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ACCESS TO HEALTH CARE FOR THE OFFICIAL LANGUAGE MINORITY COMMUNITIES:

Legal Bases, Current Initiatives and Future Prospects

Report of the Standing Committee on Official Languages

Mauril Bélanger, M.P.
Chair

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NINTH REPORT

In accordance with its Order of Reference from the House of Commons of March 20, 2003, the Standing Committee on Official Languages has examined the subject matter of Bill C-202, *An Act to amend the Canada Health Act (linguistic duality),* and has agreed on the following observations and recommendations:

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LIST OF ABBREVIATIONS

CCESMC	Consultative Committee for English-speaking Minority Communities
CCFSMC	Consultative Committee for French-speaking Minority Communities
CHT	Canada Health Transfer
CHST	Canada Health and Social Transfer
CIHR	Canadian Institutes of Health Research
CNFS	Consortium national de formation en santé
CURA	Community-University Research Alliances
FAJEFCL	Fédération des associations de juristes d'expression française de common law
FCFAC	Fédération des communautés francophones et acadienne du Canada
OLEP	Official Languages in Education Program
PHCTF	Primary Health Care Transition Fund
SSHRC	Social Sciences and Humanities Research Council of Canada

INTRODUCTION

This study is pursuant to a motion agreed to in the House of Commons on 19 March 2003 by a majority vote of 153 to 35, in which the Standing Committee on Official Languages of the House of Commons was asked to report no later than October 31 of this year on the following question:

> That Bill C-202, *An Act to amend the Canada Health Act* (*linguistic duality*), be not now read a second time but that the Order be discharged, the bill withdrawn and the subject matter of the bill be referred to the Standing Committee on Official Languages to report back to the House on or before October 31, 2003.[1]

The Minister of Health, the Honourable Anne McLellan, and the Minister of Intergovernmental Affairs, the Honourable Stéphane Dion, also wrote to the Chair of the Standing Committee on Official Languages asking that the Committee explore other mechanisms for promoting better access to health care for the official language minority communities.

In accordance with the mandate given it, the Committee decided to focus its efforts along a first axis, the determination of the legal bases of the delivery of health care to the linguistic minorities. Although the Ontario Court of Appeal put an end to a long judicial saga on 7 December 2001 by deciding that Ottawa's Montfort Hospital should be fully maintained, debate as to whether the linguistic minorities have or should have an individual or collective right to health care and social services[2] in their language continues. In Chapter 1, we present a summary of the various legal opinions we requested on that question.

In Chapter 2, the Committee presents a brief overview of the situation regarding access to health care in the minority language, including current initiatives to improve the situation. The $119 million investment announced this past March in the health component of the Canadian government's Action Plan for Official Languages[3] will be a "lever" for networking, primary care and training.

In Chapter 3, as we shall see, the entire question of access to health care for linguistic minorities must be addressed within the broader debate on the future of Canada's health system. The current mechanisms for intergovernmental cooperation must be used to improve the health services offered to linguistic minorities and, in particular, to ensure their long-term continuation. The Committee believes this issue is too important and fundamental to be reviewed every five years subject to available funding and the goodwill of political authorities of the moment. We all know that health has been the subject of intense discussions between the federal and provincial

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1 House of Commons, *Debates*, March 19, 2003, p. 4447.

2 In this report, the concept of health care includes social services.

3 Government of Canada, *The Next Act: New Momentum for Canada's Linguistic Duality. The Action Plan for Official Languages*. 2003, p. 79.

governments for some years now. It is high time that matters pertaining to the health care provided to the linguistic minorities be given the attention they deserve by the decision-makers in place. Those discussions must lead to the implementation of structural and long-term measures.

CHAPTER 1: THE CONSTITUTIONAL AND LEGAL BASES OF HEALTH CARE IN BOTH OFFICIAL LANGUAGES

The decision by the Health Services Restructuring Commission to close Montfort Hospital in February 1997, as well as the ensuing legal battle, sparked a still ongoing debate on individual and collective rights to health care and social services in the language of the minority. The question was brought to the attention of the commissions that examined the future of health care in Canada (Kirby and Romanow).[4] The Standing Committee on Official Languages asked four legal experts for opinions on the constitutional and legal bases of health care in the minority language. More specifically, we asked them to base their interpretation on four pieces of legislation we consider relevant to the question:

- the *Constitutional Act, 1867*, including the federal spending power;
- the Canadian Charter of Rights and Freedoms;
- the *Canada Health Act*;
- the *Official Languages Act*.

Constitution Act, 1867

It is important at the outset to review the distribution of powers between the two orders of government. As André Braën, law professor at the University of Ottawa, noted, the provincial governments received extensive powers in the health field under the *Constitution Act, 1867*. Apart from their jurisdiction over hospitals and asylums (s. 92(7)), they received constitutional powers in public health by virtue of the jurisdiction granted to the provinces under the Constitution over local or private matters (s. 92(16)). They also administer the provincial health insurance plans as a consequence of their power to regulate property and civil rights (s. 92(13)).[5] While the provinces have primary responsibility for the delivery of health care services, the services under the jurisdiction of the Government of Canada must not be overlooked. The government intervenes in the health care sector by virtue of its jurisdiction over criminal law, quarantine, marine hospitals, interprovincial and international trade, patents and trademarks and its powers with respect to peace, order and good government. The federal government also has direct responsibilities with respect to ensuring health care services are available to certain groups, for example, primary care for the First Nations and Inuit communities and other services for veterans and personnel of the RCMP, the Correctional Service of

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[4] We refer here to the study conducted by the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) and those of the Commission on the Future of Health Care in Canada (Romanow Commission), which submitted their final reports in the fall of 2002.

[5] *Evidence*, Standing Committee on Official Languages, Meeting No. 31, 37th Parliament, 2nd Session, 17 September 2003 (1615).

Canada and the Armed Forces. In addition, we will see further along in this section that the Government of Canada supported the establishment of provincial public health care plans through its spending power. The Government of Canada played an important role in the evolution of the Canadian health care system, and this fact cannot be omitted in the subject under discussion.

The power to make laws with regard to the use of official languages has not been formally inscribed in sections 91 and 92 of the *Constitutional Act*, 1867. Consequently, it belongs to both levels of government as part of their legislative powers. The power to legislate on linguistic matters is an "ancillary" power to the exercise of legislative authority over a class of subjects assigned to Parliament or to provincial legislatures.[6] As Professor Pierre Foucher of the University of Moncton noted, "The right to health care services in one's own language is a provincial matter."[7]

Since 1867, however, the spending power has been the central government's principal means of exercising its authority in the health field. The *Constitution Act*, 1867 grants Parliament a virtually unlimited power to tax and spend. That power has enabled it to intervene in provincial jurisdictions such as health care and to try to lead the provinces to comply with uniform national standards, indeed even to influence the spirit of policies developed under the provinces' jurisdiction.

The experts we consulted unanimously told us that Parliament may use its spending power to support the provincial governments in providing health care in both official languages. That option would be the safest legally, but more controversial politically. It could use its spending power to make direct payments to individuals, third parties or the provinces, as it is currently doing for education in minority communities, to improve social services and health care. Although it cannot directly regulate activities under provincial jurisdiction,[8] the Government of Canada may set "conditions" as to how the money is to be spent.[9] This procedure has never been challenged in court. Through its spending power, the Parliament of Canada could recognize a right to health care in the language of the linguistic minority in the *Canada Health Act* or the *Official Languages Act*, and its obligation, as is the case in education, would be to assist the provinces in carrying out that mission.

In *Reference re Secession of Quebec*,[10] the Supreme Court of Canada stated that the Constitution of Canada is based on four principles: federalism, democracy,

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[6] This is how the Supreme Court ruled in *Devine* in 1988, holding that Quebec had the necessary legislative authority to legislate on language in areas under its jurisdiction. Judge Michel Bastarache confirmed the decision in *Devine* on this point in paragraph 14 of his 1999 judgment in *Beaulac*.

[7] *Evidence*, Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0915).

[8] *Evidence,* Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0940).

[9] This argument was recently confirmed by a decision of the Alberta Court of Appeal in *Winterhaven Stables Ltd. v. Canada* [1988], 53 D.L.R., (4th), p. 434.

[10] *Reference re Secession of Quebec* [1998], 2 S.C.R. 217, p. 248-249.

constitutionalism (the rule of law) and protection of minority rights.[11] In the view of Professor Martha Jackman, of the University of Ottawa, this last unwritten principle of the Constitution could be argued to demonstrate an obligation to provide services in both official languages. Professor Jackman acknowledged, however, that, to date, the courts have interpreted the unwritten principles set out in *Reference re Secession of Quebec* as mainly negative obligations, that is to say obligations which prevent the state from acting rather than compel it to act. However, a feature of the language rights set out in the Canadian Charter of Rights and Freedoms is that they impose obligations on governments to act. The unwritten principles stated in *Reference re Secession of Quebec* thus constitute a good starting point for emphasizing the obligation to provide services in both languages:

> I do think it's possible to interpret these provisions, or principles, as imposing a duty to act. The constitutional rights of linguistic minorities mean little if they do not imply some positive obligations.[12]

Canadian Charter of Rights and Freedoms

Although the right to instruction in the language of the official language minority is entrenched in the Canadian Charter of Rights and Freedoms, that right is generally recognized as not existing in the health field. However, witnesses appearing before the various commissions on health care in Canada (Kirby and Romanow) suggested that there were individual and collective rights to health care in the language of the patient.[13] The experts' views on this question are outlined below.

Section 7 guarantees that everyone has the right to life, liberty and security of the person and the right not to be deprived of those rights except in accordance with the principles of fundamental justice. In Professor Martha Jackman's view, it could be argued that health care within the meaning of the *Canada Health Act* must be accessible in the language of the linguistic minority in order to meet the requirements of section 7.[14]

The Committee also asked whether failure to receive health care in one's language could be argued as a ground of discrimination under section 15 of the

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[11] Although they are not expressly written, those underlying constitutional principles can nevertheless give rise to substantial legal rights. The principle of the protection of minority rights moreover was successfully argued in the *Montfort* case.

[12] *Evidence*, Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0915).

[13] *Evidence*, Standing Committee on Official Languages, Meeting No. 23, 37th Parliament, 2nd Session, 27 May 2003 (0905).

[14] Professor Jackman was alluding here to the Supreme Court of Canada decision of May 8 of this year to hear the appeal of Quebec physician Dr. Jacques Chaoulli, seeking to have the provisions prohibiting the private sector from competing with the public sector in the health field ruled unconstitutional. The applicant's claims had previously been rejected by the Superior Court of Quebec and the Court of Appeal.

Charter.[15] In *Eldridge v. British Columbia*,[16] the Supreme Court of Canada ruled that a deaf person is entitled to receive health services in a language that he can understand. Failure to provide translation services constituted discrimination under section 15 of the Charter. Does that right extend to the speakers of a minority language? Opinion was divided on the question. In Professor Jackman's view, section 15 provides some very intriguing potential arguments that the Committee may wish to explore.[17] Conversely, in Professor Pierre Foucher's opinion, it is far from certain that the mother tongue is contemplated by section 15. If it were, only the mother tongue would be concerned. Secondly, a bilingual person would not benefit from this right. Thirdly, the right would accrue to every language, not just to official languages. Lastly, only translation services, not direct services, would be guaranteed.[18]

The legal experts also explored subsections 16(1) and (3) of the Charter. Subsection 16(1) guarantees equality of the official languages and subsection 16(3) represents what is called the advancement principle: it commits Parliament and the governments to advancing linguistic equality. To date, that principle has been interpreted so as not to prevent governments from passing measures that advance equality. However, it does not compel them to act. In *Beaulac*,[19] the Supreme Court agreed that subsection 16(1), which entrenches linguistic equality, means that rights that are in existence at a given time must also be implemented. However, it is important to note that this does not require governments to add rights. In concrete terms, if the right to health care in one's language were added in a statute, either the *Official Languages Act* or the *Canada Health Act*, subsections 16(1) and 16(3) would then have an impact. As a result of subsection 16(3), that act could not be challenged on the basis of other Charter provisions, and, under subsection 16(1), linguistic equality would impose positive obligations on governments to ensure that that right is implemented equally.

The experts examined subsection 20(1) of the Charter, which imposes an obligation on the federal government to provide services in both languages in the central offices and where there is significant demand. Where it offers services directly to certain groups (First Nations, Inuit communities, veterans, RCMP, Correctional Service and Canadian Armed Forces personnel), the health care which the federal government provides directly is included in the services contemplated by section 20.

With regard to the three territories, Tory Colbin, President of the Fédération des associations de juristes d'expression française de common law (FAJEFCL), contended

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[15] "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

[16] *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. par. 624.

[17] *Evidence,* Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0920).

[18] *Evidence,* Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0910).

[19] *R. v. Beaulac*, [1999] 1 S.C.R., para. 768.

that sections 16 and 20 of the Charter compelled the territorial and Canadian governments to provide health services to every French-speaking individual in the three territories where there is "significant demand" or where the "nature of the office" requires. However, in the case of the three territories, although the Government of Canada is responsible for health care, it is increasingly transferring that responsibility to the territorial governments. This devolution of responsibility has caused problems in the operation of the official languages in the health field and in various other fields as well. There is a grey area here that must be clarified.

RECOMMENDATION 1

The Committee calls on the Commissioner of Official Languages to investigate whether the Government of Canada is complying with the *Official Languages Act* when it is required to provide care directly to certain groups or communities or, again, whether it ensures its obligations are met when it transfers its responsibilities to third parties. We ask the Commissioner to report to the Committee following her investigation.

Would it be possible to amend the Charter to entrench a new right to health care in a person's language? The experts agree that it would be very difficult to go ahead with such a constitutional amendment. Recognizing a right to health care in the minority language in the Constitution of Canada would require the unanimous consent of all partners in Confederation under Part V of the *Constitution Act, 1982*. However, there is nothing preventing the Parliament of Canada and a consenting province from resorting to the bilateral procedure of the amending formula to include such a right. The Committee can only hope that provinces will follow the example of New Brunswick on the road to linguistic equality. The *Constitution Amendment Proclamation, 1993* (*New Brunswick Act*) constitutionally recognized the equality of New Brunswick's two linguistic communities by amending section 16 of the Canadian Charter of Rights and Freedoms. New Brunswick is now required to protect and advance the status, rights and privileges of the two linguistic communities.

Canada Health Act

Third, the Committee asked experts to examine the *Canada Health Act*. In its present form, the *Canada Health Act* states five conditions that the provincial and territorial governments are required to meet in their public health insurance systems to be entitled to all federal contributions paid under the Canada Health and Social Transfer (CHST). Those five conditions are universality, comprehensiveness, portability, public administration and accessibility. The FCFAC, its members and a number of Francophone community associations have frequently requested that a sixth condition, linguistic duality, be added. A number of briefs[20] were submitted to the Committee on this matter requesting that Parliament include access to health care in both official languages in the *Canada Health Act* and make it a prerequisite to federal funding. The

[20] Twelve organizations submitted a brief to the Committee, and many of them recommended the addition of a principle on linguistic duality in the *Canada Health Act.*

President of the Fédération des associations de juristes d'expression française de common law extended that argument even further: "The notion of a sixth principle of linguistic equality is essential, and perhaps even mandatory under the Constitution. Parliament has the power to attach language-related conditions to funding. I would even venture to say that it has the obligation to impose such conditions."[21]

Health Canada has expressed reservations over the proposal. The Department believes that the approach adopted to date by the Government of Canada, that of supporting provincial governments and communities in their efforts to provide official language minority communities with better access to services in their language, is more appropriate than adding a sixth principle to the Act.[22] Moreover, the legal experts consulted told Committee members that, for political reasons, it would be very difficult to amend the present *Canada Health Act*.[23]

The Committee asked the experts to consider one of the principles stated in the Act, accessibility. According to that principle, the provinces must "provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by changes made to insured persons or otherwise, reasonable access to those services by insured persons."[24] In Pierre Foucher's view, it is not out of the question from the outset that the principle of accessibility includes access to health care in the patient's language, if it is interpreted in accordance with the unwritten principle of protection for minorities. However, that interpretation has never been validated by the courts.

Official Languages Act

Fourth, the experts analyzed the *Official Languages Act*. Part VII expresses the Government of Canada's commitment to enhancing the vitality of the communities and advancing the equality of the two languages as to their status and use. According to one school of thought, it is pointless to invoke Part VII because it is non-executory, that is to say it does not create an obligation.

The Minister of Intergovernmental Affairs, the Honourable Stéphane Dion, expressed his view when he appeared before our committee on 17 March 2003 to present the Canadian government's Action Plan for Official Languages. In his view, Part VII is a political commitment and the action plan is the concrete expression of that commitment. According to the Minister, the wording of Part VII, in addition to being vague, directly involves the provinces in the implementation of a number of initiatives.

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[21] *Evidence,* Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0935).

[22] *Evidence,* Standing Committee on Official Languages, Meeting No. 24, 37th Parliament, 2nd Session, 28 May 2003 (1535).

[23] *Evidence,* Standing Committee on Official Languages, Meeting No. 30, 37th Parliament, 2nd Session, 16 September 2003 (0925).

[24] *Canadian Health Act*, 1984.

Consequently, it is hard to conceive how the Government of Canada could be held responsible for provincial initiatives.[25]

However, a recent Federal Court judgment has renewed debate on the matter. In his testimony on September 16, Professor Pierre Foucher referred to a Federal Court judgment rendered on September 8,[26] in which the Court granted an order requiring the Canadian Food Inspection Agency to comply with Part VII, which means that the Court found that that part of the Act has binding force and can lead to orders being made. If that is the case, it is quite easy to make a connection with the health issue. It would be reasonable to assume that the Government of Canada has an obligation under section 41 of the Act to do everything within its power to support and assist the development of health care in both languages. On October 14, the federal Department of Justice appealed this decision.

In addition, under paragraph 43(1)(*d*), the Minister of Canadian Heritage has an obligation to take measures on behalf of the Government of Canada to assist the provinces in providing health care in the minority language. It is now recognized that the Government of Canada spends in order to reinforce linguistic minorities' access to education and services in their language. Part VII and paragraph 43(1)(*d*) are the expression of the federal government's spending power which we explain above in this chapter. Consequently, some experts think it would be much easier and more effective, politically and from an implementation standpoint, to add a right to access to health care to the *Official Languages Act* rather than amend the *Canada Health Act*. Another possible option is ratification of a memorandum of understanding between Health Canada and the Department of Canadian Heritage (PCH) along the lines of what was signed in 1997 between the Treasury Board and PCH respecting the implementation of section 41 of the *Official Languages Act*. We return to this point in Chapter 3.

The debate initiated in recent years on the constitutional and legal bases of health care for the linguistic minorities is clearly not over. Nor can the Committee claim to have exhausted it. We hope we have shed new light on the question. As we shall see in the next chapter, a number of initiatives have already been implemented and progress is being made on this entire issue. However, those initiatives to improve access must not circumvent the right of linguistic minorities to receive care in their language. The Committee believes that a legal guarantee will have to be provided somewhere out of a concern for fairness and equality, but also to reinforce the initiatives currently being implemented in the field. This was the observation made by the community associations that we heard, and by hospital administrators working in the field. The discussion must continue, and that is why the Committee is asking the Commissioner of Official Languages to make this a priority in the coming years.

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[25] *Evidence*, Standing Committee on Official Languages, Meeting No. 14, 37th Parliament, 2nd Session, 17 March 2003, (1610)

[26] *Maires de la péninsule acadienne c. Agence canadienne de l'inspection des aliments* (2003 FC 1048).

RECOMMENDATION 2

The Committees calls on the Commissioner of Official Languages to organize a national forum at which legal experts will publicly examine the best options for consolidating the legal bases of health services for linguistic minorities, including the possibility of adding a sixth principle, on linguistic duality, to the *Canada Health Act*. We request the Commissioner report to the Committee when she has completed her work.

CHAPTER 2: ACCESS TO HEALTH CARE IN BOTH OFFICIAL LANGUAGES: CURRENT INITIATIVES AND FUTURE PROSPECTS

The issue of health and social services in the language of the minority has become increasingly prominent in the past five years. The official language minority communities have made it a priority and the focal point of their political demands.

On the Francophone side, the decision by the Health Services Restructuring Commission of Ontario to close Montfort Hospital in February 1997, and the ensuing legal battle, have shed light on the problem of health care in French for minority Francophones in Canada. However, that issue had already been a concern for Francophone and Acadian communities for some time. In June 2001, the FCFAC coordinated the preparation of an exhaustive study entitled *Pour un meilleur accès à des services de santé en français*[27] [Toward Better Access to Health Services in French], which showed that between 50% and 55% of minority Francophones have little or no access to health services in French (see Table 1).

[27] FCFA du Canada. *Santé en français — Pour un meilleur accès à des services de santé en français* : *A study coordinated for the Consultative Committee for French-Speaking Minority Communities*, Ottawa, June 2001, p. viii.

TABLE 1
FRANCOPHONES WITH ACCESS TO HEALTH SERVICES IN FRENCH
BY POINT OF SERVICE
(AS A PERCENTAGE OF THE TOTAL NUMBER OF MINORITY FRANCOPHONES)

ACCESS TO SERVICES IN FRENCH				
Type of institution	None (less than 10% of situations)	Little (between 10% and 30% of situations)	Partial (between 30% and 90% of situations)	Full (more than 90% of situations)
Medical clinics	28.7%	25.5%	19.9%	25.9%
Community health centres	50.6%	3.9%	8.0%	37.1%
Home services	25.2%	24.8%	19.5%	30.5%
Hospitals	33.7%	19.3%	18.5%	28.5%

Source: FCFA du Canada. *Santé en français — Pour un meilleur accès à des services de santé en français*: *Study coordinated for the Consultative Committee for French-Speaking Minority Communities*, Ottawa, June 2001, p. 25.

In the Quebec Anglophone community, access to health and social services offered in English varies with a number of factors such as demographic weight, economic restrictions and changing government priorities. In the spring of 2000, the Missisquoi Institute conducted a survey of Quebec Anglophones' perceptions of the health and social services obtained in their language. While access to services in the Montreal administrative region was quite high, it was a problem in the regional Anglophone communities. When it appeared before our committee, the Quebec Community Group Network presented a table revealing that, in the regions where Anglophone communities represent less than 2.5% of the regional population, the percentage of health and social services accessible in English is quite low: Lower St. Lawrence (17.9%), Saguenay-Lac-Saint-Jean (16.3%), Quebec City (31.7%), Mauricie (22.8%), Chaudière-Appalaches (43.3%) and Lanaudière (41.1%). (See Table 2.)

The Association representing the Anglophone population of the Gaspé peninsula — the Committee for Anglophone Social Action — numbering some 10,000 or 10% of the population, commented on the results of the Missisquoi Institute Survey before the Committee. Whether prenatal care, palliative care or preventive medicine is involved, "[…] the [Gaspesian] English-speaking community is in crisis in terms of access to health services."[28]

[28] *Evidence*, Standing Committee on Official Languages, Meeting No. 38, 37th Parliament, 2nd Session, 21 October 2003 (1020).

It should be pointed out here that the right to health care and social services in English is recognized in Quebec as the result of amendments in 1986 to the Act respecting health services and social services. Article 15 of this legislation provides that "English-speaking persons are entitled to receive health services and social services in the English language."[29]

In 1999, the federal Health Minister, the Honourable Allan Rock, established a consultative committee for french-speaking minority communities (CCFSMC). A year later, a similar committee was organized for English-speaking minority communities (CCESMC). The two committees had the same mandate, to advise the federal Minister of Health on ways to support and assist each of the linguistic minorities in the field of health, in accordance with section 41 of the *Official Languages Act*. Each Committee was composed of individuals working in the field of health with expertise in the area.

[29] *Act respecting health services and social services*, R.S.Q., c. S-4.2, article 15.

TABLE 2

Use of English in various health and social service (H&SS) situations

Region	Doctor	CLSC	Info-Santé	Emergency room	Hospital overnight	Public long-term care	Private residence	Private nursing services	Community-based group	Aggregate service in English	Total service situations	% of services delivered in English	Index relative to provincial average	Regional rank	Use of English in H&SS situations, relative to provincial average
	English speakers receiving service in English (%)														
Quebec (province)	86	66	61	73	80	70	72	75	78	5,072	6,727	75.4	1.00	n/a	n/a
01 Bas-Saint-Laurent	26	6	31	28	n/a	n/a	n/a	n/a	n/a	13	72	17.9	0.24	15	very low
02 Saguenay-Lac-Saint-Jean	42	n/a	n/a	8	12	n/a	n/a	n/a	n/a	19	114	16.3	0.22	16	very low
03 Québec	52	21	21	20	27	43	18	n/a	21	59	187	31.7	0.42	13	very low
04 Mauricie-Centre-du-Québec	31	26	13	4	39	19	n/a	62	15	26	116	22.8	0.30	14	very low
05 Estrie	79	72	56	40	63	61	56	89	75	407	630	64.6	0.86	7	low
06 Montréal	93	74	69	83	83	75	73	82	80	1,861	2,255	82.5	1.09	2	high
07 Outaouais	92	68	42	69	74	67	70	69	45	347	473	73.4	0.97	4	average
08 Abitibi-Témiscamingue	54	43	27	59	63	50	82	100	100	119	215	55.6	0.74	10	very low
09 Côte-Nord	76	71	83	65	92	100	86	95	95	237	301	78.8	1.05	3	high
10 Nord-du-Québec	86	84	100	73	87	89	100	89	71	139	167	83.5	1.11	1	high
11 Gaspésie-Îles-de-la-Madeleine	83	70	60	58	60	66	65	82	74	279	402	69.5	0.92	6	low
12 Chaudière-Appalaches	49	46	70	14	44	67	100	n/a	56	34	78	43.3	0.57	11	very low
13 Laval	73	44	55	47	72	89	83	30	64	191	322	59.4	0.79	8	very low
14 Lanaudière	56	16	48	41	38	40	81	72	100	52	126	41.1	0.54	12	very low
15 Laurentides	64	43	43	49	56	52	65	97	67	186	334	55.7	0.74	9	very low
16 Montérégie	75	59	48	78	94	59	82	63	94	674	935	72.1	0.96	5	average

Notes:

1. Findings are based on 3,126 survey respondents.
2. The index is calculated by comparing the regional result with the provincial average.
3. The "high" use of English in health and social services situations in Region 10 is due to the particular organization of services in Cree and Inuit communities of northern Quebec.

Source: CROP and Missisquoi Institute survey on attitudes, experiences and issues for Quebec's Anglophone communities, June 2000.

Source: Consultative Committee for English-Speaking Minority Communities, Report to the Federal Minister of Health, July 2002, p. 12.

In its final report,[30] the CCFSMC recommended to the federal Minister of Health that **five levers of intervention** be implemented to improve the accessibility of French-language health care services.

- The implementation of community **networking** between representatives of the Francophone community, Francophone health professionals, officials of educational institutions, officials of health institutions, professional associations and political representatives. The networks should be used to establish priorities adapted to each community and ensure that the model put in place is compatible with the health system of the province or territory concerned. Note that Recommendation 28 of the report of the Commission on the Future of Health Care in Canada (Romanow Commission) supported the networking initiative.[31]
- The creation of a **Canada-wide consortium for training** in the health sciences to meet the shortage of professionals capable of serving Francophone communities. This national network of universities and colleges, community partners and community health care facilities would be given a mandate to act on strategies related to the recruitment and training of future health care professionals.
- The introduction of **intake facilities** for the delivery of health care services in French. The solutions adopted to improve access to health care services in French will depend on the specific circumstances in each community. The proposed models for delivering care are designed mainly for primary care, although specialized care is not overlooked.
- Increased use of new **technologies** to strengthen the patient-professional relationship and put an end to the geographic isolation of some communities. Development of the health information highway will make it possible to communicate with service points all over the country quickly and effectively using sound, images and data transmission. The new technologies could also be used to provide medical staff with training.
- Better access to **information** on the health of minority Francophones. It was agreed that it was necessary to gather more reliable information on the question. That would subsequently help in setting more specific targets for future programs and infrastructures as well as health promotion and disease prevention programs.

One year later, the CCESMC came to the same conclusions as the CCFSMC in its report to the federal Minister of Health, the Honourable Anne McLellan. The means of intervention that the Anglophone Committee proposed in its report to improve the accessibility of health care in English are similar in all respects to those put forward by

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[30] Consultative Committee for French-Speaking Minority Communities, *Report to the Federal Minister of Health*, September 2001, p. 49.

[31] Recommendation 28 states: “Governments, regional health authorities, health care providers, hospitals and community organizations should work together to identify and respond to the needs of official language minority communities.” See Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, Final Report, November 2002, p. 154.

the CCFSMC: networking and cooperation, training and human resources development, service delivery models, technology and strategic information.[32]

In their respective reports, the two consultative committees agreed to give priority to three of the recommendations: networking, training and primary health care. In the following pages, the reader will be able to see what progress has been made in those areas. Initiatives could also eventually be taken in information (research), although much work remains to be done. The persons responsible for implementing certain levers of intervention appeared before the Committee to discuss progress made, but also the challenges that remain to be met. Their comments are summarized below.

Networking

In their testimony of 27 May 2003, the officials of Société Santé en français presented a complete picture of the situation regarding health care in the minority language. The newly incorporated agency is a major stakeholder on the issue of health care in French outside Quebec. Société Santé en français is composed of delegates representing the five main partners in the health world: health institutions, community organizations devoted to health services, health professionals, training institutions and federal and provincial government representatives. The 17 networks representing all the provinces and territories where Francophones live in the minority are represented in Société Santé en français, which, in a way, constitutes a “national network”. Those provincial and territorial networks are organizations of individuals who represent the aforementioned five main partners. Organizational structures vary from region to region, reflecting varied resources and needs of the various communities. In a number of provinces, the networks were established in conjunction with measures confirming the will of the respective provincial governments to take part in that mechanism for joint action and to more fully recognize the health services needs of its Francophone minority.[33]

In 2002-2003, Health Canada[34] paid out $1.9 million to the Société Santé en français, which was used to introduce the networking initiative, to maintain existing networks and conduct feasibility studies to lay the ground work for the networks’ introduction and to create the national network to support the various priority initiatives. The Canadian government’s Action Plan for Official Languages has consolidated this

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[32] Consultative Committee for English-Speaking Minority Communities, *Report to the Federal Minister of Health*, July 2002, p. 21.

[33] The Government of Nova Scotia has just created the position of French-language services coordinator in the Department of Health. The Department of Health of Prince Edward Island co-chairs that province's network. Ontario's Ministry of Health and Long-Term Care is considering matching its network of French-language service coordinators with the four networks created in that province. The Government of Newfoundland and Labrador has just announced a financial contribution to the operation of the province's network. In British Columbia, the provincial Ministry of Health and a number of regional boards are taking part in the network's activities. In Manitoba, a working group is attempting to determine the best approach to ensuring official recognition of the Francophone network within the provincial health system. The transition phase has made it possible to lay the ground work for networks in all provinces and territories.

[34] *Evidence,* Standing Committee on Official Languages, Meeting No. 24, 37th Parliament, 2nd Session, 28 May 2003 (1540).

action by providing funding in the amount of $10 million for Francophone networks and $4 million for Anglophone networks over the next five years.

Primary Care

Primary care is the first level of contact with the health system. It includes visits to the doctor, a call to a health line, promotional, prevention and rehabilitation services often called upon by health service users.

The CCFSMC made primary care a priority from the start of its work. In the health component of the Action Plan for Official Languages, $30 million has been allocated for 2003-2006 to support this lever of intervention. The funds come from Health Canada's Primary Health Care Transition Fund (PHCTF), a program introduced in 2000. Of PHCTF's total $800 million budget over five years, $20 million has been made available to Francophone minorities and $10 million to Quebec Anglophones, also over five years. We note here that that amount is less than the $25 million per year that the CCFSMC considered necessary in its September 2001 report to introduce infrastructures in which Francophones would be able to obtain first-line care.

Société Santé en français has already allocated the $20 million among the provinces and territories to show their members what kind of funding will be available at the provincial and territorial level. It will be up to the networks to establish the kind of projects they want to introduce, in accordance with PHCTF criteria.

However, Société Santé en français is concerned that the PHCTF will expire on 31 March 2006. While the Consortium national de formation en santé will receive funding until 2008 under the Action Plan for Official Languages, the projects put forward by the networks in the area of primary care may not have the necessary financial resources to remain in place if the PHCTF disappears. Access to permanent funding is perhaps the greatest challenge facing the networks in the coming years.

RECOMMENDATION 3

The Committee recommends the Government of Canada ensure that the funds it allocates to the linguistic minorities for primary care by the PHCTF are guaranteed at least until 2008 and permanently thereafter.

RECOMMENDATION 4

The Committee recommends to Health Canada that it submit an annual report on funds granted to minority language communities under the PHCTF so that Parliament and the players concerned may know precisely the level of performance and the amounts spent. The report should also provide a breakdown of the funds accorded by Health Canada for other levers of intervention proposed by the CCFSMC and the CCASMC.

Training

Access to services in the language of the patient is possible only where there is a sufficient number of professionals in the field to provide those services. Prior to 1999, health training programs in French were virtually non-existent. The creation of the National Health Training Centre in 1999 laid the ground work for continuing training in those disciplines outside Quebec. The second phase of that project is called the Consortium national de formation en santé (CNFS). That agency's mission is to implement a network of post-secondary institutions[35] in French to support both the training institutions that offer or could offer training in the health field and researchers who can reinforce health research relating in particular to the Francophone minority communities.

Under the Action Plan for Official Languages announced by the Government of Canada last March, CNFS obtained $63 million for the next five years (2003-2008) and the Quebec Anglophone community $12 million. The 10 participating institutions of the CNFS have set as their objective to admit approximately 2,500 students in 15 training disciplines where there is a linguistic interaction between patient and professional. A number of challenges lie in the way of achieving that objective: recruiting young Francophones, offering training programs in the regions and keeping new graduates at home. In addition, new graduates entering the labour market will ensure higher quality services in French, but will not meet needs, which according to CNFS officials, are for "three or even four times more professionals in the health field".[36] It will be important for CNFS officials to adequately assess results, in order to have an idea of the progress made on training at the end of this second phase. For example, it will be useful for the CNFS and decision-makers to have a fairly accurate idea of the costs involved in training a Francophone professional for various health professions along with indicators of the successful retention of professionals in their home community.

RECOMMENDATION 5

The Committee calls on the CNFS to develop performance indicators on the retention of health professionals in home community and to inform the Committee of those indicators.

Research

Mr. Christian Sylvain, Director, Corporate Policy and Planning, Social Sciences and Humanities Research Council of Canada (SSHRC), admitted that there was a lack

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[35] Université Sainte-Anne (Nova Scotia), Université de Moncton (New Brunswick), Entente Québec/Nouveau-Brunswick, Collège communautaire du Nouveau-Brunswick (Campbellton), Université d'Ottawa (Ontario), Cité collégiale (Ontario), Université Laurentienne (Ontario), Collège Boréal (Ontario), Collège universitaire de Saint-Boniface (Manitoba), and the Faculté Saint-Jean (Alberta).

[36] *Evidence,* Standing Committee on Official Languages, Meeting No. 36, 37th Parliament, 2nd Session, 7 October 2003 (0955).

of research on official languages.[37] Grants awarded for projects concerning official languages and linguistic minorities represent a small percentage of SSHRC's total budget, for a number of reasons. It is often more difficult for the smallest Francophone universities and colleges to get involved in major research trends. The teachers of those academic institutions must often devote most of their time to teaching, to the detriment of research. Furthermore, as Professor Anne Gilbert of the University of Ottawa's Centre interdisciplinaire de recherche sur la citoyenneté et les minorités francophones said, researchers who work on linguistic issues produce good research, but do not get the same recognition. Their work focuses more on understanding and solving social problems in the field, a form of action research which is very useful for the immediate community, but does not get the same recognition from funding organizations. To correct the situation, the SSHRC introduced the Community-University Research Alliances program (CURA) in 1999. According to Christian Sylvain of the SSHRC, the small Francophone colleges and universities are quite well-positioned in the first funding rounds of the CURA program.[38]

In addition, the Canadian government's Action Plan for Official Languages provides for the creation of a new strategic research field on the theme of "citizenship, culture and identity," which will offer funding for studies on linguistic duality and linguistic minorities. We hope that, in the next few years, these various measures will increase the amount of research conducted on linguistic minorities in general and on health related issues in particular.

RECOMMENDATION 6

The Committee recommends that the SSHRC pay particular attention, especially over the next five years, to research projects on health issues specific to the official language minority communities.

RECOMMENDATION 7

The Committee calls on the SSHRC to conduct renewed promotion of its programs to researchers in the official language minority communities.

The Canadian Institutes of Health Research (CIHR) are the main subsidizing body for research in the health field. The CIHR comprise 13 institutes, each operating in a specific field. When they testified before the Committee, the CIHR admitted that they had only just recently begun to take an interest in health care for official language minorities. Contact with the Anglophone and Francophone consultative committees (CCESMC and CCFSMC) is still in the early stages. It should be noted that the CIHR

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[37] *Evidence,* Standing Committee on Official Languages, Meeting No. 34, 37th Parliament, 2nd Session, 30 September 2003 (0930).

[38] *Evidence,* Standing Committee on Official Languages, Meeting No. 34, 37th Parliament, 2nd Session, 30 September 2003 (0945).

are considering supporting one of the 10 members of the Consortium national de formation en santé (CNFS)[39] in the coming months.

The Committee doubts the CIHR's seriousness in implementing the Canadian government's official languages programs and its involvement in research on the health of the official language minority communities. The 2002-2003 annual report on official languages submitted to the Treasury Board Secretariat reveals major deficiencies in various areas. For example, at the time this report is written, the position of "Official Languages Champion" has been vacant for six months and has not yet been staffed. And yet this is a strategic position in the federal public service. The champion is responsible for increasing the visibility of the official language program within the federal institutions and for acting as a high-level interlocutor for the official language minority communities.

For all these reasons, we believe that the CIHR must do more. The 13 institutes of the CIHR focus on the specific health priorities for a number of particular Canadian groups, and, based on the testimony before us, the health issues related to the linguistic minorities are simply absent from their strategic planning. An exhaustive study prepared for Health Canada in 2001 states that "specific Canadian research is needed in this area."[40]

The Committee believes that the CIHR should be added to the 29 institutions designated to ensure the implementation of sections 41 and 42 of the *Official Languages Act*. If necessary, it will be called upon to prepare an annual action plan, after first consulting the official language minority communities regarding their needs. In his appearance before our committee, Marc Bisby, Vice-President for research at CIHR, gave his approval to that proposal.[41] Now that health and social services are a priority for the official language minority communities, the Committee is firmly convinced that the CIHR has a preponderant role to play in the field. The dialogue that the Institutes have opened with the linguistic minorities is a good start, but we must ensure that those consultations are held at regular intervals and on an annual basis. The action plans that are developed will enable parliamentarians to ensure the necessary follow-up.

RECOMMENDATION 8

The Committee calls on the CIHR to appoint a new official languages champion as soon as possible and to inform the Appointments Committee.

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[39] *Evidence,* Standing Committee on Official Languages, Meeting No. 34, 37th Parliament, 2nd Session, 30 September 2003 (1025).

[40] Sara Bowen, *Language Barriers in Access to Health Care*, Study prepared for Health Canada, November 2001, p. VIII.

[41] *Evidence*, Standing Committee on Official Languages, Meeting No. 34, 37th Parliament, 2nd Session, 30 September 2003 (1045).

RECOMMENDATION 9

The Committee recommends that the Government of Canada add the CIHR to the list of federal institutions designated within the accountability framework adopted in August 1994 to ensure the implementation of sections 41 and 42 of Part VII of the *Official Languages Act*.

RECOMMENDATION 10

The Committee recommends that a fourteenth institute be created at the CIHR to explore all issues of health care related to official language minority communities.

New technologies (InfoHealth)

The use of new information and communications technologies (ICT) in the field of health care is often called telehealth or infohealth. The intent of telehealth is to share information among the various health care providers and facilities and to provide health services over short and long distances.[42] We have not considered this lever of intervention in depth in the context of our work, but recent developments permit us to view its future implementation optimistically. When he testified, the National Coordinator with Intergovernmental Francophone Affairs, Mr. Edmond LaBossière, noted the commitment by ministers of Francophone Affairs to make telehealth a priority. At the recent Ministerial Conference on Francophone Affairs held in Winnipeg in September 2003, the participating ministers adopted an intergovernmental action plan on Francophone affairs in connection with "opportunities for intergovernmental cooperation with respect to regional French-language health lines or a national French-language health line."[43]

To conclude this section, the Committee enthusiastically reviewed the various initiatives that have been taken in the past five years. For example, we note networking and the development of the CNFS, which may be cited as genuine models of joint action and team work. Despite the gains made to date, however, it is now necessary to think of the future. The levers of intervention cited above (networking, primary care, training, research and telehealth) will sooner or later have to face the challenges raised by the recurrent funding of these initiatives. The Canadian government's Action Plan for Official Languages has of course provided a promising start toward achieving the recommendations of both consultative committees. However, it should be borne in mind

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[42] The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians — The Federal Role, Volume two — Current Trends and Future Challenges*, January 2002, p. 110.

[43] Canadian Intergovernmental Conference Secretariat site: http://www.scics.gc.ca/cinfo03/830802004a_e.html

that the investments under the plan, which are spread over a five-year period, are relatively modest in proportion to Health Canada's overall budget. That is why the Committee believes it is more than ever necessary to make linguistic minority health care one of the issues addressed within the intergovernmental cooperation mechanisms existing between the federal and provincial governments in this sector. We address this question in the next chapter.

CHAPTER 3: INTERGOVERNMENTAL COOPERATION MECHANISMS IN THE HEALTH FIELD

In this chapter, we use the term "intergovernmental cooperation" to mean the sum of all relations instituted between the various levels of government of a federation to achieve common objectives.

Intergovernmental cooperation in official languages is generally recognized as being well-established. In education, since 1970, the federal government has signed bilateral agreements with each of the provincial and territorial governments (departments of education) and provides financial support to cover a portion of the additional costs incurred to provide instruction in the primary language. The Official Languages in Education Program was one of the Laurendeau-Dunton Commission's main recommendations. In addition, through the Department of Canadian Heritage, the Government of Canada also signs federal-provincial agreements on services in the minority language on a multi-year basis with the provincial and territorial governments in key areas for the development and vitality of the official language minority communities: the economy, justice, social services and recreation to name a few.

On September 23, Hilaire Lemoine, Director General, Official Languages Support Programs, at the Department of Canadian Heritage, provided some historical background on the Official Languages in Education Program (OLEP). In the past 30 years, the Program has evolved in accordance with the principles of mutual respect and partnership with the participating governments. Since 1998, the action plan approach including performance indicators has resulted in increased transparency and accountability in the Program's management. Mr. Lemoine closed his presentation by emphasizing that the Program had previously been cited "as a model of federal-provincial cooperation".[44]

In the course of the work by the Commission on the Future of Health Care in Canada (Romanow Commission), a number of Francophone associations[45] asked that an intergovernmental health cooperation program be created, similar to what currently exists in the education field. That request was reiterated by Anglophone and Francophone associations that appeared before us. Mr. Gilles Beaulieu, Vice-President of the Régie régionale de Beauséjour, N.B., supported such a proposal:

> This idea (creating an OLEP) goes in the same direction as our proposal to dedicate a special fund. Better still, your proposal ensures a framework and a

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[44] *Evidence,* Standing Committee on Official Languages, Meeting No. 32, 37th Parliament, 2nd Session, 23 September 2003 (0930).

[45] FCFA du Canada, *Brief Presented to the Commission on the Future of Health Care in Canada*, Regina, 4 March 2002.

> commitment of the various levels of government to develop health care services in a minority community. For minority language communities, an intergovernmental forum could certainly develop programs in the area of health promotion, disease prevention and training for Francophones in the health sciences. It would also allow for increased use of new technologies such as telemedicine and information technologies, and thus facilitate greater access to health care services for the Francophone population in a minority setting. Such an agreement would also allow health care institutions to maintain their assets and ensure their development.[46]

The Committee believes that OLEP is a practical model which could be drawn on in whole or in part to improve access to health care for linguistic minorities. We believe this proposal deserves careful study by the Government of Canada.

It is important, however, that the fundamental principles of such a program be based on those that have made OLEP a success. First the program will have to be introduced in a manner that respects the provinces' areas of jurisdiction, in accordance with the principles of mutual respect and equal partnership between governments. We would point out that the National Coordinator of Francophone Affairs, Edmond LaBossière, reminded the Committee that the provinces, territories and communities have achieved very different degrees of advancement with regard to health care in the language of the patient; a program of this kind would therefore have to afford all the necessary flexibility to accommodate differences in the field. The second principle that must be respected is constant participation by the official language minority communities at all stages of the process. The networks could play this role by identifying priorities in the field and adding value to program management. Third, the system's transparency and financial accountability will have to be ensured. The idea here is for taxpaying citizens to have an idea of the costs associated with offering health services in the minority language. Fourth, we believe that this kind of program should be administered by Health Canada given its natural expertise in the field. The decision to assign responsibility to that federal institution is consistent with the spirit and letter of section 41 of the *Official Languages Act*. We suggest that a memorandum of understanding be ratified between Health Canada and Canadian Heritage (PHC) along the lines of what already exists between the Treasury Board and PHC. We are referring here to the memorandum of understanding signed in 1997 between the Treasury Board and Heritage Canada for the implementation of section 41. That agreement serves to encourage federal institutions to take the government's commitment to promoting the vitality and development of the official language communities into account in their overall strategic planning and evaluation process.

Thus, as a result of the importance of health for the development and vitality of the linguistic minorities, the Committee on Official Languages believes that the entire issue of access to health care for the official language minorities, including the creation of the intergovernmental cooperation program, will have to be raised within two years in the context of future federal-provincial-territorial conferences of health ministers. Those

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[46] *Evidence,* Standing Committee on Official Languages, Meeting No. 35, 37th Parliament, 2nd Session, 1 October 2003 (1535).

talks will have to take place before the expiry date of the federal-provincial-territorial agreements on health in 2005-2006. It is time that this fundamental issue was addressed in the fora where the future of the health system is discussed.

RECOMMENDATION 11

The Committee calls on the Government of Canada to have one of the future federal-provincial-territorial conferences of health ministers focus primarily on the question of health care for linguistic minorities.

RECOMMENDATION 12

The Committee recommends that the Government of Canada create an intergovernmental cooperation program in the health field, a program to be managed by Health Canada which will provide financial support to the provincial and territorial governments in providing health care for the linguistic minorities. That program should be based on the following principles: respect for the provinces' areas of jurisdiction, equal partnership, participation of the community health networks and accountability.

Finance Canada, the CHST and the *Official Languages Act*

The Canadian Health and Social Transfer (CHST) is the largest transfer the federal government makes to the provinces and territories. It contributes to the funding of health care, post-secondary education, social assistance and social services in the form of cash payments and transfers of tax points. At the federal-provincial conference held in Toronto in January of this year for the renewal and long-term viability of health care, the prime ministers agreed to create the new Canada Health Transfer (CHT) in April 2004. The CHT, which will replace the CHST, will improve the transparency and accountability of federal aid to the provinces and territories. In all, $34.8 billion will be flowing into provincial health and social programs over the next five years.[47]

The CHST currently affords the provinces and territories a degree of independence in allocating payments among social programs based on their priorities, while complying with the principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility. Neither the present CHST nor the future CHT entails conditions respecting linguistic duality or the number of Anglophones or Francophones. Instead, the transfer is made in accordance with a complex formula based in part on the number of inhabitants per province, without regard to demo-linguistic statistics.

In addition, Finance Canada explained, when it appeared before our committee, that the CHST is governed by the *Federal-Provincial Fiscal Arrangements Act* and by

[47] *Evidence,* Standing Committee on Official Languages, Meeting No. 32, 37th Parliament, 2nd Session, 23 September 2003 (1020).

certain federal accounting regulations. When they appeared, the officials from Finance Canada were unable to confirm that the *Official Languages Act* applied to the CHST (apart from the obligation to make their documents available to the public in English and French). We remind the reader that the commitments stated in section 41 of Part VII of the *Official Languages Act* apply to all federal departments, agencies and Crown corporations.

The Committee believes that the prime ministers' 2003 Health Care Renewal Accord represented a fine opportunity for the Government of Canada to express the health care needs of the official language minority communities to its stakeholders. The Canadian government should give more attention to this issue in its future discussions with the provincial and territorial governments. Future agreements must not remain silent on this matter. For example, the needs of the official language minority communities should have been identified a priority sector in the new Health Reform Fund.[48] The same applies to the future Health Council, which will be created in the next few months to facilitate co-operation among governments We recommend that members of the official languages minority communities be represented on it.

RECOMMENDATION 13

In the light of the prime ministers' 2003 Health Care Renewal Accord, in which a fund of $16 billion was set up to support reform to health care and in which front-line health care, home care and the skyrocketing costs of prescription drugs were targeted specifically, the Committee recommends that the Government of Canada target as well health care in minority language communities in the current agreement and in future ones.

RECOMMENDATION 14

The Committee recommends the Government of Canada ensure the official language minority communities are represented on the Health Council.

Conclusion

A number of initiatives have been put forward in recent years to improve health care for the linguistic minorities. The communities themselves have adopted the issue as their own. In every province, the networks are in place or are being established. The Consortium national de formation en santé is functional and has been turning out graduates in the health science professions for a number of years now. It is also important to refute the myth that it necessarily costs more to provide health care in the language of the patient. We quote here the testimony of the President and CEO of the Montfort Hospital, Mr. Gérald Savoie, who is quite eloquent in this regard.

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[48] This new fund provides for investments of $16 billion in primary health care, home care and coverage of prescription drugs.

> I can tell you that Montfort hospital is the most efficient hospital in Ontario. We are being compared with the other 138 hospitals. We provide services in both languages, namely, in the language chosen by the client. […] We were able to demonstrate that we are capable of providing all of that at a very affordable price.[49]

However, although considerable progress has been achieved, the situation remains fragile and vulnerable to political change. The Standing Committee on Official Languages wishes to reiterate the importance of stable, long-term commitment by governments to ensure that the initiatives currently in place are sustained. Ideally, access to health care for the linguistic minorities should be protected or reinforced by firm and clear statutory provisions.

[49] *Evidence,* Standing Committee on Official Languages, Meeting No. 35, 37th Parliament, 2nd Session, 1 October 2003 (1640).

LIST OF RECOMMENDATIONS

CHAPTER 1: THE CONSTITUTIONAL AND LEGAL BASES OF HEALTH CARE IN BOTH OFFICIAL LANGUAGES

RECOMMENDATION 1

The Committee calls on the Commissioner of Official Languages to investigate whether the Government of Canada is complying with the *Official Languages Act* when it is required to provide care directly to certain groups or communities or, again, whether it ensures its obligations are met when it transfers its responsibilities to third parties. We ask the Commissioner to report to the Committee following her investigation.

RECOMMENDATION 2

The Committees calls on the Commissioner of Official Languages to organize a national forum at which legal experts will publicly examine the best options for consolidating the legal bases of health services for linguistic minorities, including the possibility of adding a sixth principle, on linguistic duality, to the *Canada Health Act*. We request the Commissioner report to the Committee when she has completed her work.

CHAPTER 2: ACCESS TO HEALTH CARE IN BOTH OFFICIAL LANGUAGES: CURRENT INITIATIVES AND FUTURE PROSPECTS

RECOMMENDATION 3

The Committee recommends the Government of Canada ensure that the funds it allocates to the linguistic minorities for primary care by the PHCTF are guaranteed at least until 2008 and permanently thereafter.

RECOMMENDATION 4

The Committee recommends to Health Canada that it submit an annual report on funds granted to minority language communities under the PHCTF so that Parliament and the players concerned may know precisely the level of performance and the amounts spent. The report should also provide a breakdown of the funds accorded by Health Canada for other levers of intervention proposed by the CCFSMC and the CCASMC.

RECOMMENDATION 5

The Committee calls on the CNFS to develop performance indicators on the retention of health professionals in home community and to inform the Committee of those indicators.

RECOMMENDATION 6

The Committee recommends that the SSHRC pay particular attention, especially over the next five years, to research projects on health issues specific to the official language minority communities.

RECOMMENDATION 7

The Committee calls on the SSHRC to conduct renewed promotion of its programs to researchers in the official language minority communities.

RECOMMENDATION 8

The Committee calls on the CIHR to appoint a new official languages champion as soon as possible and to inform the Appointments Committee.

RECOMMENDATION 9

The Committee recommends that the Government of Canada add the CIHR to the list of federal institutions designated within the accountability framework adopted in August 1994 to ensure the implementation of sections 41 and 42 of Part VII of the *Official Languages Act*.

RECOMMENDATION 10

The Committee recommends that a fourteenth institute be created at the CIHR to explore all issues of health care related to official language minority communities.

CHAPTER 3: INTERGOVERNMENTAL COOPERATION MECHANISMS IN THE HEALTH FIELD

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APPENDIX A
LIST OF WITNESSES

Associations and Individuals	Date	Meeting
"Fédération des communautés francophones et acadienne du Canada"	27/05/2003	23
Georges Arès, President		
Diane Côté, Liaison Officer		
"Société Santé en français"		
Hubert Gauthier, President		
Armand Boudreau, Director general		
Department of Health	28/05/2003	24
Marcel Nouvet, Assistant Deputy Minister, Information, Analysis and Connectivity Branch		
Gigi Mandy, Director, Intergovernmental Affairs Directorate, Health Policy and Communications Branch		
Quebec Community Groups Network	11/06/2003	28
James Carter, Coordinator, Community Health and Social Services Network		
Sara Saber Freedman, Researcher, Missisquoi Institute		
"Fédération des associations de juristes d'expression française de common law"	16/09/2003	30
Tory Colvin, President		
Rénald Rémillard, Executive Director		
University of Moncton		
Pierre Foucher, Law professor		
University of Ottawa		
Martha Jackman, Titular Professor, Faculty of Law		
University of Ottawa	17/09/2003	31
André Braën, Law Professor		
Department of Canadian Heritage	23/09/2003	32
Hélène Cormier, Director, Policy, Official Languages Support Programs		
Hilaire Lemoine, Director General, Official Languages Support Programs		

Associations and Individuals	Date	Meeting
Department of Finance Glenn R. Campbell, Chief, CHST and Policy Development Federal-Provincial Relations and Social Policy Branch Krista Campbell, Senior Policy Analyst, CHST and Policy Development, Federal-Provincial Relations and Social Policy Branch Martine Lajoie, Senior Policy Analyst, CHST and Policy Development, Federal-Provincial Relations and Social Policy Branch	23/09/2003	32
Canadian Institutes of Health Research Mark Bisby, Vice-President, Research Michèle O'Rourke, Strategic Initiatives Associate, Institute of Health Services and Public Research	30/09/2003	34
Social Sciences and Humanities Research Council of Canada Anne Gilbert, Professor, Department of Geography, University of Ottawa; Research Director, Interdisciplinary Research Center on Citizenship and Minorities Christian Sylvain, Director, Corporate Policy and Planning		
Montfort Hospital Gérald Savoie, President and CEO	01/10/2003	35
"Régie régionale de la santé Beauséjour" Gilles Beaulieu, Vice-President, Operation and Planning		
"Consortium national de formation en santé" Pierre Gaudet, Director General François Houle, Assistant Vice-Rector Academic, University of Ottawa	07/10/2003	36
Office of the Commissioner of Official Languages Dyane Adam, Commissioner Gérard Finn, Advisor to the Commissioner Johane Tremblay, Director, Legal Services Branch Guy Renaud, Director General, Policy and Communications Branch Michel Robichaud, Director General, Investigations Branch	08/10/2003	37
Committee for Anglophone Social Action Kim Harrison, Executive Director Stella Kennedy, Board Director, Health and Social Services, Social Worker, "Centre Jeunesse Gaspésie-Les Îles"	21/10/2003	38
Intergovernmental Francophone Affairs (Provinces and Territories of Canada) Edmond LaBossière, National Coordinator		

APPENDIX B
LIST OF BRIEFS

“Assemblée des aînées et aînés francophones du Canada”

“Chambre économique de l’Ontario”

Committee for Anglophone Social Action

“Fédération des communautés francophones et acadienne du Canada”

“Fédération Franco-TéNOise”

“Fédération nationale des femmes canadiennes-françaises”

French Language Health Services Network of Eastern Ontario

Victor Goldbloom

Marjorie Goodfellow

Quebec Community Groups Network

“Réseau fransaskois santé en français”

“Société des Acadiens et Acadiennes du Nouveau-Brunswick”

APPENDIX C
LETTER TO THE CHAIR FROM THE MINISTERS OF HEALTH AND INTERGOVERNMENTAL AFFAIRS

Mr. Mauril Bélanger, Chair
Standing Committee on Official Languages
Room 835, Confederation Building
House of Commons
Ottawa, ON KIA 0A6

Dear Mr. Bélanger,

This letter is in relation to the study being undertaken by the Standing Committee on Official Languages further to the motion adopted by the House of Commons to have the Committee study the subject matter of Bill C-202.

In undertaking such a study, it would be useful for the Committee to hear from the minority official language communities from across the country as well as from provincial and territorial authorities most affected.

Health care has emerged as a particular priority for minority language communities. This Government has demonstrated its commitment to meeting the challenges these communities face by the announced investment of $119 million over five years in the community health sector. To further these efforts, it would be helpful for the Committee to explore alternative mechanisms to foster improved access to health care for these communities.

We will follow with interest the work of the Committee and look forward to receiving its findings and recommendations.

Yours truly,

Original signed by:
A. Anne McLellan
Minister of Health

Original signed by:
Stéphane Dion
Minister of Intergovernmental Affairs

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests the government to table a comprehensive response to this report.

A copy of the relevant Minutes of Proceedings, (*Meetings Nos. 23, 24, 28, 30, 31, 32, 34, 35, 36, 37, 38 and 39 which includes this report*) is tabled.

Respectfully submitted,

Mauril Bélanger, M.P.
Chair

SUPPLEMENTARY OPINION TO THE REPORT OF THE STANDING COMMITTEE ON OFFICIAL LANGUAGES BY THE BLOC QUÉBÉCOIS

The Bloc Québécois deems it appropriate to append a supplementary opinion to this report in order to clarify some of the positions proposed therein. The Bloc is pleased to have been a committed participant in the meetings of the Committee and to have contributed to the debates held there. The recommendations overall are in keeping with what the Bloc Québécois considers should be the spirit of this report, more specifically, as regards respect for provincial jurisdictions. The Bloc does, however, consider it appropriate to make the following points.

Creation of a 14th institute of health research

RECOMMENDATION 10

The Committee recommends that a fourteenth institute be created at the CIHR to explore all issues of health care related to official language minority communities.

The Bloc Québécois usually opposes the existence of the Canadian Institutes of Health Research (CIHR), because they are an obvious example of encroachment in an area under Quebec's jurisdiction. Their existence must, nevertheless, be acknowledged. We can recognize a certain importance and validity to the creation of a fourteenth CIHR Institute, which would focus more on access by francophone minorities outside Quebec to health care in their language.

Although the Bloc Québécois continues to oppose the objectives promoted by the Government of Canada through the CIHRs, we recognize the importance of francophone minorities outside Quebec having access to health care in their own language.

"National" Health Council

RECOMMENDATION 14

The Committee recommends the Government of Canada ensure the official language minority communities are represented on the Health Council.

As indicated by the Government of Quebec in September 2003, Quebec will not be involved in the creation of the National Health Council and will not sit on it, since an agency with a similar mandate exists already in Quebec: the Conseil du bien-être et de la

santé, and the Government of Canada's creation of a "national" council is blatant encroachment in a field of jurisdiction of Quebec and the provinces.

The Bloc Québécois is pleased at recommendation 14, because it permits francophone minorities outside Quebec to be fairly represented on the future council. The Bloc Québécois recognizes as well the importance the Committee wishes to attach to respect for the official languages in this context.

Finally, the Bloc Québécois supports the Government of Quebec's intention to share information and work with the federal government's health council. The Bloc Québécois continues, however, to oppose any participation by Quebec in the council created by Ottawa.

In conclusion, the Bloc Québécois would like to point out the importance of the evidence given before the Committee in recent weeks to the members of the Committee

Benoît Sauvageau
MP for Repentigny
Bloc Québécois critic
for official languages and Canadian and
international Francophonies

MINUTES OF PROCEEDINGS

Wednesday, October 29, 2003
(*Meeting No. 39*)

The Standing Committee on Official Languages met *in camera* at 4:03 p.m. this day, in Room 112-N Centre Block, the Chair, Mauril Bélanger, presiding.

Members of the Committee present: Carole-Marie Allard, Mark Assad, Mauril Bélanger, Eugène Bellemare, John Bryden, Yvon Godin, Benoît Sauvageau, Raymond Simard and Yolande Thibeault.

In attendance: *Library of Parliament*: Marion Ménard, Analyst.

The Committee commenced consideration of a draft report concerning its study on the subject matter of Bill C-202 and on access to health care in both official languages.

It was agreed, — That the draft report, as amended, be adopted as the Ninth Report of the Committee.

It was agreed, — That the report be entitled: *Access to Health Care for the Official Language Minority Communities: Legal Bases, Current Initiatives and Future Prospects*.

It was agreed, — That the Committee append to its report dissenting or supplementary opinions from the opposition parties provided that they are no more than two pages in length and submitted electronically to the Clerk of the Committee, no later than 12:00 p.m., on October 30, 2003.

It was agreed, — That the Chair, Clerk and researchers be authorized to make such grammatical, translation and editorial changes as may be necessary without changing the substance of the report.

It was agreed, — That, pursuant to Standing Order 109, the Committee request that the government table a comprehensive response to the report.

It was agreed, — That, in addition to the 550 copies printed by the House, the Committee print 450 additional copies of the report on *Access to Health Care for the Official Language Minority Communities: Legal Bases, Current Initiatives and Future Prospects* with a special cover.

It was agreed, — That the Chair present the report to the House.

It was agreed, — That the work of the Committee be communicated to the public by a news release.

At 4:52 p.m., the Committee adjourned to the call of the Chair.

Marc-Olivier Girard
Clerk of the Committee