primary care models in recent years, but these models differ greatly in terms of structure, governance, services and funding. According to the Canadian Association of Community Health Centres (CACHC), the provinces continue to focus their efforts disproportionately on primary care (which is to say, clinical care), despite a growing body of evidence from around the world highlighting the need for comprehensive primary health care services that integrate action on the social determinants of health.

In Ontario, recent reports and consultations have called for the creation of community hubs that would serve as central access points for health, social, cultural and recreational services for every strata of society. This approach calls for more than mere partner co-location and is only viable when services are fully integrated. As such, it is closer to the primary health care model advocated by CACHC.

In its report of July 2015, the Advisory Panel on Healthcare Innovation observed that the organization and funding of health services in Canada is poorly integrated. The Panel also found that despite research and evidence demonstrating the benefits of different methods, such as hiring nurse practitioners or using virtual care and mobile health units, little large scale innovation is taking place in Canada.

While the federal government is not directly involved in the delivery of health services to Canadians, except in some particular instances, a significant number of federal departments have responsibility for determinants of health that are inseparably bound to healthcare for diverse populations, including many vulnerable population groups (e.g. seniors, Aboriginal communities, women, immigrants and refugees, the unemployed, military personnel).

TRENDS AFFECTING FRANCOPHONE COMMUNITIES IN MINORITY SETTINGS

In recent years, several provincial governments (New Brunswick, Alberta, Prince Edward Island) have centralized the management of health services under regional or provincial networks. Some of the managers we interviewed believe this trend is resulting in service reductions for Francophone community members and less engagement of Francophone communities in governance of health services.

According to the Société Santé en français (SSF), economic problems such as unemployment and issues of geographic isolation (in regions like the Yukon), make it more difficult to maintain a stable Francophone population that is prepared to demand and fight for French-language health services. In some large centres (like Vancouver), the dispersal of the Francophone population also hampers the delivery of French-language health services.

A number of study informants also referred to major challenges related to Francophone staff recruitment and retention, particularly in specialized fields like psychology and medicine.

Another trend is the chronic lack of reliable statistical data on the primary health care needs of Francophone community members. According to SSF officials, factors that impede effective information sharing among care providers include database fragmentation, lack of information on language, and the imperatives of access to information and privacy legislation.

Several studies have highlighted the widespread perception that Francophones who speak English do not need French-language health services. A study conducted in 2010 by the Atlantic Evaluation Group revealed that this attitude is encountered throughout the healthcare system, despite considerable evidence – ranging from minor cases of miscommunication to serious medical errors – demonstrating the importance of treating distressed and vulnerable patients in their mother tongue.

A number of studies have also shown that language barriers can result in: longer wait times; an imperfect understanding of medical problems on the part of care providers; an increased risk of diagnostic error; and poor treatment follow up by patients, often leading to inadequate pain control.

Care providers are also known to take additional precautions when treating patients who have a language barrier: they request more tests, which can result in longer hospital stays or delays in diagnosis and treatment.

Finally, language barriers can have an impact on the documentation of informed consent or cause breaches in patient confidentiality, given the need to rely on translators and interpreters. Accreditation organizations like Accreditation Canada and the Canadian Centre for Accreditation increasingly recognize that linguistic accessibility has a major impact on the quality of health services and are working to establish standards for effective and secure patient-centred communication.

MODELS OF PRIMARY CARE AND PRIMARY HEALTH CARE



ONTARIO

In Ontario, services are provided to the Francophone community through four types of primary health care centres, all of them community-based: (1) centres that cater exclusively to Francophones or mixed families; (2) bilingual centres that serve both Francophones and Anglophones as

government-designated French-language service providers; (3) non-designated Anglophone organizations that offer a limited range of targeted programs in French, delivered by Francophone personnel; and (4) organizations that serve Francophones, Anglophones and Aboriginal people.

Since most centres serve a vast geographic territory, inter-agency cooperation plays an important role in helping clients navigate the healthcare system. Several centres offer programs that directly tackle the social determinants of health. All centres practice an interprofessional approach in which physicians, mental health workers, health promoters and other providers work together to improve service delivery and access to care. In most of the Ontario CHCs that completed our interview questionnaire, clients must meet certain eligibility criteria to receive primary health care services, but community-based programs and prevention/promotion activities are made available to the entire population.

Francophone staff numbers vary greatly in Ontario centres, depending on the number of programs each centre offers in French, and whether it serves a primarily Francophone client population or a population that also includes Anglophone and/or Aboriginal members.

In Ontario CHCs, all employees (physicians, nurse practitioners, nutritionists and other providers) receive an annual salary, whereas physicians who work in clinics or in private practice are otherwise usually remunerated on a fee-for-service basis.

Based on the comments we recorded, the Ontario government appears to be more interested in adding satellites to existing CHCs than in creating new CHCs, the rationale being that they prefer to work with “known quantities” than to establish entirely new administrative and community-based structures.



NEW BRUNSWICK

Since New-Brunswick is an officially bilingual province, all primary care services must be provided in English and French. However, this requirement is not systematically enforced across the province, according to several study informants. Until the early 2000s, Community Health Centres delivered a range of care, prevention and promotion services and were

popular in the province. This model has now been sidelined, however, due a shortfall in infrastructure funding. Since 2006, the province's CHCs have become more narrowly-focused on the delivery of clinical primary care. According to CACHC, many of these centres have cut back on illness prevention and health promotion programs.

Today, different organizations throughout the province are variously referred to as “health centres,” “community health departments,” or “community health centres.” These entities are managed by two province-wide networks of the Department of Health: the Horizon Health Network and the Vitalité Health Network. Each network has its own independent board.

In New Brunswick, clients do not need to register in order to receive medical services. The vast majority of physicians are paid on a fee-for-service basis and treat their own patients and, in an emergency, their colleagues' patients, when appropriate.

According to CACHC, most Community Health Centres in New Brunswick work in isolation from each other, to the detriment of organizational development, networking and resource-sharing.



NOVA SCOTIA

Few Community Health Centres in Nova Scotia provide any French-language services – one exception is the Clare Health Centre (Centre Dr. Lionel J. d'Entremont), which delivers services in both official languages. The Clare Health Centre was built by the municipality to address gaps in service, following pressure from doctors and the community. The municipality manages the Centre and covers certain operational costs, including maintenance, medical supplies and support staff.



PRINCE EDWARD ISLAND

The Centre de santé Évangéline, established in 1995, was a pioneer in Canada with respect to the movement to create Community Health Centres for Francophones in minority settings. Initially, the Centre operated independently and provided a range of integrated services, including effective referral services. In 2010, all Community Health Centres in the province were placed under the control of Health PEI. Today, the Centre de santé Évangéline is considered a “primary health care centre” by Health PEI, although it still has the core characteristics of a Community Health Centre. Its bilingual staff serves both Francophone and Anglophone clients from the Évangéline area and provides specialized health services in French to patients from outside the area.



ALBERTA

Alberta has a system of 42 Primary Care Networks in which groups of family physicians collaborate with government health authorities and other health providers. Three English-only CHCs operate in Alberta: two in Calgary and one in Edmonton. Recently, Calgary's Francophone community launched its first CHC, with advice and support from CHCs in Ontario and Manitoba. The Clinique francophone de Calgary, which is currently governed by the board of directors of the Association canadienne-française de l'Alberta, Calgary regional office (ACFA Calgary), provides services to Francophones and to persons who live under the same roof as a Francophone. The clinic is currently looking for a family physician, but has a nurse practitioner, a psychologist, and an occupational therapist. Most of its services are provided in French only.



MANITOBA

Manitoba has a fairly large number of Community Health Centres, most of them located in Winnipeg. They include Canada's oldest CHC, the Mount Carmel Clinic, established in 1926. As in New Brunswick, the health centres that provide services to Francophones are primarily personal and transitional care facilities that offer medical and emergency services in both official languages. Some centres in smaller communities also provide community-oriented services, such as home care, palliative care, and activities that promote healthy living.

Only two of the health centres that currently provide services in French seem to have the necessary attributes to match the primary health care model advocated by CACHC and SSF: the Centre de santé Saint-Boniface and the Centre de santé Youville, both of which are located in Winnipeg.

The first board of directors of the Centre de santé Saint-Boniface was created in January 1999. In July of that year, a staff of 12 began working at Saint-Boniface General Hospital. The Centre quickly made its mark with a comprehensive approach to wellness in which doctors, nurses, dietitians, nutritionists and mental health counsellors worked together under one roof. Over time, the Centre has established numerous partnerships with the community in order to enhance services for the Francophone population. It has also played an active role in training bilingual personnel.

The Centre de santé Youville offers bilingual primary health care services. According to CACHC, however, the extent to which all programs and services are actually available in both official languages is not clear.

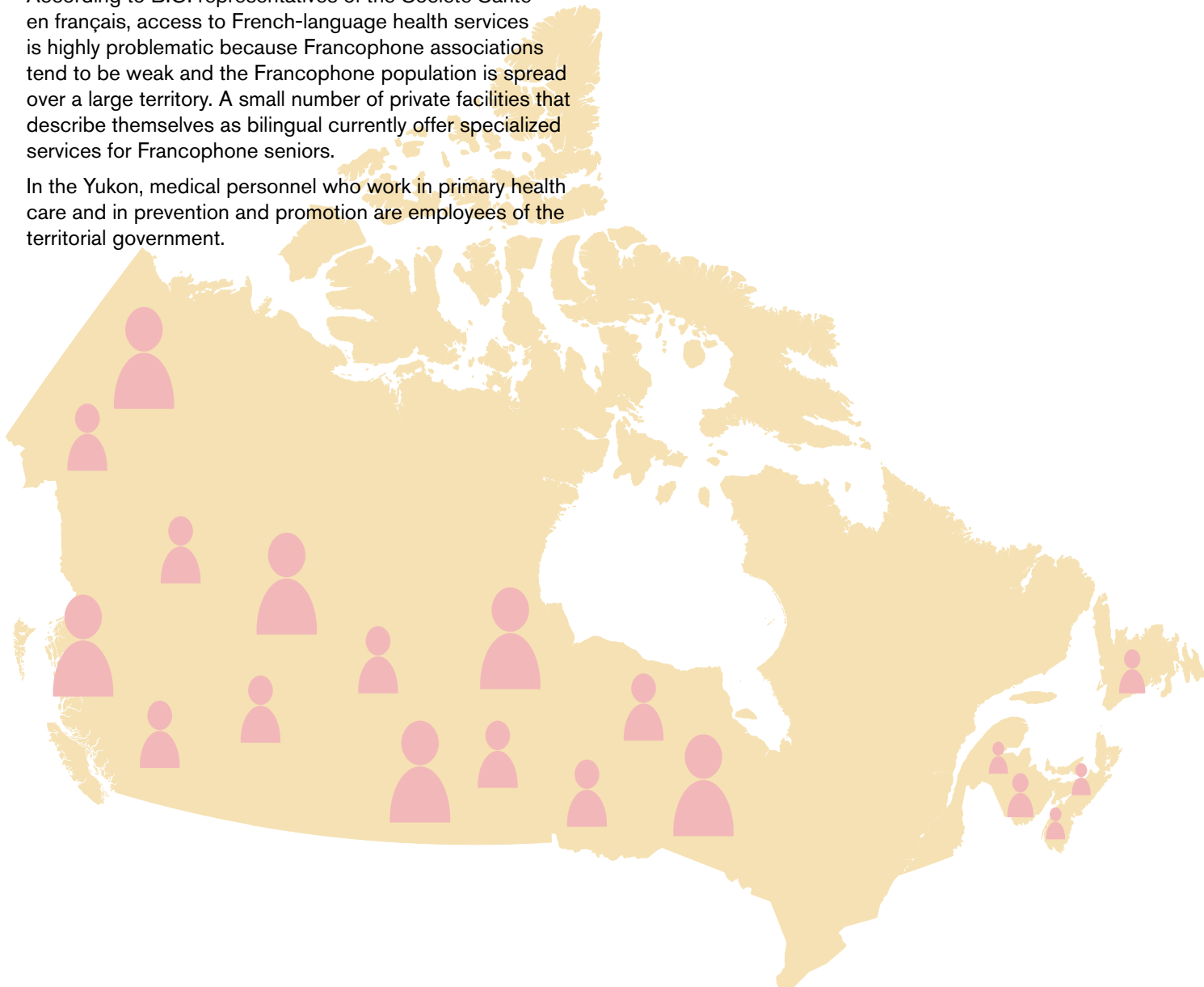


BRITISH COLUMBIA & YUKON

There are no Francophone or bilingual Community Health Centres in British Columbia or the Yukon.

According to B.C. representatives of the Société Santé en français, access to French-language health services is highly problematic because Francophone associations tend to be weak and the Francophone population is spread over a large territory. A small number of private facilities that describe themselves as bilingual currently offer specialized services for Francophone seniors.

In the Yukon, medical personnel who work in primary health care and in prevention and promotion are employees of the territorial government.



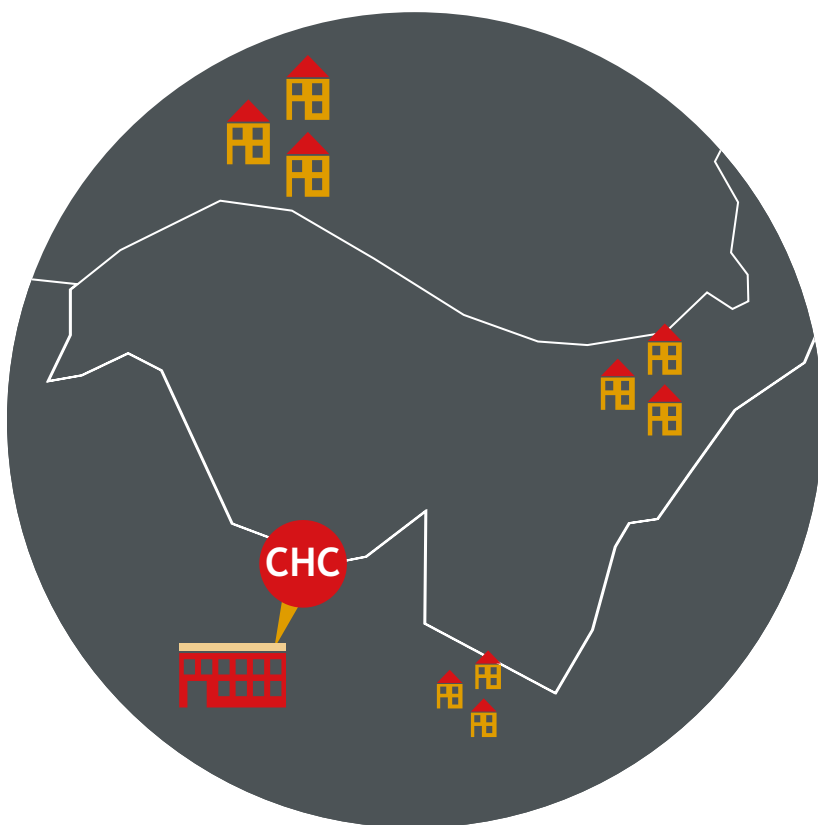
CHALLENGES AND BARRIERS

The most significant barriers for CHCs serving Francophones in minority settings are lack of stable funding and the fact that new programs are established with time-limited funding, a practice that creates expectations that cannot be met when funding runs out.

Some Francophone-only centres serve very large territories, a factor that creates large obstacles in making services and programs accessible to all community members. Transportation problems represent another barrier, limiting the ability of Francophones to participate in health promotion activities.

The recruitment of French-speaking or bilingual staff is also a challenge. In urban areas, Community Health Centres face significant competition from other health institutions, particularly in more specialized clinical fields. In remote areas, Francophone general practitioners and specialists are both in short supply.

Professional training is more expensive in remote areas: travel times are longer and plane tickets cost more. As a result, centres are not always able to provide professional training and development for their staff.



“Some Francophone-only centres serve very large territories, a factor that creates large obstacles in making services and programs accessible to all community members.”

CONCLUSION

While the parameters of this study did not allow us to establish a complete inventory of primary health care models for Francophones in minority settings, the interviews and comments we collected shed light on a number of trends and issues:

- **Francophone communities must continually adapt to the political and economic realities associated with policy and investment in primary health care. As a result, Francophone communities find themselves with a variety of different primary care and primary health care models.**
- **Many Francophone communities face political challenges when they try to establish CHCs. Therefore, it is important for them to work in close partnership with national organizations like the Société Santé en français and the Canadian Association of Community Health Centres. These organizations can help communities forge links with Francophone and bilingual organizations in other parts of Canada.**
- **Establishing a Community Health Centre in a minority setting can be a long and arduous process. Communities that have done so successfully emphasize the importance of:**
 - securing the support of a health sector champion (a physician or other health professional) to enhance the project's credibility;
 - involving key partners, such as Francophone school boards, provincial and territorial Francophone advocacy groups, community organizations, the Francophone community, and municipalities;
 - hiring a nurse practitioner early in the process so that promotion/prevention programs can be incorporated into the basket of services;
 - establishing a Francophone governance model that is responsive to the health needs of Francophones.
- **It is important to begin with a small-scale project and to recruit Francophone physicians and/or nurse practitioners in order to attract clients and demonstrate to funding agencies that such infrastructure is needed to better serve the Francophone population.**
- **In a time of budget cuts, it is important to work in partnership with other established health centres and institutions in order to reduce project start-up costs.**
- **It would be beneficial for the Canadian Association of Community Health Centres and the Société Santé en français to calculate the impact of investments in CHCs for Francophones on rates of disease and usage of hospital and emergency services.**
- **Projects should be tailored and adapted to regional needs (e.g. centres that operate in French but also provide services to Anglophones and Aboriginal people; rural CHCs that offer ambulatory and palliative care beds, etc.).**
- **Governance by and for Francophones ensures responsiveness to the real needs of communities and provides a means of capitalizing on the diverse skills and relationships of trust that volunteers can bring to an organization.**
- **The community hub model developed in New Brunswick and Ontario provides a means of creating a comprehensive basket of services for Francophones (health, culture, employment, etc.) and presents a number of advantages for both funding agencies and clients. According to CACHC, the community hub model can be traced back, in principle, to the local community service centres (CLSCs) created in Quebec in the 1970s. CLSCs were among the country's first Community Health Centres.**
- **The federal government has agreed to fund a pilot Community Health Centre for Alberta's Francophone population on a three-year experimental basis (the Clinique francophone de Calgary). This sets an important precedent which communities can pursue with the federal government.**

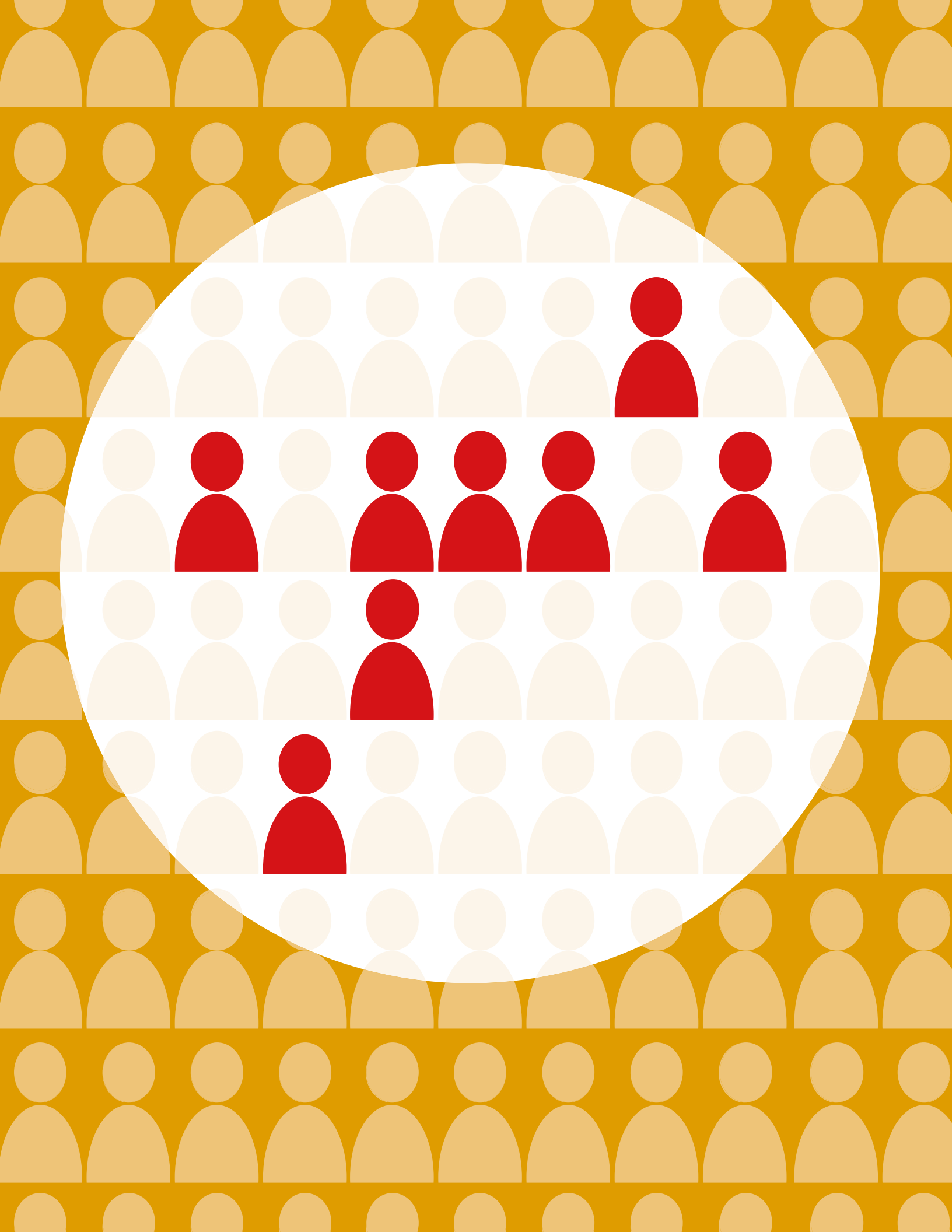
RECOMMENDATIONS

Although this study sheds important light on a number of trends and developments in the delivery of primary health care for Francophones in minority settings, a more in-depth study focused on two or three specific Community Health Centre organizations would be helpful in terms of documenting the stages involved in establishing a CHC (background, barriers, solutions, budgets, care models, governance, staff recruitment, etc.).

At present, a body of evidence to validate or justify the benefits of establishing CHCs for Francophones in minority settings is lacking in several provinces. Now that the experimental Clinique francophone de Calgary is underway, indicators could be developed to immediately begin measuring the impact of this new centre on its clientele and the local Francophone population.

The federal government and national associations, such as the Canadian Association of Community Health Centres and the Société santé en français, should work together to help minority Francophone communities develop Community Health Centres that can address their unique needs. Tools, resources and enhanced funding should be provided to facilitate: the identification of needs; joint action on the part of key players; advocacy at the provincial, territorial and municipal levels; and initial project development.

Finally, the Canadian Association of Community Health Centres and the Société santé en français should persuade the federal government to incorporate a set of positive reinforcement measures into the health transfer system to encourage the provinces and territories to actively invest in appropriate primary health care for the Francophone population. Measures of this kind are known to have made a substantial contribution toward the creation and enhancement of Canada's French-language education system.



1 STUDY PRESENTATION

1.1 BACKGROUND

Francophones in minority settings across Canada have vastly different access to primary care¹ and primary health care² services, depending on their province or territory of residence. Access varies within provinces as well, from one community to the next. Every jurisdiction has its own mechanisms in this area, in a spectrum that ranges from clinics that offer only a limited number of services in French to Francophone community health centres (CHCs) that offer a comprehensive range of programs and services exclusively in French.

In 2015, the Canadian Association of Community Health Centres (CACHC) and Société Santé en français (SSF) agreed to undertake an overview of the primary care and primary health care models currently used to in Canada deliver services to Francophone communities in minority settings.

Many studies have shown that integrated health care models that build on interprofessional collaboration tend to generate better outcomes in disease prevention, health promotion and chronic disease management, while also reducing the use of services, including hospital and emergency services. Therefore, the primary health care centres on which this study focused primarily and which are recommended by CACHC and SSF reflect the following core attributes:³

- not-for-profit organization receiving public funding
- multidisciplinary, collaborative approach
- comprehensive and integrated range of primary care services
- focus on community engagement and participation

This study focuses on the governance, service delivery, and operational models that prevail in Francophone communities located in minority settings. It also examines some of the challenges and barriers facing communities and identifies opportunities for growth and development.

The goal of this study is not to provide an exhaustive analysis but to gain a better understanding of certain trends and models in the area of primary care and primary health care, as well as to identify strategies that can effectively address the needs of Francophone communities in terms of French-language health services.

1.2 METHODOLOGY AND LIMITATIONS

Methodology

The Axion research firm conducted an Internet survey targeting organizations that actively promote the community health centre model (e.g., the British Columbia Federation of Community Health Centres and the Wellesley Institute), as well as the Canadian Association of Community Health Centres and the directors of the Société Santé en français and its

¹ "Primary care:" front line clinical services provided by care providers such as family physicians, nurse practitioners, nurses and others.

² "Primary health care:" the entire range of front line services and supports, including primary clinical care, prevention/promotion services, community health initiatives and other supports to address the social determinants of health.

³ Hogg, W. et al., The Comparison of Models of Primary Care in Ontario (COMP-PC) study: methodology of a multifaceted cross-sectional practice-based study, www.openmedicine.ca/article/view/218/259, site consulted in May 2005.

networks, in order to gather information on the primary health care models used to provide services to Francophones in minority settings. Several studies submitted by CACHC and the SSF were also consulted for this report.

Axion also developed a questionnaire which was completed, in whole or in part, by the managers of 12 health centres that serve Francophone communities in minority settings and are CACHC members. The latter were part of a group of approximately twenty representatives selected by the advisory committee.

Given the complexity of the issue, the questionnaire comprised approximately fifty questions and took roughly an hour to complete. Unfortunately, few managers had the time to provide all the necessary information. A better approach might have been to divide the questionnaire into several sections and to obtain a series of interviews at different times or with different individuals (e.g., board chair, founding member, executive director).

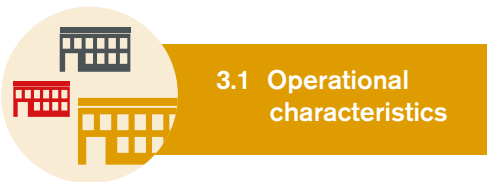
In areas where no primary health care model is in place for the Francophone community, Axion interviewed representatives of the local Société Santé en français network to obtain their views on the feasibility of establishing a Community Health Centre and the steps the community had taken to achieve this goal.

No health centre serving Francophones communities in Saskatchewan, Newfoundland and Labrador, the Northwest Territories or Nunavut could be identified. Due to study restrictions, no representative of the Société Santé en français from any of those provinces and territories was consulted for this study.

A few targeted interviews were also carried out with members of the study's advisory committee and with CACHC and SSF executives, in order to clarify certain data or to collect specific information on CHC models in the different regions.

Finally, a consultation was held during the 2015 CACHC Conference with representatives of CHCs providing services to Francophone communities in minority settings.

For the sake of clarity, the information in section 3 of this report is organized thematically in four sub-sections:



Before addressing these themes, the authors begin by examining major trends in primary health care in Canada, as well as the impact of these trends on the delivery of services to Francophone communities in minority settings.

The section on operational characteristics examines the clientele of community health centres (Francophones and bilingual persons) and the issues of membership, inclusion and exclusion.

The section on governance examines board composition as well as accountability structures (e.g., entities that are satellites of other centres or hospitals, direct service delivery by regional health networks).

The section on services presents different models of primary care and primary health care delivery. Some of these models focus almost entirely on primary clinical care, while others offer primary care as well as disease prevention, health promotion and community wellbeing services and programs.

The section on funding explains the methods used by the provinces to establish and maintain models of primary health care.

The next two sections deal with the challenges and barriers facing CHCs and they examine opportunities to grow and enhance services for Francophone communities.

The report concludes with recommendations for facilitating the implementation of primary health care services tailored to the needs of Francophone communities in minority settings.

Limitations

The fact that only a small number of people in each region were interviewed is potentially problematic and should be kept in mind when interpreting the information presented in this report with respect to challenges, barriers and growth opportunities. Some of the answers cited in these pages may simply reflect the personal opinion of respondents.

We should also add that this project had a limited budget and, as a result, does not provide a complete inventory of the primary care models currently in place in communities in Canada.

HEALTH CARE TRENDS

2 IN CANADA

2.1 ISSUES INFLUENCING THE CANADIAN HEALTH CARE SECTOR

Social Determinants Of Health

Health Canada has defined a range of social determinants that have a significant impact on the health of Canadians, including income and social status, social support systems, education, employment and working conditions, social and physical environments, personal health practices, coping skills, healthy child development, gender and culture. Some studies even suggest that these determinants have a greater influence on the health of Canadians than biomedical or lifestyle factors.⁴

According to the report entitled *Community Health Centres: An Integrated Approach to Strengthening Communities, and Improving the Health and Wellbeing of Vulnerable Canadians and Their Families*, (see footnote 4 below) Canada's community health centres serve the most vulnerable populations, providing assistance through a variety of programs that target most of the social determinants of health defined by Health Canada.

A Multiplicity Of Primary Care And Primary Health Care Models

Several provinces have developed primary care models in recent years, but these models differ greatly in terms of structure, governance, services and funding. According to the Canadian Association of Community Health Centres (CACHC), the provinces continue to focus their efforts almost exclusively on primary care (which is to say, clinical care), despite a growing body of evidence from around the world highlighting the need for comprehensive primary health care services that also target the social determinants of health.

In Ontario, recent reports and consultations have called for the creation of additional community hubs that would serve as central access points for health, social, cultural and recreational services for every strata of society. This approach calls for more than mere partner co-location and is only viable when services are effectively integrated. This vision is very closely aligned with the comprehensive primary health care model advocated by CACHC.

In Ontario and New Brunswick, small regional hospitals are being closed, one example being the Penetanguishene site of Georgian Bay General Hospital. In New Brunswick, regional hospitals are being turned into long-term care centres or primary care centres. In Ontario, the provincial government is calling on many CHCs to enlarge their basket of services to include some of the services formerly provided by regional hospitals.

⁴ CACHC, *Community Health Centres: An Integrated Approach to Strengthening Communities, and Improving the Health and Wellbeing of Vulnerable Canadians and Their Families*, www.cachc.ca/wp-content/uploads/

downloads/2012/10/CACHCA-Position-Paper-CDN-Federal-Government-role-in-community-primary-health-care.pdf, May 2009, report consulted in September 2015.

Health Care System Fragmentation⁵

In its report of July 2015, the Advisory Panel on Healthcare Innovation observed that the organization and funding of health services in Canada is poorly integrated. The report goes on to state that so long as the system is organized around providers and so long as those providers are paid out of separate funding envelopes, patient-centred care will be difficult to achieve.

Lack Of Innovation In Health

The report of the Advisory Panel on Healthcare Innovation also states that despite research and evidence demonstrating the benefits of different methods, such as hiring nurse practitioners or using virtual care and mobile health technologies, little large scale innovation is taking place across Canada.

The Role Of The Federal Government In Health

While the federal government is not directly involved in the delivery of health services to Canadians, except in some particular cases such as military personnel, First Nations reserves and federal prisons, several federal departments directly or indirectly work on social determinants of health that impact the health of individuals, families and communities.

2.2 TRENDS AFFECTING FRANCOPHONE COMMUNITIES IN MINORITY SETTINGS

Centralization Of Health System Management

In recent years, several provincial governments (New Brunswick, Alberta, Prince Edward Island) have centralized the management of health services under regional or provincial networks. Some of the managers we interviewed believe this trend is resulting in service reductions for Francophone community members and less Francophone engagement in governance of health services.

Maintaining A Critical Mass Of Francophones

According to the Société Santé en français (SSF), economic problems such as unemployment and issues of geographic isolation (in regions like the Yukon), make it more difficult to maintain a stable Francophone population that is prepared to demand and fight for French-language health services. In some large centres (like Vancouver), the dispersal of the Francophone population also hampers the delivery of French-language health services.

⁵ Government of Canada, Unleashing Innovation: Excellent Healthcare for Canada, Report of the Advisory Panel on Healthcare Innovation, <http://www.healthycanadians.gc.ca/>

publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf. Report consulted in July 2015.



“In recent years, several provincial governments have centralized the management of health services under regional or provincial networks. Some of the managers we interviewed believe this trend is resulting in service reductions for Francophone community members and less Francophone engagement in governance of health services.”

Recruitment And Retention Of Bilingual Personnel

A number of study respondents also spoke of Francophone staff recruitment and retention problems, particularly in specialized fields like psychology and medicine. A study on the recruitment and retention of bilingual health and social service personnel in minority settings in Winnipeg and Ottawa indicates that failure to promote Francophone culture in the workplace discourages bilingual personnel from working in these settings.⁶

The results of the aforementioned study also show that the capacity to treat patients in both official languages is not appreciated and valued by managers and this often generates heavier workloads.

Still, the number of young bilingual professionals is on the rise in some provinces (such as New Brunswick) thanks to training programs established by the Consortium national de formation en santé and by local educational institutions.

Lack Of Statistical Data

There is a chronic lack of reliable statistical data on the primary health care needs of Francophone communities in minority settings across Canada. According to SSF officials, the factors that impede effective information sharing among care providers include database fragmentation, lack of information on language, and the imperatives of access to information and privacy legislation.

Ontario recently created a system for collecting statistical data on CHCs. The new system is generating a convincing body of evidence on the health status of Francophones treated at these centres.

Attitude Toward Francophones

Several studies have highlighted the widespread perception that Francophones who speak English do not require French-language health services. A study conducted in 2010 by the Atlantic Evaluation Group⁷ revealed that this perception is encountered throughout the healthcare system, despite considerable evidence – ranging from minor cases of miscommunication to serious medical errors – which demonstrates the importance of treating distressed and vulnerable patients in their mother tongue.

⁶ De Moissac, Danielle, et al. Le recrutement et la rétention des professionnels de la santé et des services sociaux bilingues en situation minoritaire, <http://ustboniface.ca/file/documents---recherche/Recrutement-et-retention-des-professionnels-bilingues-2014.pdf>, report consulted in September 2015.

⁷ Atlantic Evaluation Group, Final Report: French Language Services in Long Term Care <http://santeipe.ca/wp-content/uploads/Final-Report-French-Language-Services-in-Long-Term-Care.pdf>, report consulted in September 2015.



“A number of studies have also shown that language barriers can result in longer wait times, an imperfect understanding of medical problems on the part of care providers, an increased risk of diagnostic error, and poor treatment follow-up by patients, often leading to inadequate pain control.”

Linguistic Accessibility

Accreditation organizations like Accreditation Canada and the Canadian Centre for Accreditation increasingly recognize that linguistic accessibility has a major impact on the quality of health services and are working to establish standards for effective and secure patient-centred communication.⁸

Accreditation Canada has launched a pilot project with official language communities, the Société Santé en français and Health Canada to develop new tools to evaluate linguistic accessibility. Measures will be established by Accreditation Canada to identify gaps in French-language communication. The New Brunswick Heart Centre in St. John has agreed to test the new tools at its accreditation assessment four years from now.

Impact Of Language Barriers On Patient Safety

A number of studies have also shown that language barriers can result in longer wait times, an imperfect understanding of medical problems on the part of care providers, an increased risk of diagnostic error, and poor treatment follow-up by patients, often leading to inadequate pain control.

Care providers are also known to take additional precautions when treating patients who have a language barrier: they request more tests, which can result in longer hospital stays or delays in diagnosis and treatment.

Finally, language barriers can have an impact on the documentation of informed consent and can cause breaches in patient confidentiality, given the need to rely on translators and interpreters.

⁸ Tremblay, Suzanne and Ghislaine Prata. Pour des services de santé linguistiquement et culturellement adaptés, <https://santefrancais.ca/>

[wp-content/uploads/Normes---tude-am--ricaine-FR.pdf](#), report consulted in September 2015.

COMPONENTS OF PRIMARY

3 HEALTH CARE MODELS

3.1 OPERATIONAL CHARACTERISTICS

3.1.1 Central Region

In Ontario, services are provided to the Francophone community through four types of Community Health Centres, all of them community-based: (1) centres that cater exclusively to Francophones or mixed-language families (e.g., Centre communautaire de l'Estrie and Centre francophone de Toronto); (2) centres that serve both Francophones and Anglophones as government-designated French-language service providers (e.g., Centretown Community Health Centre in Ottawa); (3) non-designated Anglophone organizations that offer a limited range of targeted programs in French, delivered by Francophone personnel (e.g., TAIBU Community Health Centre in Scarborough); and (4) organizations that serve Francophones, Anglophones and Aboriginal people through a shared governance arrangement (e.g., CHIGAMIK Community Health Centre in Midland and Lafontaine).

Most of these centres serve a vast geographic territory: the Centre francophone de Toronto serves all of Toronto; the Centre de santé communautaire de l'Estrie serves the entire Francophone population of Stormont, Dundas, Glengarry and Prescott-Russell counties; and the CHIGAMIK Community Health Centre serves the entire catchment area of the North Simcoe Muskoka Local Health Integration Network (LHIN). Many centres also have satellites that offer a variety of programs and services, including primary care.

The Centretown Community Health Centre in Ottawa serves Francophones and Anglophones in the Centretown, old Ottawa-South and Glebe neighbourhoods. It also provides certain French- and English-language services to the entire City of Ottawa, as well as services dedicated to Francophone immigrants and other groups at risk of chronic disease across the entire Champlain LHIN catchment area.

TAIBU Community Health Centre in Scarborough offers a range of health services and primary health promotion programs, primarily to the Black community in the Greater

Toronto Area. TAIBU has been delivering a French-language health promotion program since 2013, thanks to time-limited funding that is set to end in March 2016. The centre currently provides no other French-language services to the Black community in the GTA.

Most centres rely on a collaborative inter-agency approach to help clients navigate the healthcare system, offering a wide range of programs (employment, housing, immigrant integration, early childhood, food banks) on their own or in partnership with other organizations. These programs directly target the primary social determinants of health identified by the World Health Organization.⁹

All of these centres practice an interprofessional approach in which physicians, mental health workers, health promoters and other providers work together to improve service delivery and access to care. Through group meetings, cooperation among colleagues and internal referrals, interprofessional teams are able to take all aspects of patient care into account.¹⁰

In most of the Ontario CHCs that completed our interview questionnaire, clients must meet certain eligibility criteria (e.g., place of residence, language spoken, target groups, etc.) to receive primary care services (such as physician care), whereas community-based programs and prevention/promotion activities are usually made available to the entire population.

Francophone staff numbers vary greatly at bilingual Ontario CHCs, depending on budget, the number of programs each centre offers in French, and whether it serves a primarily Francophone client population or a population that also includes Anglophone and/or Aboriginal members. At present, 8 out of 20 employees at the CHIGAMIK Community Health Centre are Francophones (40% of staff), while 85 of the 150 employees at Centretown Community Health Centre in Ottawa speak both official languages (55% of staff).

⁹ World Health Organization, Social Determinants of Health, http://www.who.int/social_determinants/en/, site consulted in May 2015.

¹⁰ Centre de santé communautaire de l'Estrie, Qui sommes-nous?, www.csceestrie.on.ca/qui-sommes-nous/mission-et-vision, site consulté en mars 2015.

“All of these centres practice an interprofessional approach in which physicians, mental health workers, health promoters and other providers work together to improve service delivery and access to care.”



In Ontario CHCs, all employees (physicians, nurse practitioners, nutritionists and other providers) receive an annual salary, whereas physicians elsewhere who work in clinics or in private practice are typically remunerated on a fee-for-service basis.

Based on the comments we recorded, the Ontario government is more interested in adding satellites to existing centres than in creating new CHCs at this time. The rationale is that it is less challenging to work with “known quantities” than to establish entirely new administrative and community structures.

According to CACHC, Francophone community health centres in Ontario have created a permanent collaborative network in order to strengthen the capacity of individual centres to plan strategically, lobby government and share resources.

3.1.2 Eastern Region

The Eastern Region is composed of the Atlantic provinces of New Brunswick, Nova Scotia and Prince Edward Island.

New Brunswick

Since New-Brunswick is an officially bilingual province, all primary care services must be provided in English and French. However, this requirement is not systematically enforced across the province, according to several interview subjects.

Until the early 2000s, community health centres delivered a range of prevention and promotion services and were popular in the province. This model has now largely been abandoned due a shortfall in infrastructure funding. Since 2006, health centres have become more narrowly focused on the delivery of primary care. According to CACHC, many of these centres have cut back on prevention and promotion programs and have been forced to abandon their community-based activities.

Today, different organizations are variously referred to as “health centres,” “community health departments,” or “community health centres.” For the purposes of this study, we examined two CHCs: the Centre scolaire-communautaire Samuel-de-Champlain in St. John and the Centre de santé Noreen-Richard in Fredericton.

These entities are managed by two province-wide networks of the Department of Health: the Horizon Health Network and the Vitalité Health Network, each of which is endowed with its own independent board. These networks operate hospitals, medical facilities, clinics and community-based health services.

In New Brunswick, clients do not need to register in order to receive medical services. Physicians are typically paid on a fee-for-service basis and treat their own patients and, in an emergency, their colleagues' patients when appropriate.

According to CACHC, there are now approximately thirty "community health centres" in New Brunswick. These centres provide ambulatory care and drop-in clinics, and emphasize cooperation between physicians, nurse practitioners and other providers. They also offer lifestyle and behaviour focused prevention and promotion programs such as chronic disease prevention, smoking cessation and health education.

According to CACHC, most community health centres in New Brunswick work in isolation and only some of them now possess all the characteristics of the primary health care model advocated by CACHC. Centres in New Brunswick concentrate on primary care, to the detriment of organizational development, networking and resource sharing.

Nova Scotia

Few community health centres in Nova Scotia provide French-language services – one exception is the Clare Health Centre, which delivers services in both official languages. Clare is home to the largest Acadian community in Nova Scotia. It has a Francophone university and college.

The Clare Health Centre was established by the municipal council in response to pressure from the community and physicians, who sounded the alarm about physician shortages, excessive wait times and service gaps.

The municipality responded with considerable ingenuity and daring by ordering the construction of a new building to house the Health Centre. In addition to managing the Centre, the municipality also covers certain operational costs, including maintenance, medical supplies and support staff.

Prince Edward Island

The Centre de santé Évangéline, established in 1995, was a pioneer in the movement to create community health centres for minority Francophones in Canada. Initially, the Centre operated independently and provided a range of integrated services, including effective referral services. In 2010, all community health centres in the province were placed under the control of Health PEI. Today, the Centre de santé Évangéline is considered a "primary health care centre" by Health PEI. Its bilingual staff serves both Francophone and Anglophone clients from the Évangéline area and provides specialized health services in French to patients from outside the area. The Centre does not have a doctor at this time.

3.1.3 WESTERN REGION

Both Alberta and Manitoba have CHCs that provide services to Francophones communities in minority settings and they have the core attributes of the comprehensive primary health care model prioritized by this study.

Alberta

Alberta has a system of 42 Primary Care Networks in which groups of family physicians collaborate with other health providers and government health authorities. According to a recent study by Hubert Gauthier and Nadia Benomar, these networks lack awareness of the issue of French-language services and have little or no statistical or qualitative data on the Francophones who inhabit the remote areas they serve. Gauthier and Benomar go on to state that the decision to provide services in French is predicated on the existence of a critical mass of Francophone patients.¹¹

In addition to its Primary Care Networks, Alberta has three English-only CHCs: two in Calgary and one in Edmonton. In May 2015, Calgary's Francophone community launched its first CHC, with advice and support from CHCs in Ontario and Manitoba. The Clinique francophone de Calgary, which is currently governed by the board of directors of the Association canadienne-française de l'Alberta, Calgary regional office (ACFA Calgary), provides services to Francophones and to persons who live under the same roof as a Francophone.

The clinic is currently looking for a family physician, but provides the services of a nurse practitioner, a psychologist and an occupational therapist. Most of its services are

¹¹ Gauthier, Hubert and Nadia Benomar. Un meilleur accès en Alberta aux services de santé primaires en français par l'intermédiaire des

Primary Care Networks, 28 pages, report consulted in 2015.

provided in French only. Clients must enrol in order to see a nurse practitioner or (eventually) a physician, but enrolment is not required to access other services.

Manitoba

Manitoba has a fairly large number of community health centres, most of them located in Winnipeg. They include Canada's oldest CHC, the Mount Carmel Clinic, established in 1926. As in New Brunswick, health centres that serve Francophones are primarily personal and transitional care facilities providing medical and emergency services in both official languages. Some centres in smaller communities also provide community-oriented services, such as home care, palliative care, and activities that promote healthy living.

Only two of the centres that currently provide services in French seem to have the core attributes of the primary health care model advocated within this study: the Centre de santé Saint-Boniface and the Centre de santé Youville, both of which are located in Winnipeg.

The Centre de santé Saint-Boniface, was established in Winnipeg in 1999 through the combined efforts of the Société franco-manitobaine, the Collège universitaire de Saint-Boniface, and the Grey Nun Congregation of Manitoba. The first board of directors of the Centre de santé Saint-Boniface was created in January 1999. In July of that year, a staff of 12 began working at Saint-Boniface General Hospital.

The Centre quickly made its mark with a comprehensive approach to wellness in which doctors, nurses, dietitians, nutritionists and mental health counsellors work together under one roof.

Over time, the Centre has established numerous partnerships with the community in order to enhance services for the Francophone population. It has also played an active role in training bilingual personnel.

The Centre de santé Youville offers bilingual primary health care services. According to CACHC, however, the extent to which programs and services are actually available in both official languages is not clear.

British Columbia And The Yukon

There are no Francophone or bilingual community health centres in British Columbia or the Yukon.

According to representatives of the Société Santé en français in British Columbia, access to French-language health services is highly problematic because Francophone associations tend to be weak and the Francophone population is spread over a large territory. A small number of private facilities that describe themselves as bilingual currently offer specialized services for Francophone seniors.

In the Yukon, medical personnel who work in primary health care, as well as in prevention and promotion, are employees of the territorial government.



“Governance plays a crucial role in the maintenance of French-language services and in the development of models that promote cooperation, service integration, and Francophone community engagement.”

3.2 GOVERNANCE

3.2.1 Central Region

Governance plays a crucial role in the maintenance of French-language services and in the development of models that promote cooperation, service integration, and Francophone community engagement.

Francophone Community Health Centres

In Ontario, all Francophone CHCs have an independent board of directors comprising 12 to 14 Francophone members. Board members serve a mandate of two to three years. In order to ensure board stability, the mandates of only three or four members terminate each year. Some centres include a limit of two or three mandates per board member in their statutes and regulations. However, this practice is not widespread.

In some centres, the managing director and one or two staff members sit as non-voting board members. In some instances, the outgoing chair is allowed to remain as a board member. No board member is remunerated, and deriving any benefit from such a position is strictly prohibited.

Centres that serve a large territory have a minimum number of regional representatives on their boards to ensure a better understanding of regional needs (e.g., five regions, two members per region).

With a single exception, centre representatives indicated that they have no difficulty recruiting Francophone board members. One centre with a large catchment area asks exiting board members to help find a replacement, subject to board approval. This approach ensures continuity in a board's regional representation.

The boards of Francophone centres work in French and all members speak French fluently.

According to respondents, Francophone governance is essential if French-language services are to be maintained. In English-language or bilingual establishments, French-language services have a tendency to disappear when Francophone engagement declines.

Francophone - Aboriginal — Anglophone Community Health Centre Model

The CHIGAMIK Community Health Centre has implemented a unique governance model. Its board is composed of twelve members: four Francophone representatives; four First Nations, Métis and Inuit representatives; and four members representing the Anglophone community and other groups in the region. Meetings are conducted in English.

Bilingual Health Centre Model

In order to be designated bilingual by the Ontario Ministry of Health and Long-Term Care, CHCs that serve both Francophones and Anglophones are required to have a number of Francophone board members that is representative of the Francophone population they serve. For example, the bylaws of the Centretown Community Health Centre stipulate that the board must have a minimum of two Francophones among its twelve elected members.

3.2.2 Eastern Region

New Brunswick

In New Brunswick, health centres are managed by regional health networks (Horizon or Vitalité) and do not have their own independent boards. The networks oversee a range of services delivered in medical offices, hospitals, clinics and other facilities. Each network is itself overseen by a board of directors that is elected by the population and/or appointed by the New Brunswick Health Minister.

Study respondents felt that this new centralized governance model has deprived the community of the ability to plan services at the local level. To mitigate this shortcoming, advisory committees have been established in some regions to examine health and wellness issues. These committees are composed of municipal representatives, parents and other stakeholders. They have no decision-making power.

Nova Scotia

The Clare Health Centre has a unique governance structure in which the municipality owns the building and manages the centre's support staff. The Centre's administrator reports to the municipality's chief administrative officer, while physicians operate as independent workers paid by the province. The salary of the nurse practitioner is paid by the community health board.

Nova Scotia has created community health boards across the province. The small community of Clare fought hard to obtain its own health board and was ultimately successful. Each year, all the health boards, including the Clare Community Health Board (CCHB), make presentations on local health needs to the Nova Scotia Health Authority. The CCHB is an advisory group composed of ten volunteers whose role includes relaying information between the Francophone community and the provincial Health Authority. The powers of health boards are fairly limited.

Prince Edward Island

The Centre de santé Évangéline no longer has its own governance structure. It is now managed directly by the provincial government, through Health PEI.

3.2.3 Western Region

Manitoba

In Manitoba, some primary health care centres report directly to the province's Regional Health Authorities (RHAs), an arrangement similar to that found in New Brunswick. Other centres, like the Centre de santé Saint-Boniface, have their own boards.

The St. Claude Health Centre and the Centre Albert-Galliot Medical Clinic both report to the board of the Southern Health-Santé Sud RHA, one of Manitoba's five regional health authorities. The 14-member board is appointed by the province.

In order to engage the Francophone community in the management and delivery of health services, CHCs have established issue tables whose members gather every three months to discuss community health needs.

The Centre de santé Saint-Boniface is managed by a member-elected board with a maximum membership of 20. Board members serve mandates of one, two or three years, for a maximum of six consecutive years. The Centre's founding members (the president and executive director of the Société franco-manitobaine, the rector of the Université de Saint-Boniface, and the chief executive officer of the Corporation catholique de la santé du Manitoba) continue to play an important role in its development, as the Corporation's only members.

Alberta

The Clinique francophone de Calgary is managed by the board of directors of the Association canadienne-française de l'Alberta, Calgary regional office (ACFA-Calgary). However, this situation may be about to change: project managers are recommending the formation of an independent board composed of representatives of the Francophone community, political decision-makers, health professionals, health sector managers, and representatives of educational institutions.

3.3 SERVICES

3.3.1 Central Region

The primary health care services provided by CHCs vary greatly in Ontario. The services most commonly provided include:

- physician or nurse practitioner consultations
- nursing care (blood tests, injections, vaccines, anonymous HIV testing)
- prenatal and postnatal care
- home visits
- telephone consultations with a nurse
- foot care
- nutrition counselling
- care for seniors in the community
- integrated services for diseases such as diabetes
- vaccination clinics
- mental health services (consultations, support groups, treatment for addictions and compulsive gambling, LGBT community support)
- school-based addiction counselling

Some services are limited to enrolled clients and patients treated by centre doctors and nurse practitioners, while other services, such as vaccinations and senior care, are made available to the entire population. Certain programs (including mental health and addiction services) are offered in partnership with community organizations.

Centres also offer prevention and promotion programs, such as:

- falls prevention
- information on nutrition, diabetes, obesity, etc.
- prenatal and postnatal infant care
- early childhood development support
- parent education

Centres also offer a variety of social programs designed to address the primary determinants of health such as housing, employment, immigrant integration, community development and education.

Certain French- and English-language programs are limited to clients who reside within a centre's catchment area, while other programs target Francophones who reside within a larger area. This is a distinction that clients sometimes have difficulty grasping.

Community Health Centre services vary markedly because every centre is striving to respond to the unique needs of its community. New organizations like the CHIGAMIK Community Health Centre, offer a more limited number of programs and services, while more established centres generally offer more services, having had more time to develop partnerships with other community organizations (e.g., housing and addiction services) or with government agencies.

At present, the TAIBU Community Health Centre in Scarborough offers a small number of French-language health promotion programs. TAIBU CHC would eventually like to be recognized as an officially bilingual centre with the capacity to serve Scarborough's Francophone population of African descent.

Several Francophone Community Health Centres have become community hubs and offer a wider range of services. For example, the Centre francophone de Toronto and the Centre de santé communautaire de l'Estrie both provide employment and immigrant integration services. The Centre francophone de Toronto offers arts and culture programs and legal aid services.

3.3.2 Eastern Region

New Brunswick

Health centres in New Brunswick deliver primary care services:

- **medical services (including drop-in and appointment clinics and minor surgical procedures)**
- **support and treatment services (nutrition, psychology, inhalation therapy, speech therapy)**
- **diagnostic examinations (blood and other sample collection)**
- **clinics (diabetes, lithotripsy, urodynamics, psychiatry)**
- **According to interview subjects, over 90% of the services provided in New Brunswick centres fall under the heading of primary care.**

The St. Joseph Community Health Centre and the Lamèque Hospital and Community Health Centre, two former community hospitals, deliver a wider range of services, including primary health care, outpatient care, diagnostics and rehabilitation. More recently, palliative care services were added. According to study respondents, these organizations dedicate approximately 85% of their activities to primary care and 15% to prevention and health promotion.

Nova Scotia

The Clare Health Centre and its physicians and nurse practitioners dedicate their efforts almost entirely to primary care. The Centre's physicians also visit other facilities in the community, such as seniors' homes and the Université Sainte-Anne. Mental health and addiction services are offered by external agencies. The Clare Health Centre offers blood test services and a diabetes clinic on a weekly basis. According to CACHC, few promotion and prevention programs are offered in Nova Scotia, due to a lack of provincial funding.

3.3.3 Western Region

Manitoba

The Centre de santé St. Claude and the Centre Albert-Galliot Medical Clinic are strictly primary care centres, but are associated with a number of active care and long-term care facilities. Clients do not need to enrol in order to access services. Home care, mental health and dietician services are delivered by other community partners.

The Centre Albert-Galliot houses the clinic, community partners, and several health sector businesses in an effort to broaden the range of services available in French.

Services include:

- **pharmacy**
- **physiotherapy**
- **chiropractic**
- **therapeutic massage**
- **dentistry**
- **physical fitness**

The Centre de santé Saint-Boniface offers a variety of primary health care programs designed to address the needs of the community and help clients manage their health. As with Community Health Centres in Ontario, clients must enrol in order to receive primary care services. All other programs are made available to the entire population.

The Centre offers the following services:

- **medical services (examinations, prenatal and postnatal care, minor surgery, chronic disease monitoring)**
- **nutrition services**
- **mental health services (individual, family and group counselling; psychosocial rehabilitation; crisis intervention)**

Like centres in other regions, the Centre de santé Saint-Boniface has established close ties with community partners involved in prevention and promotion. The Centre has a community development team that works to address various determinants of health, including housing, education, nutrition, transportation and safety. In 2013-2014, the Centre introduced health promotion programs aimed at adolescents and seniors (e.g., “Grouille ou rouille” – “Use it or lose it”), and a cognitive behavioural therapy program for adolescents.

The Centre also offers bilingual services through the Health Links program, in cooperation with the Provincial Health Contact Centre. Qualified nurses are available to take calls around the clock.

Alberta

The Clinique francophone de Calgary is looking for a doctor but already offers the services of a nurse practitioner, a psychologist and an occupational therapist. Much remains to be done, since the clinic's goal is deliver a comprehensive range of services like centres in Ontario and Manitoba.

3.4 FUNDING

3.4.1 Central Region

Community Health Centres in Ontario receive almost all of their funding from the provincial government. Certain centres derive a small percentage of their funding from their municipality (2-4%) or from fundraising activities (1-3%). Centres that offer immigrant settlement programs also receive federal government funding.

CHC budgets vary widely, depending on the size of the catchment area, the number of satellite offices, and the range of programs provided. The annual budgets of the CHCs included in this study ranged from \$3 million to \$12 million.

Unsurprisingly, newer CHCs in the early stages of development have smaller budgets. When the Centre de santé communautaire de l'Estrie opened its doors in 1991, it had an annual budget of \$1 million but now has a budget of over \$9 million. CHIGAMIK Community Health Centre, launched less than five years ago, currently has a budget of \$3 million, which is at the low end for centres included in this study.

The French-language services of the TAIBU Community Health Centre are funded under the Canada-Ontario Agreement. This funding will end in March 2016. In summer 2015, the Centre applied to hire a Francophone nurse practitioner to serve its French-speaking clientele.

3.4.2 Eastern Region

New-Brunswick

In New Brunswick, CHCs are funded by the provincial government. Since physicians are paid on a fee-for-service basis by the province, it is difficult to fully evaluate the total budget of the health centres contacted for this study. A respondent from a centre that employs six persons (or full-time equivalents) indicated that the centre's annual budget was approximately \$350,000, not counting physician remuneration.

Nova Scotia

According to CACHC, CHCs in Nova Scotia receive no government funding, with the exception of the North End Community Health Centre in Halifax, which receives a small amount of core provincial funding. Expenses at the Clare Health Centre (maintenance, support staff, medical and administrative costs) are covered by the municipality. Physicians and nurse practitioners are paid by the provincial government and the Regional Health Authority. Physicians, in turn, pay rent to the municipality for the use of its premises. The province recently granted annual operational funding in the amount of \$40,000 to the Clare Health Centre.

3.4.3 Western Region

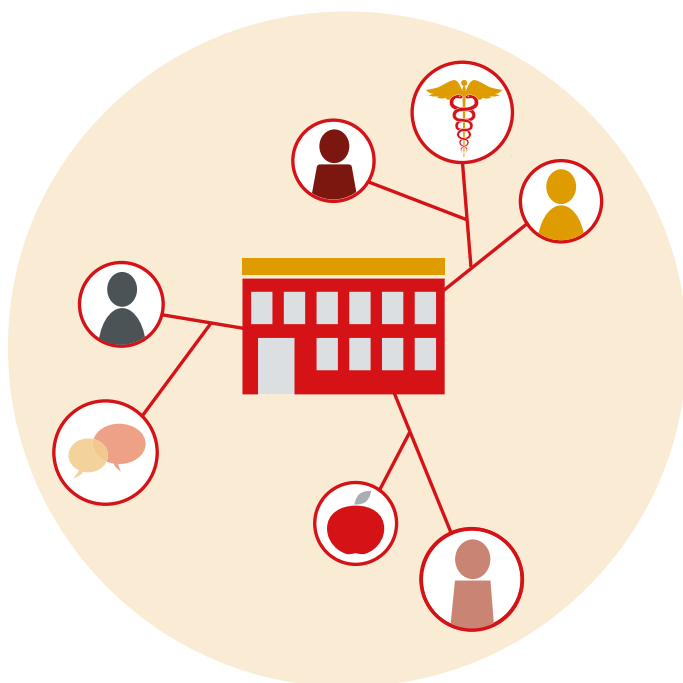
Manitoba

In Manitoba, Community Health Centres are entirely funded by the province through the Regional Health Authorities. The St. Claude Health Centre and the Centre Albert-Galliot Medical Clinic are required to cover physicians' salaries. The centres also receive a small amount of funding from the Société Santé en français for time-limited projects such as the Télésanté project.

The annual budget of the Centre de santé Saint-Boniface is \$3.1 million, 80% of which is earmarked for human resources.

Alberta

The Clinique francophone de Calgary recently opened its doors with the financial support of the Government of Canada. It is anticipated that 80% of the clinic's funding will come from the federal government for a three-year period, while 20% will be provided through the Alberta government's Francophone Secretariat and its Community Initiatives Program. It is important to note that the Clinique francophone does not receive funding from the Alberta Ministry of Health and Wellness. The centre will need to find other sources of funding to ensure its long-term survival. It plans to recruit a small number of Francophone physicians who will be paid on a fee-for-service basis to ensure that the centre receives the base funding it needs.



“Several Francophone Community Health Centres have become community hubs and offer a wider range of services.”

4 CHALLENGES AND BARRIERS

ONTARIO

Funding is the greatest challenge facing CHCs in Ontario. Centres complain about the lack of stable, adequate funding, adding that new programs are put in place with time-limited funding, creating expectations that cannot be satisfied once funding comes to an end. Time-limited funding makes it difficult for centres to make medium- and long-term plans.

Furthermore, new needs are emerging, particularly in the field of mental health, but funding to address those needs is often inadequate.

In some parts of Ontario, the regional health system governance structure (Local Health Integration Networks - LHINs) is failing to meet the unique needs of Francophone communities. According to respondents, some LHINs do not understand the needs of Francophones and therefore fail to respond appropriately, even though support is widely available from networks and organizations with expertise in French-language service planning.

Some Francophone-only CHCs serve very large territories, a factor that can hinder client recruitment and retention. Transportation problems represent another barrier, limiting the ability of Francophones to participate in health promotion activities.

The recruitment of French-speaking or bilingual staff is also a challenge. In urban areas, Community Health Centres face significant competition from other health institutions, particularly in more specialized fields (e.g., chiropody). In remote areas, Francophone general practitioners and specialists are both in short supply.

Professional training is more expensive in remote areas: travel times are longer and plane tickets cost more. As a result, centres are not always able to provide professional training for their staff.

EASTERN REGION

Like Ontario, the Eastern region faces long-standing problems in the areas of funding and recruitment. Interview subjects indicated that the region's needs are very real but that financial resources are sorely lacking. According to CACHC, one of the funding challenges facing CHCs in New Brunswick is the concentration of resources in primary care, with little funding for comprehensive primary health care including prevention and promotion programs.

According to centre managers, issues of personnel retention are also having a negative impact on the accessibility of French-language services in New Brunswick.

In Nova Scotia, professional isolation is a major problem for Francophone doctors. A critical mass of professionals is needed in order to break through this isolation – a difficult goal to achieve in smaller communities.

In recent years, the Consortium national de formation en santé has provided French-language training to medical students outside Quebec through the Université de Sherbrooke and the Université Sainte-Anne. Most physicians at the Clare Medical Centre received this training and subsequently chose to remain in the region, thus ensuring culturally appropriate care for the community.

In Prince Edward Island, where formerly independent Community Health Centres are now managed by the Department of Health and Wellness, respondents felt that the current system neglects the elderly in favour of the young. Referral services are in fact few, while many services are geared to the needs of young families. CHC managers are currently studying the possibility of re-introducing certain community services.

“Like Ontario, the Eastern region faces long-standing problems in the areas of funding and recruitment. In the Western region, recruitment and retention of bilingual professionals is even more of a problem.”



WESTERN REGION AND THE NORTH

In the Western region, recruitment and retention of bilingual professionals is even more of a problem. In Manitoba, some health professionals are resigning from their positions because the distance between their place of work and their place of residence is simply too great. Compounding the problem is the fact that personnel sharing is still far from common in health centres.

In Alberta, where a Francophone clinic was recently launched, funding shortfalls and the clinic's financial dependency on the federal government are already contentious issues. Respondents indicated that the recruitment of Francophone personnel is also a problem. At the time of this writing, the centre was still looking for a doctor.

Client recruitment is another problem at the Clinique francophone de Calgary, given the geographic dispersal of the Francophone community.

In their study of Primary Care Networks in Alberta, Hubert Gauthier and Nadia Benomar found that the most significant barriers to the development of French-language services are the identification and recruitment of bilingual staff and an imperfect understanding of the concept of active offer.

In British Columbia, where the Maison de la francophonie has been in existence since 1993, there are still no Francophone or bilingual CHCs. Reasons cited for this gap include a lack of commitment on the part of Francophone professionals, the fragmentation of Francophone organizations, and the geographic dispersal of the Francophone population over a vast territory.

In the Yukon, another territory that does not have a Francophone or bilingual CHC, the community has been trying to secure funding since 2003 but has had no success. All orders of government appear to be “passing the buck” on the issue of funding. Interview respondents indicated that Francophones tend not to remain in the Yukon for very long and therefore do not develop a strong sense of allegiance to the Francophone community.

5 OPPORTUNITIES FOR GROWTH

ONTARIO

At a time when Ontario government ministries are facing chronic financial pressures, one approach being put forward is the creation of new entities out of existing CHCs, the rationale being that it is easier to open a satellite office than to create an entirely new structure.

Starting small and offering a limited range of services is strongly recommended. A small project is easier to start and can help secure the confidence of funding agencies.

Making well-paid placements available to students is suggested as a way of to recruit more Francophone professionals and encourage them to work in a Francophone environment. Another recommendation is to give nurse practitioners a larger role in community health so that more care can be delivered at a lower cost.

Since LHINs sometimes have difficulty grasping the needs and realities of Francophones, some commentators argue that Francophone health planners should have a role to play in the management of health sector resources dedicated to Francophone health in Ontario.

EASTERN REGION

New Brunswick respondents felt that the Francophone community needs to exert political pressure to draw attention to the need for more Community Health Centres. For example, attention should be drawn to the fact that health services can be accessed more rapidly at a CHC than at a doctor's office. Getting health professionals involved in the process will also be important, in order to increase the chances of success.

It is important to ensure that Francophones have a real decision-making role to play (for example, Francophone community governance) rather than simply an advisory role. Respondents also felt that centres should start with small-scale projects and expand from there in stages.

Since Nova Scotia provides little or no funding for CHCs, municipalities have a potential role to play in building and managing these resources. CACHC has called on all Community Health Centres in Nova Scotia to work together to secure annual core funding from the provincial government. Also noteworthy: some postsecondary institutions are addressing the shortage of Francophone professionals by reserving spots for Francophone students.

WESTERN REGION

Like their counterparts in New Brunswick, respondents in Manitoba also stated that the province's Francophone community needs to get involved if it hopes to see an increase in the number of centres offering primary health care and community services in French. In order to effectively "sell" its ideas, the community will also need to present solid documentation and a clear rationale.

One suggestion for increasing the recruitment of Francophone professionals is to train more professionals from the region, the assumption being that local professionals are more likely to stay after completing their education.

In Alberta, collaboration with one or more primary care networks could generate effective strategies for serving the Francophone population and ensuring long-term survival of the Clinique francophone.

In British Columbia, the Francophone education sector (Conseil scolaire francophone de la Colombie-Britannique and Collège Éducacentre) is considering launch a Francophone Community Health Centre project, drawing on the example of the Conseil scolaire Franco-Sud in Alberta. British Columbia is also looking at partnerships with English-language Community Health Centres as a possible option.

"It is important to ensure that Francophones have a real decision-making role to play (for example, Francophone community governance) rather than simply an advisory role. Respondents also felt that centres should start with small-scale projects and expand from there, in stages."



CONCLUSION AND

6 RECOMMENDATIONS

CONCLUSION

While the parameters of this study did not allow us to establish a complete inventory of primary health care models services provided in Francophone communities, the interviews and comments we collected shed light on a number of trends:

- Francophone communities must continually adapt to the political and economic realities associated with planning and investment in primary health care. As a result, different types of CHCs have sprung up (leasing arrangements with health agencies, physician recruitment on a fee-for-service basis, creation of or participation in physician networks, etc.)
- Many Francophone communities face similar challenges when they try to establish CHCs, which is why it is important for them to work in close partnership with national organizations like the Société Santé en français and the Canadian Association of Community Health Centres. These organizations can help communities forge links with Francophone and bilingual organizations in other parts of Canada.
- Establishing a Community Health Centre in a minority setting can be a long and arduous process. Communities that have done so successfully emphasize the importance of:
 - *securing the support of a health sector champion (a physician or other health professional) to enhance the project's credibility;*
 - *involving key partners, such as Francophone school boards, provincial and territorial Francophone advocacy groups, community organizations, the Francophone community, and municipalities;*
 - *hiring a nurse practitioner early in the process so that promotion/ prevention programs can be incorporated into the basket of services;*
 - *establishing a Francophone governance model that is responsive to the health needs of Francophones.*
- It is important to begin with a small-scale project and to recruit Francophone physicians and/or nurse practitioners, in order to attract clients and demonstrate to donor agencies that such infrastructure is needed to better serve the Francophone population.
- In a time of budget cuts, it is important to work in partnership with established health centres and institutions in order to reduce project start-up costs.
- The Canadian Association of Community Health Centres and the Société Santé en français should calculate the impact of investing in French-language CHCs on rates of disease and the use of hospital and emergency services.
- Projects should be tailored to regional needs (centres that operate in French but also provide services to Anglophones and Aboriginal people; rural CHCs that offer ambulatory and palliative care beds; Anglophone-governed centres offering certain services in French in areas that lack a critical mass of Francophones, etc.)



“Many Francophone communities face similar challenges when they try to establish CHCs, which is why it is important for them to work in close partnership with national organizations like the Société Santé en français and the Canadian Association of Community Health Centres.”

- **Governance by and for Francophones ensures responsiveness to the real needs of communities and provides a means of capitalizing on the diverse skills and relationships of trust that volunteers can bring to an organization.**
- **The community hub model developed in New Brunswick and Ontario provides a means of creating a comprehensive basket of services for Francophones (health, culture, employment, etc.) and presents a number of advantages for both funding agencies and clients. According to CACHC, the community hub model can be traced back to the local community service centres (CLSCs) created in Quebec in the 1970s.**
- **The federal government has agreed to fund a pilot primary health care centre for Alberta’s minority Francophone population on a three-year experimental basis (the Clinique francophone de Calgary). This sets an important precedent which communities can pursue with the federal government.**

RECOMMENDATIONS

This study sheds a useful light on a number of trends and developments in the delivery of primary health care for Francophone communities in minority settings.

However, a more in-depth study focused on two or three specific models would be helpful in terms of documenting the stages involved in establishing a CHC (background, barriers, solutions, budgets, care models, governance, staff recruitment, etc.). Such a study could provide crucial data and information to organizations planning to launch a CHC and spare them the work of having to collect data from Francophone CHCs across Canada. Examining a CHC that has experienced significant barriers might also provide useful lessons.

At present, a body of evidence to validate or justify the benefits of establishing CHCs for Francophones is lacking in several provinces. Now that Clinique francophone de Calgary is underway, indicators should be developed to immediately begin measuring the impact of this new centre on its clientele.

The federal government and national associations, such as the Canadian Association of Community Health Centres and the Société santé en français, should work together to help Francophone communities develop Community Health Centres that reflect their unique needs. Tools, resources and enhanced funding should be provided to facilitate: the identification of needs; joint action on the part of key players; advocacy at the provincial, territorial and municipal levels; and initial project development.

Finally, the Canadian Association of Community Health Centres and the Société santé en français should persuade the federal government to incorporate a set of positive reinforcement measures into the health transfer system to encourage the provinces and territories to actively support the creation of primary health care centres for the Francophone population. Measures of this kind are known to have made a substantial contribution toward the creation and enhancement of Canada's French-language education system.

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