FOR LINGUISTICALLY AND CULTURALLY ADAPTED HEALTH SERVICES

Linguistic accessibility is a determinant of the quality and security of health services

Report on the studies:

Standards for culturally and linguistically appropriate services in health: an exploratory study of American standards and Study on linguistically and culturally adapted health services: a Pan-Canadian portrait

The *Société Santé en français* and its member networks work in favor of improved access to linguistically and culturally adapted services for Francophones living in a minority context. The Société and its networks recently initiated work to develop a comprehensive global strategy, adapted to different intervention environments, and leading towards the implementation of Canadian standards for linguistically and culturally competent care in health facilities. The present documents represent a part of this work.

Note: The present document was translated from the original French version. The two Studies were conducted in 2011 and 2012. Certain references and links may have changed or no longer be available on the internet. When possible, references were made to the English version of documents.

The Société Santé et Mieux-être en français of New Brunswick (SSMEFNB) and the Société Santé en français (SSF) wish to particularly express their appreciation to members of the steering committee, Annie Bédard, Jacinthe Desaulniers, Monique Langis, Caroline Vézina and Gilles Vienneau, and to all the other persons who offered advice and gave of their time for revision of the content.

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STUDY ON LINGUISTICALLY AND CULTURALLY ADAPTED HEALTH SERVICES:

a Pan-Canadian portrait

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SULTREM INC.

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We wish to extend our appreciation to the members of the steering committee: Annie Bédard, Jacinthe Desaulniers, Monique Langis, Caroline Vézina and Gilles Vienneau whose expertise and advice contributed to the realisation of this study.

Note: The present document was translated from the original 2012 French version. Certain references and links may have changed or no longer be available on the Internet. When possible, references were made to the English version of documents.

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EXECUTIVE SUMMARY

The Canadian health care system is characterised by a constant desire to ensure the quality and safety of the care and services provided. It is within this context of quality and safety that the current study positions the issue of linguistic access to health services in French for Francophone and Acadian minority communities in Canada.

This study provides a global overview of health systems in Canada in order to increase understanding of the context within which the development of health services in French in a linguistic minority setting is situated. The study also presents the approaches and practices which could enrich future reflection on the pertinence of adopting standards on linguistic and cultural accessibility in the area of health care.

The term "cultural and linguistic competency" refers to the capacity of an organisation and its staff to offer competent care and to communicate effectively with clients of diverse backgrounds

Normative Approach

Standards have become necessary in the health sector, perhaps more so than in any other area of human activity. They prescribe the rules, directives or characteristics necessary to guarantee optimal quality of a product or a service. Standards may take various forms: laws, codes, protocols, regulations, directives or conventions.

The American standards for culturally and linguistically appropriate health services (CLAS standards) have stimulated the interest of the *Société Santé en français* and of its Networks and were the subject of a previous study.[1] The present study seeks to continue this reflection with the goal of examining the pertinence of adopting a normative approach within the context of health systems in Canada.

The ultimate goal of the CLAS standards in the United States is to improve the delivery of health services to minority populations of diverse racial and ethnic origins in order to reduce health disparities. The CLAS standards are composed of fourteen directives, recommendations or requirements which serve to inform, guide and facilitate the implementation of culturally and linguistically appropriate services by health establishments and professionals.

The Quality Approach in the Canadian Health System

The goal of the Canadian health insurance system is to ensure that all Canadians have reasonable access to necessary hospital and medical services without having to pay directly for these services.

Canadians want a viable healthcare system which provides timely access to quality services. The same is true for Canadian Francophone and Acadian communities living in a linguistic minority setting.

Core principles of the Canadian health system

1. Universality
2. Accessibility
3. Portability
4. Comprehensiveness
5. Public Administration

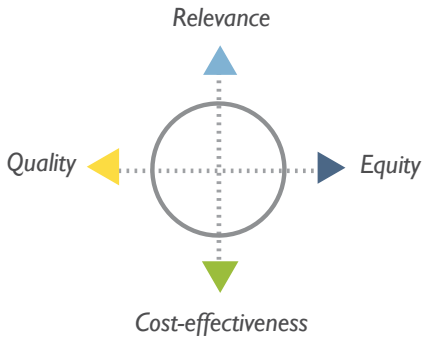
From the time of its creation, the movement *Santé en français* adopted the World Health Organisation's (WHO) global health approach which defines improvement in personal state of health as the reason for the existence of a health care system.

According to the WHO, this approach places four important dimensions of a health system in inter-relation as depicted in the health compass diagram[2]: relevance, quality equity and cost effectiveness. Within a system founded upon a client-centered approach, the concept of quality is influenced by client expectations which evolve with a client's ability to understand the impact of determinants of good and poor health and to judge what applies best according to one's circumstances.

[1] *Standards for culturally and linguistically appropriate services in health: an exploratory study of American standards,* Tremblay S., Prata G., Société Santé et Mieux-être en français du Nouveau-Brunswick, 2011.

[2] Towards unity for health: challenges and opportunities for partnership in health development: a working paper / Charles Boelen – WHO. Geneva, 2002.

THE HEALTH COMPASS[2]



Canadian Standards Organisations

In Canada, two organisations stand out with regard to the development of standards pertaining to evaluation of the quality and safety of health services within establishments, programs and amongst health professionals. They are:

- Accreditation Canada;
- The Canadian Institute for Patient Safety.

Recognising the importance of communication in the patient/professional relationship, these two normative organisations adopted standards in this area, without however rendering explicit any measures to be undertaken in order to reduce linguistic barriers and their impact upon the issue of informed consent.

Political Environment

Linguistic duality is a reality which is at the core of the Canadian nation. Canada has two official languages, one federal linguistic policy and separate linguistic policies within each of its ten provinces and three territories. In 1982, a Constitutional Law, the Canadian Charter of Human Rights and Freedom, established English and French as the two official languages of Canada.

When the Federal government transferred powers in a number of areas to the provinces and territories, including jurisdiction over health, no provisions were made for linguistic guarantees. The delivery of services in the language of minority communities was thus associated with provincial laws, policies and norms. Within this context, the Francophone population does not enjoy the same rights nor have access to the same services across all provinces and territories. The degree of protection afforded to the official minority language is generally proportional to the level of services offered in that language.

Health as a Provincial Jurisdiction

Canada has a national health insurance system encompassing thirteen distinct provincial and territorial health plans which, however, share certain common characteristics and basic safety standards.

The principles regulating the Canadian health care system reflect Canadian values and are defined within the Canadian Health Act. Federal, provincial and territorial governments collaborate on a number of policies and programs relating to health.

Among the mechanisms for collaboration, the 1990 Federal-Provincial accord on health established the basis of federal financing, the national standards and the objectives of the national health policy.

The Ministerial Conference on the Canadian Francophonie is an organisation for intergovernmental collaboration which acts in support of the health priorities of French-speaking communities and other areas of interest to them.

The Health System

Health systems are extremely complex structures which reflect the organisation and the values of the societies within which they were developed. The Canadian health system is in evolution, transitioning from a curative approach to one that is more focused on the patient and on primary level health services.

In a comparative study of the structures and characteristics of different health systems, Snowden and Cohen (2011) described the Canadian health system as a state owner-operator model characterized by a universal healthcare system, that is, a system where all citizens have access to health services regardless of their financial situation, as well as a decentralised system giving provinces responsibility for the organisation and delivery of health services.[3]

[3] Snowden, A. et Cohen, J. *Strengthening Health Systems Through Innovation: Lessons Learned.* International Centre for Health Innovation, 2011.

A lack of consolidated strategies for the organisation and delivery of health services at a national level, the limited power afforded to Canadian consumers in the selection of their health services and the quasi-absence of competition amongst health service providers are among the factors which influence all dimensions of the Canadian health system. Snowden and Cohen (2011) point out that the Canadian health system tends to promote a sense of passivity amongst consumers who have little decisional power as regards to the choice of their health care services and providers.

A major challenge to the sustainability of the Canadian health system will be the ability to evolve towards innovative models which promote self-determination and community responsibility for chronic disease management, particularly for the adoption of healthy lifestyles and the well-being of citizens. Many initiatives to increase linguistic accessibility implemented by the *Santé en français* Networks and Francophone and Acadian minority communities are oriented towards the promotion of self-determination for health among members of these communities.

Declining birth rates and an aging population are also factors which threaten the vitality and economic situation of Canadians. Declining birth rates are partially offset by immigration rates which have increased over the last decade. The Canadian health system is influenced by these transformations of Canadian society on two levels:

- Health system clients have increasingly diverse cultural backgrounds and may present with very complex health needs;
- The health system has a culturally diverse workforce often educated outside of Canada within very diverse educational systems.

Conceptual Framework

Our study proposes a conceptual framework which establishes relationships between the different levels of influence on the health system in order to better situate practices which favor linguistically and culturally adapted services.

All interventions, from the simplest to the most complex, have an effect upon the system as a whole, which in turn has an effect upon each of the interventions implemented.[4]

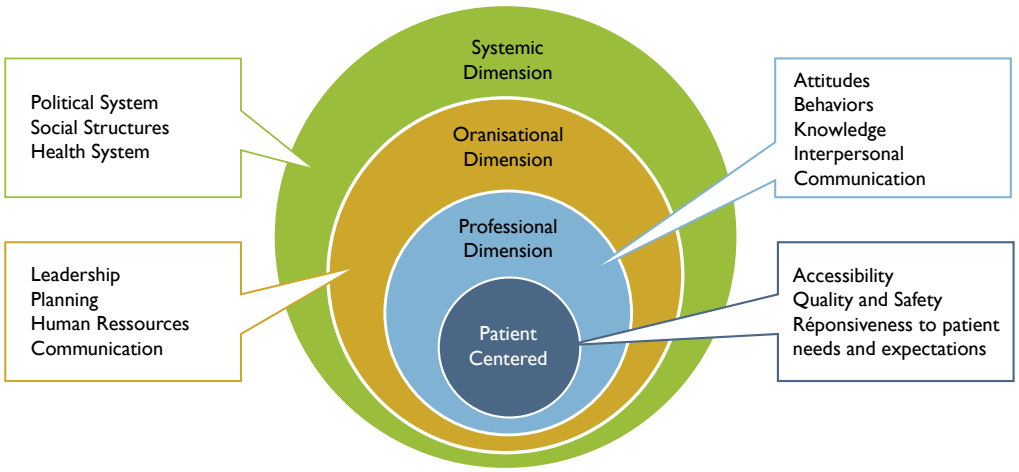
This graphic representation of the client-centered conceptual framework recognises the importance of acting upon each dimension of the health system in order to effect the changes required for linguistic accessibility and cultural competency for Francophone minority communities.

Approaches and Observations: Dimensions of the Conceptual Framework

For each of the approaches or practices identified in this report, concrete examples are presented and the provinces from which the examples originate are identified. General observations are made which enable relationships between linguistic accessibility to services and implementation of different measures to be identified.

- In Canada, linguistic duality is a reflection of history, rights and law. Each province or territory has adopted its own approach to linguistic accessibility;
- In the area of health, authority was decentralised to the provinces and no constitutional provision was foreseen to guarantee the rights of official language minorities;
- There is a direct link between the presence of a provincial legislative framework for French language services and the development of approaches addressing linguistic accessibility.

CONCEPTUAL FRAMEWORK



[4] *Campbell S. Pour une approche systémique du renforcement des systèmes de santé.* Alliance pour la recherche sur les politiques et les systèmes de santé, OMS 2009.

SYSTEMIC DIMENSION

- The approaches identified focused mainly upon linguistic accessibility with few measures identified for cultural adaptation. Cultural competency initiatives identified were most commonly associated with newly arrived residents and Aboriginal communities.
- A legislative or regulatory framework for French language services is required in order to assure the sustainability of a significant offer of services which is integrated within each province.
- There exist a variety of provincial systemic approaches designed to facilitate access to French-language health services. No single approach works in isolation. The combination of more than one approach contributes to a more significant offer of French-language services.

THE APPROACHES

I. Active Offer of Services
II. Designation
III. Service Access Plans or Programs
IV. Provincial coordination mechanisms and positions
V. Planning Entities
VI. Provincial or regional linguistic accessibility services (interpretation)
VII. *Santé en français* Networks

ORGANISATIONAL DIMENSION

- The existence of Francophone or bilingual primary health care establishments facilitates the health care management of Francophone clients and contributes to the integration of French-language services within the health system.
- The challenges associated with linguistic accessibility for minority communities are amplified at the secondary, tertiary and specialised levels of healthcare service. Access to French-language services largely depends upon the availability of professional staff able to express themselves in French.
- Linguistic access and interpretation services do exist but appear to be infrequently utilised by Francophone communities in certain regions, a fact which may indicate that these services fail to meet their specific needs.
- The limited capacity of health systems to adapt to cultural and linguistic needs will likely be accentuated in the future as a result of the demographic changes in Canada and may lead to the creation of parallel structures which are poorly integrated within the health system.

THE APPROACHES

I. Francophone University Hospitals
II. Francophone community Health Centers
III. Designated and bilingual establishments and organisations
IV. Establishments created as a result of initiatives of cultural communities
V. Linguistic modalities for adaptation of the offer of services

PROFESSIONAL DIMENSION

- No explicit standards appear to exist which would provide a framework for examining communication between individuals belonging to a linguistic minority population and health professionals.
- The best services are provided by bilingual or French-speaking employees. Language training efforts are required targeting professionals who already have a certain linguistic capacity in French. However, language training alone will not be sufficient to meet demand in the Canadian context.
- Sensitization to cultural diversity is an issue of increasing interest to governments, health establishments and professional associations.
- The lack of systematic data collection on linguistic competencies of health care providers and professionals continues to be a significant problem for the planning and organisation of linguistically adapted services.

THE APPROACHES

I. Promotion and awareness of culturally and linguistically adapted practices.
II. Language training and support for linguistic competencies
III. Direct support for professional activities
IV. Identification of professionals able to offer services in French

AN ACTIVE OFFER OF SERVICES IS AN IMPORTANT PRACTICE WHICH ENCOMPASSES THE THREE DIMENSIONS OF THE HEALTH SYSTEM AND WHICH IS GROUNDED IN BOTH LINGUISTIC AND CULTURAL CONSIDERATIONS.

PROMOTION OF LINGUISTIC ACCESSIBILITY IN HEALTH

In general, access to a significant offer of services in French within a minority context, as observed in this study, is a reflection of a hierarchical approach wherein each step serves as a foundation for the following step.

THE ROLE OF THE SANTÉ EN FRANÇAIS NETWORKS

The study has enabled confirmation of the important role which communities can play in the area of health. We observed a link between an increase in French-language services in the provinces and the actions of the networks and communities on the front line. Even in provinces where the offer of services remains weak, the initiatives and projects put forth by the *Santé en français* Networks are a reflection of community engagement towards action to improve their access to health services. However, results remain difficult to quantify in the absence of data associated with linguistic accessibility.

THE ROLE OF HEALTH STANDARDS

A normative approach represents a strong impetus for situating the discussion on linguistic and cultural accessibility within a context which reflects values central to health organisations and professionals, namely quality, efficiency and safety of services.

THE AMERICAN CLAS STANDARDS

American standards for culturally and linguistically appropriate services have favored the development of modalities for linguistic accessibility within health establishments in the United States. These standards also define the notion of cultural and organisational competencies. The CLAS standards encompass, within the same framework, three themes which are essential for the improvement of services to minority populations and to the reduction of health disparities, namely:

- Culturally competent care
- Modalities for linguistic accessibility
- Key components of organisational support for cultural competency

We find certain elements of CLAS standards in many systemic approaches described in this report. The criteria for an active offer of services in Manitoba correspond particularly well to the CLAS standards on linguistic accessibility.

Standards and accreditation organisations

The CLAS standards have served as powerful leverage to influence American national health accreditation organisations that have gradually adopted the principles underlying the CLAS standards and adapted their own standards to encompass issues of communication and cultural and linguistic competencies in health.

Using the CLAS standards as a source of inspiration along with the criteria for an active offer of services and for designation, discussions could be undertaken with Accreditation Canada, the Canadian Institute for Patient Safety and other agencies representing health professionals in order to render existing standards more explicit regarding linguistic competence and the reduction of language barriers in the health sector. Such an initiative was launched in 2007 by the *Santé en français* Network in Prince Edward Island and remains a promising avenue to explore in 2012.

Conclusion

In order to ensure the quality and safety of health services, governments, managers and professionals must take into account the existence of language barriers which not only represent an obstacle to accessibility but also an opportunity to realise gains in efficiency and effectiveness in the delivery of health services.

Different approaches have been developed and implemented in the provinces and territories in order to ensure a linguistically adapted offer of services. In the absence of such modalities or specific sites offering services in French, the offer of services remains limited.

The *Santé en français* Networks play a leading role in the identification of solutions adapted to the Canadian reality. Over the last decade, Francophone and Acadian communities in Canada have demonstrated their capacity to organise themselves, to create partnerships and to implement creative solutions which enable them to actively participate in improving their health.

As for the normative approach, it has proven itself in the United States and continues to generate progress in the understanding of the impact of linguistic and cultural barriers on health. A normative approach combined with different modalities put into place to favor linguistic access could be a promising future path to follow in Canada.

In Canada, the use of standards for cultural and linguistic competencies in health represents an innovative approach. Their integration within explicit and recognised national standards and within the codes of ethics of health professionals could have a positive impact on the quality and safety of health services.

INTRODUCTION

In order to enrich a reflection on the pertinence of adopting linguistic and cultural accessibility standards in the health sector, the *Société Santé et Mieux-être en français du Nouveau-Brunswick (SSMEFNB)* retained the services of the firm Sultrem Inc. to conduct a study with the objective of developing a pan-Canadian portrait of linguistically and culturally adapted services.

This report is a continuation of the reflection on linguistic and cultural competency standards initiated in a previous study entitled *Standards for culturally and linguistically appropriate services in health: an exploratory study of American standards*[1]. The previous report provided insight into the American environment in which standards were developed, as well as an overview of some Canadian institutions or programs which could play a role in the implementation of similar standards in Canada.

Based upon a theoretical framework and a review of existing approaches and practices in Canada, the present study will present findings, key factors and avenues for exploration which allow continued discussion. The purpose of this report is not to provide proof of the existence of linguistic and cultural barriers in accessibility to health care, but rather to identify and examine current practices in Canada which contribute to reducing these barriers.

The health system in Canada is characterized by a constant preoccupation with ensuring the quality and safety of health care and services. The present study situates the question of linguistic accessibility for Francophone and Acadian communities in Canada within a context of quality and safety of health services.

Objectives of the pan-Canadian study :

- Provide a global perspective of the Canadian health care system in order to better understand the context in which the development French-language health services for minority community is situated and the manner in which the concepts of linguistic and cultural adaptation can be integrated;
- Provide a situational update using a conceptual framework (integrative model) of the concept of linguistically and culturally appropriate health services;
- Present developments and exemplary and promising practices in Canada;
- Share observations and findings to enrich reflection on the issue of standards for linguistically and culturally adapted health services.

Methodology

We reviewed the literature on the characteristics of the Canadian health care system, the most recent studies on linguistic and cultural adaptation in health care in Canada and exemplary practices primarily involving the offer of French-language health services in Canada. A survey of relevant websites, including government websites and those of the *Société Santé en français* (The *Société*) Networks, allowed us to enrich the information collected.

In order to gain a better understanding of certain realities which are insufficiently documented, we also gathered information from the Executive Directors of the *Santé en français* (SSF) Networks and conducted interviews with key stakeholders.

A theoretical framework was proposed to take into account factors having an influence upon the health system and the offer of French-language services. Lastly, an exchange took place with members of the steering committee in order to validate the framework of this study.

[1] *Standards for culturally and linguistically appropriate services in health: an exploratory study of American standards,* Tremblay S., Prata G., Société Santé et Mieux-être en français du Nouveau-Brunswick, 2011.

Limits of the present study

The present study did not include visits to health facilities. We nevertheless took note of a report by Forgues (2011)[2] on the offer of services in four bilingual establishments in Canada in order to incorporate relevant elements in our review.

Time constraints did not allow us to take into consideration all of the French-language health initiatives realized or underway in Canada. We afforded particular attention to practices that had an impact in terms of significant achievement or population targeted.

We have also included some examples from Quebec, while recognizing that the Quebec context is complex in that it includes both measures of protection of the French-speaking majority language as well as measures designed to protect the English-speaking minority.

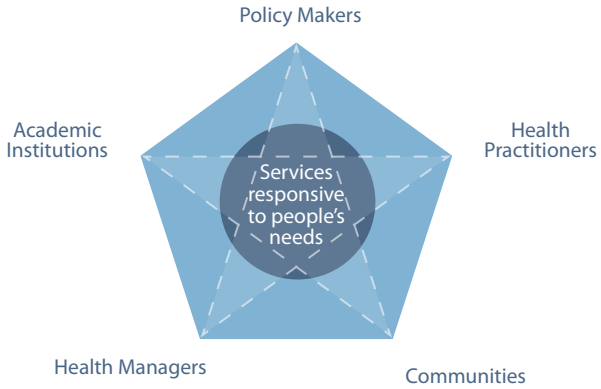
The following chapters will deal with French-language health services in Canada, standards and normative organisations, models of excellence, language barriers and the overall context and organisation of the Canadian health system. This will be followed by a presentation of the conceptual framework and a description of the approaches and practices underway to encourage linguistic and cultural competence in the health sector in Canada.

[2] Forgues, É., Bahi, B., Michaud, J. *The offer of health services in French in a minority context,* Canadian Institute for Research on Linguistic Minorities, November 2011.

1 GENERAL CONTEXT: STANDARDS AND QUALITY IN HEALTH

1.1 FRENCH-LANGUAGE HEALTH SERVICES IN CANADA

Since 2002, the *Société Santé en français* (the *Société*) and the 17 *Santé en français* Networks in Canada have been working to improve access to French-language health services for francophone and Acadian minority communities. In 2004, they undertook an ambitious planning process – **Setting the Stage** – in order to develop plans for the provision of French-language health services in each province and territory, with the exception of Quebec. Implementation of the recommendations of this initiative continues within the communities in 2012, the results of which contribute to enriching knowledge in the area of health services adapted to the needs of Francophone communities. The actions of the *Santé en français* Networks in their respective settings is based upon the partnership model of the World Health Organisation[3] which allows for the engagement and active contribution of primary stakeholders in the area of health.



Over the last ten years, numerous strategies have successfully been advanced and more than 250 initiatives for the improvement of French-language services have been implemented by the *Santé en français* Networks and their partners in different areas of health including:

- Primary health care services;
- Health promotion;
- Access to health care and services;
- Children and youth;
- Seniors;
- Mental health.

The *Société Santé en français* and its Networks continue their reflection to identify and develop a global and mobilizing approach which would allow for significant advances in access to quality and safe French-language health services across the country.

1.2 THE NORMATIVE APPROACH

American standards for culturally and linguistically appropriate health services (CLAS standards) have stimulated the interest of the *Santé en français* Networks, the *Société* and their partners over the past few years. These standards were the subject of a previous study[4] which confirmed the intention of the *Santé en français* Networks to pursue their reflection on the pertinence of adopting a normative approach within context of the provincial, territorial and Federal health systems.

The American experience demonstrates that standards are pertinent in the health sector. A standard refers to *what should be*. A standard prescribes rules, guidelines or characteristics in order to ensure the optimal quality of a product or service, according to whether it is formulated for industry, information technologies, construction, management practices and professional services or for health services. Standards then take various forms: laws, codes, protocols, regulations, norms, guidelines, structures, rules, conventions, or specific technical standards.

For Professional Associations and Professional Orders (agencies that regulate a profession), standards are statements that regulate the conduct of professionals both legally and professionally. Standards are general statements that serve to guide, support and promote services which are of high quality, competent, safe and ethically sound.

There is no universal definition for the expression "cultural and language competencies." In general, it refers to the ability of an organisation and its staff to provide competent care and to communicate effectively with clients from diverse backgrounds who have limited knowledge of the language spoken by the majority.

[3] Towards unity for health: challenges and opportunities for partnership in health development: a working paper / Charles Boelen – WHO Geneva, 2002.

[4] Tremblay S., Prata G., *Standards for culturally and linguistically appropriate services in health: an exploratory study of American standards*, Société Santé et Mieux-être en français du Nouveau-Brunswick, 2011.

American standards

American standards for culturally and linguistically appropriate services - *CLAS Standards* - were developed by the *Office of Minority Health* on the basis of revisions of laws, regulations, contracts and standards required by Federal and State agencies and by the large American national organisations, with the contribution of committees of experts, administrators, researchers and with public consultations.

The ultimate goal of CLAS standards is to improve the delivery of health services to minority populations of diverse racial and ethnic backgrounds in order to reduce health disparities.

CLAS standards (Appendix I) include fourteen directives*, recommendations or obligations that serve to inform, guide and facilitate the implementation of culturally and linguistically appropriate services by health establishments and professionals. They are grouped into three themes:

- Culturally competent care
- Access to language services
- Organisational support of cultural competence

CLAS standards for access to language services (standards 4 to 7) were formally adopted by the American Federal government and are **mandatory** for institutions seeking Federal funds from publicly funded health insurance programs such as *Medicare,* for persons aged 65 and over, and *Medicaid*, for persons with a low income.

This study will focus on the context of the Canadian health care system to better understand the links and relationships between the various components of this system and will critically examine the approaches and practices already in place in Canada to provide culturally and linguistically appropriate health services.

*** Note: following completion of the present report, new enhanced National CLAS Standards were adopted in 2013.**

1.3 QUALITY IN THE CANADIAN HEALTH SYSTEM

In a reflection on linguistic and cultural adaptation of health services, we believe it is important to highlight the main values of the Canadian health system.

Canadians place great importance on their health and on their health care system. The goal of the Canadian health insurance system is to ensure that all Canadians have reasonable access to necessary hospital and medical services without having to directly pay for these services.

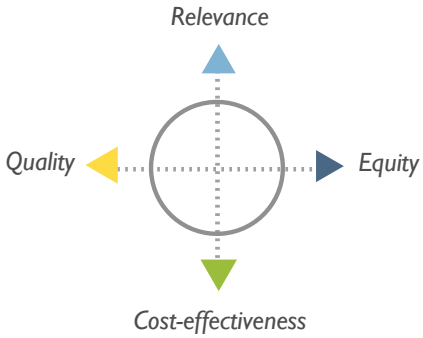
CORE PRINCIPLES OF THE CANADIAN HEALTH SYSTEM

1. Universality
2. Accessibility
3. Portability
4. Comprehensiveness
5. Public Administration

One of the main distinguishing characteristics when compared to other health systems, including that of the United States, is the universality of care. Canadians want a viable health care system which provides timely access to quality services.

From the time of its creation, the movement Santé en Français adopted the World Health Organisation's (WHO) global health approach which defines the reason for the existence of a health care system as being an improvement in personal state of health.

THE WHO HEALTH COMPASS



This approach places four important dimensions of a health system in inter-relation as depicted in the health compass diagram: relevance, quality, equity and cost effectiveness.

- **Quality:** ability to offer satisfactory responses to a person's health needs. Quality is measured by its constituent components: reactivity, effectiveness and safety.
- **Equity:** to offer services to everyone, without distinction, and to reduce factors of discrimination (race, sex, ethnicity, socio-economic status, etc.).

  Another definition: to equip each individual to protect and promote their health.
- **Relevance:** prioritize response to the most important problems.
- **Cost-effectiveness:** make the best use of available resources for a given service.

The health system attempts to maintain equilibrium between quality and availability of services for all and between relevance and efficiency. Within a system founded upon a client-centered approach, the concept of quality is influenced by client expectations which *"evolve with the ability to understand the impact of determinants of good and poor health and to judge what applies best according to one's circumstances"*.[5]

The *Santé en français* Networks and Francophone communities have an important role to play in the dissemination of health information to the population and in the promotion of activities favoring self-determination and community accountability for the adoption of healthy lifestyles. *Santé en français* Networks play a key role in this regard. They have elaborated a national health promotion strategy and, since their creation, have facilitated the implementation of initiatives which provide structure in these areas.

1.4 IMPACT OF LINGUISTIC AND CULTURAL BARRIERS IN HEALTH

Concerns about linguistic and cultural barriers in health are not new. Numerous studies on both an international and national level have demonstrated that linguistic and cultural barriers to accessing health services hinder the quality, efficiency and effectiveness of the services provided and present risks for patient safety.

Beyond communication and the relationship between the patient and health professional, access to appropriate primary health care services allows clients to act directly on determinants of their health. Language barriers decrease the probability that clients living in a language minority situation will make use of health promotion services, thus leading to an increase in health services required.

The lack of French-language documentation and brochures to keep Francophone patients well-informed about their condition and the follow-up required adds to the risk of non-compliance with treatment plans.[6]

Linguistic and cultural adaptation appeals to our health system values of equity, universality, safety and clinical ethics. Efforts to increase cultural and linguistic adaptation within our health care system must recognize the systemic nature of accessibility problems.

ACCORDING TO VAILLANCOURT ET AL. (2012),

"A PERSON'S WELL-BEING WILL INCREASE IF THE SERVICES ARE AVAILABLE IN THE LANGUAGE THEY PREFER".[7]

In Canada, despite the existence of data associating cultural and linguistic barriers to an increase in risks related to patient safety and a decrease in health system effectiveness and efficiency, no explicit standard exists to oblige health organisations and health professionals to address this problem.

IMPACT OF LANGUAGE BARRIERS FOR CLIENTS

- Decrease in access to health services and increase in consultations without appointments
- Reluctance to seek care
- Increase in probability of diagnostic and treatment errors
- Increase in time required for consultation and in the number of diagnostic tests
- Decease in the probability of adherence to the treatment plan and increased risk of adverse medication reactions
- Decrease in satisfaction

IMPACT OF LANGUAGE BARRIERS FOR PROFESSIONALS

- Increase in duration of intervention
- Difficulties in obtaining informed consent
- Decrease in teaching due to language limitations
- Diagnostic errors and inappropriate treatment
- Clinical ineffectiveness leading to dissatisfaction for patients and providers.

1.5 LANGUAGE, CULTURE AND HEALTH – AREAS OF RESEARCH IN DEVELOPMENT IN CANADA

In the United States, literature, research and studies abound on the relationships between language, culture and health, on cultural and linguistic barriers and on cultural and linguistic competencies in health. The research provides abundant evidence-based data to support the implementation of innovative practices.

In Canada, this area of research is under-developed, but appears to generate a certain interest among researchers. Research studies have primarily focused on Aboriginal or immigrant populations and have, until very recently, afforded little attention to the impact of language barriers on official language minority communities. An annotated literature review on language barriers in health carried out by the *California Endowment Fund* in 2003, analysed by Health Canada with the goal of evaluating the validity of the evidence demonstrated a minimal level of interest in this subject in Canada.

[5] Towards unity for health: challenges and opportunities for partnership in health development: a working paper / Charles Boelen – WHO Geneva, 2002

[6] AIIC. *Projet soins infirmiers en Français : Rapport synthèse*. August, 2007.

[7] Vaillancourt, F et al., *Official Language Policies of the Canadian Provinces. Costs and benefits in 2006,* Fraser Institute January 2012.

Table: Geographical distribution of the studies noted in the California Endowment annotated bibliography and in the Health Canada summary analysis[8].

Location of the study	Number of studies noted in the annotated bibliography	Number of studies noted
United States	85	60
United Kingdom	20	10
Australia	16	9
Canada	4	1
South Africa	3	1
Thailand	1	1
Other countries	6	0
Total	135	82

Sarah Bowen and Norman Segalowitz are among the Canadian researchers who have devoted themselves to the problem of language barriers in health, with a particular focus on official language minorities.

Sarah Bowen

Sarah Bowen is an associate professor in the Department of Public Health Sciences at the University of Alberta and has authored several studies on the influence of language barriers in impeding access to health services for communities living in a linguistic minority situation in Canada.

In a report prepared for Health Canada in 2001, Sarah Bowen emphasizes that patients in a linguistic minority situation in Canada are more at risk of receiving health services which are less safe as a result of communication problems.

This study highlights the importance for health organisations to address the issue of language barriers as one of quality of services and risk management[9].

Norman Segalowitz

Professor Norman Segalowitz, Associate Director of the *Centre for the Study of Learning and Performance* at Concordia University in Montreal, suggests that the issue of language barriers in health offers researchers from different branches of linguistic science invaluable opportunities to conduct basic research and contribute to the advancement of knowledge on communication in a medical context[10]. He sets forth the importance of differentiating the indirect links (economic factors, social, geographical, etc.) from the direct links (related to language) when assessing the effects of language barriers on access to health services for communities living in a minority situation.

In recent years, several other researchers have distinguished themselves in the exploration of new aspects related to language, culture and health. They are supported, among others, by the research arm of the ***Consortium national de formation en santé*** (the CNFS) which acts in complementarity with its university components and the Joint Commission of Health Research on Francophone minority communities. The CNFS contributes to building an environment conducive to the development of research, encourages networking, supports thematic research teams and disseminates the knowledge thus acquired.

Network of expertise (knowledge transfer) of the Société Santé en français

It is not only important to generate evidence, but methods must also be developed for transferring newly acquired knowledge. The Network of expertise established by the *Société Santé en français* is a national initiative that contributes to supporting knowledge transfer between the *Santé en français* Networks and their partners across the country by means of informational surveillance and virtual conferences on topics of general interest.

[8] An Examination of the Strength of Evidence in "Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature" Research Report prepared by OLCDB, Health Canada, January 2008.

[9] Bowen S. *Barrières linguistiques dans l'accès aux soins de santé.* Santé Canada, 2001. *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf*

[10] Segalowitz, Norman, Kehayia, Eva # 2011 *La Revue canadienne des langues vivantes*, 67, 4 (novembre), p. 480–507 doi:10.3138/cmlr.67.4.480

2 CANADIAN NORMATIVE ORGANISATIONS

The organisation with a national mandate for assessment of the quality of services of health establishments and programs in Canada is Accreditation Canada.

In this section, we present Accreditation Canada and its requirements for communication as well as the Canadian Patient Safety Institute (CPSI), which is a influential regarding patient safety standards. An entire system for the evaluation of professional practice by associations and professional orders also exists for the different health professions, which however is not the subject of this study.

2.1 ACCREDITATION CANADA

Accreditation Canada is an independent non-profit organisation providing health and social service organisations with an external review of the quality of their services, conducted by volunteer peer visitors/surveyors and based on standards of excellence. Accreditation Canada is accredited by the *International Society for Quality in Health Care* and has over 1 000 clients (central organisations) including regional health authorities and representing over 5 500 establishments*, programs and community services from both the private and public sectors[11].

*** Note: data was drawn from the web site in 2012 and may have changed.**

Accreditation in Canada:

- Required by the Royal College of Physicians and Surgeons of Canada for all establishments wishing to accept medical students.
- Obligatory in Quebec and Alberta
  - QC - Accreditation Canada or Conseil québécois d'agrément
  - AB – Accreditation Canada
- In Ontario, accreditation is required to obtain certain contracts from the Ontario government, such as home care services. Also, costs associated with the accreditation process are subject to a grant in the area of long term care.
- In Nova Scotia, establishments must undergo a peer review process conducted by Accreditation Canada.
- Accreditation is optional in the other provinces and Territories.

Accreditation Canada standards are standards of excellence which are regularly revised in the framework of an elaborate consultative process. These standards evaluate governance, risk management, leadership, prevention of infections and medication management, as well as services in numerous sectors of clinical activity.

Accreditation Canada's standards and criteria reflect a concern with the language proficiency of the treatment team, particularly in the context of informed consent or the transmission of information regarding treatment and services. However, Accreditation Canada standards do not render explicit the obligation for an establishment or its staff to conform to specific standards on linguistic accessibility related to official languages. We find no reference to modalities which the organisation must put into place to ensure effective communication with minority language clients in order to minimize risks associated with language barriers.

A few avenues of collaboration with Accreditation Canada were initiated over the last few years. In 2007, Accreditation Canada was sensitized to the needs of Francophone communities as the result of a national initiative of the *Société Santé en français* entitled *Setting the Stage*. In the context of this initiative, the Prince Edward Island French-language health services Network demonstrated the inevitable nature of cultural and linguistic dimensions as systematic parameters for assessing the quality of health services and requested:

"THAT THE CCHSA SHOULD CONTINUE TO INCREASE AWARENESS OF THE IMPACT OF COMMUNICATION CHALLENGES ON THOSE ACCREDITATION STANDARDS THAT CONSIDER HOW HEALTH INSTITUTIONS RESPOND TO THE LANGUAGE NEEDS OF THE LINGUISTIC MINORITY COMMUNITIES, CLIENTS AND FAMILIES THROUGH THE FOLLOWING ACTIONS:..." [12]

[11] *www.accreditation.ca*

[12] The impact of communication challenges on the delivery of quality health care to minority language clients & communities, 2007. *www.santeipe.ca/userfiles/file/PositionPaper_FLHSN_EN.pdf*

Another avenue of collaboration on linguistic accessibility put forth by the *French Language Health Services Network of Eastern Ontario* suggested the potential involvement of Accreditation Canada in a process of designation of establishments able to offer services in French. This project has not as yet been realized.

These initiatives have however confirmed the willingness of Accreditation Canada to develop collaborations to improve the delivery of health services in French to Francophone and Acadian minority communities in the country. It is ultimately through patient safety and risk management that Accreditation Canada attempts to address the issues of health communication. However, the non-binding nature of the language requirements for Accreditation Canada contrasts with the U.S. patient and family-centered communication standards of the *Joint Commission* which are more explicit and binding in nature.

2.2 Canadian Patient Safety Institute

Established in 2003, the Canadian Patient Safety Institute (CPSI) is a not-for-profit organisation that raises awareness and promotes the delivery of safe health services. The CPSI issues non-binding guidelines or principles, promotes exchange by providing relevant documents and commissioned research and provides education and training activities for patient safety. Its objective is to stimulate the engagement of governments, health organisations, leaders and health care providers in improving quality and patient safety[13].

Surveys conducted by the CPSI revealed little integration of patient safety concepts within the Canadian curriculum of health professional schools. In 2006, the CPSI initiated a process to identify practical and effective interventions to integrate within health science education. The Canadian inter- professional framework focusing on skills related to patient safety was published in 2008. These skills are divided into six domains, with 23 key competencies and 140 enabling competencies[14].

One of the six domains of competence is to *communicate effectively for patient safety.* The objective is to promote patient safety through effective health care communication. No explicit reference is made to measures to be taken in order to decrease risks associated with language barriers and obtaining informed consent for clients living in a linguistic minority context.

The issue of language barriers in communication between the patient and the health professional is not addressed in the document. Yet, effective communication cannot take place if both parties do not understand each other to begin with.

Conversation is at the heart of all human relationships and is the foundation of the physician-patient relationship[15]

Another accreditation body, the Royal College of Physicians and Surgeons of Canada's accreditation committee issued a statement[16] to the effect that medical residents must perfect the ability to communicate with patients and be able to understand the principles and practices for obtaining informed consent. This is considered to be particularly important when:

- There is a language barrier;
- There is a physical barrier;
- A disagreement arises with the patient;
- A situation arises where patients call them into question.

The Canadian Institute for Patient Safety emphasizes that the following factors are essential for widespread adoption of the Safety Competencies:

- The framework must be incorporated within recognized regional and national standards;
- Standards organisations in the health professions should examine competencies related to patient safety in light of their respective missions;
- The framework will exert a greater influence on health care services if it is incorporated into regional and national standards;
- Powerful levers of change, such as accreditation visits, program standards, the issuance of health professional titles, and evaluation processes can rapidly facilitate the incorporation of patient safety competencies within health care training and practice. [17]

[13] *www.patientsafetyinstitute.ca/english*

[14] Frank JR and S. Brien, *The Safety Competencies - Enhancing patient safety across the Health Professions*. Ottawa (Ontario); Canadian Patient Safety Institute; First Edition. Revised August, 2009.

[15] O'Neil, Centrality of language, p 179, 2005.

[16] www.royalcollege.ca/portal/page/portal/rc/common/documents/accreditation/communication_skills_e.pdf 2001.

[17] Frank JR and S. Brien, *The Safety Competencies - Enhancing patient safety across the Health Professions.* Ottawa (Ontario); Canadian Patient Safety Institute; First Edition. Revised August, 2009, p.32.

3 POLITICAL ENVIRONMENT AND THE CANADIAN HEALTH SYSTEM

Access to health services for Francophone minority communities is a major challenge in the Canadian context, an officially bilingual country with more than 34.6 million inhabitants spread over a vast territory. The complexity of legislative environments within a federated system adds to the challenges. Furthermore, important demographic factors such as low birth rates, aging of the Canadian population and increasing immigration which is more and more diversified are transforming the Canadian landscape and exerting strong pressures on the health system.

3.1 LINGUISTIC DUALITY AND RIGHTS

Linguistic duality is at the heart of the Canadian nation and is evidenced on a political level within the country with the development of two official languages: English and French. The Canadian Charter of Rights and Freedoms of 1982, a Constitutional Law, establishes English and French as the official languages of Canada. Article 23 defines the right to education in the language of the linguistic minority, thus establishing the legal and constitutional framework by which each province and territory provides services in both official languages.

Canada has two official languages, a Federal language policy and language policies in each of the ten provinces and three Territories[18]. New Brunswick is the only officially bilingual Canadian province.

The goal of the Federal policy on official languages is:

- To assure the respect and equality of the two official languages in Federal institutions;
- To support the development of Francophone and Anglophone minority communities in order to progress towards equal status and use of the French and English languages.

However, the Canadian Constitution as well as the Law on Official Languages (LOL) guarantees official language minority communities rights **solely with respect to Federal institutions.**

When the Federal government transferred powers to the provinces and territories in a number of areas, including health, legislative guarantees did not accompany this transfer and the delivery of services in official minority languages was associated with provincial laws, policies and standards. This still constitutes a major difference between Canadian and international linguistic minorities in the area of health.

3.2 LEGISLATIVE FRAMEWORK AND FRENCH-LANGUAGE SERVICES IN THE CANADIAN PROVINCES AND TERRITORIES

Despite the fact that French is one of the two official languages in Canada, Francophones do not benefit from the same rights nor have access to the same services in all of the provinces and territories.[19]

[18] Johnson, M. *À double tranchant. La politique linguistique à l'égard du français au Québec et au Canada* ICMRL, Novembre 2009. (Available in French only).

[19] Deveau, K; Landry, R.; Allard, R. (September 2009). *The utilisation of French Language Government Services. A Study on the factors associated with the utilisation of government services in French by Nova Scotian Acadians and Francophones*. [Research report]. Canadian Institute for Research on Linguistic Minorities.

LEGISLATIVE /REGULATORY STATUS OF FRENCH IN EACH PROVINCE AND TERRITORY[20]

Place	Legislative Tool	Comments
National	Canadian Charter of Rights and Freedoms, article 23	Constitutional protection of the right to education in French
Alberta	Alberta Language Law (1988) confirms the unilingual Anglophone status of the government	Little significant offer of French-language health services
British Columbia	No law on official languages and French-language services	Rights of article 23 extended to Francophone immigrants
Prince Edward Island	*French Language Services Act* (1999) New law being drafted*	Non binding with the exception of education
Manitoba	Law of 1870 - Manitoba Policy on French-language services (1989)	No law on French-language services, but policies and regulations
New Brunswick	Law on official languages (1969, 2002) Law on language and health services (2002, 2010). Policy and guidelines on official languages	Only officially bilingual province
Nova Scotia	Law on French-language services (2004) Other regulations and policies on French-language services	The province seeks to make progress in the area of linguistic accessibility
Nunavut	Law on official languages (Inuit, French, English) (2008)	Includes an obligation of services Law is not in application
Ontario	Law on French-language services (1986, 1990)	Guarantees services in the regions where Francophones reside (25 designated regions)
Quebec	French the official language since 1974 Charter of the French language (1977)	Context of protection of the French language
Saskatchewan	Law on the use of French and English in Saskatchewan (1988)	French and English can be used in the National Assembly
Newfoundland and Labrador	No law on official languages or on French-language services	Existence of the Office of French-language services
Northwest Territories	Law on official languages in the Northwest Territories (1988, 1990)	Recognizes and confers rights for the use of eleven official languages, including French and English
Yukon	Law on languages (1988, 2002) Policy on French-language services	Recognizes that French and English are the official languages

* Note: the new PEI French Language Services Act was enacted in December 2013.

[20] From many sources including the following web site: *www.tlfq.ulaval.ca/axl/amnord/cnd-lois_ling.htm, Leclerc, Jacques.*

As indicated in the previous Table, an asymmetry exists between provinces and territories as regards to language rights. We have chosen to group the provinces into three categories according to the level of protection afforded to the minority language and the services offered:

- Provinces affording a greater level of protection on the matter of official languages and French-language services, that is, Ontario, Québec, New Brunswick, Manitoba and Nova Scotia;
- Provinces/territories with laws on official languages, but with few French-language public services: Saskatchewan, the Yukon, the Northwest Territories, Nunavut and Prince Edward Island;
- Provinces with no law on official languages or French-language services and few or no French-language public services: British Colombia, Alberta and Newfoundland-Labrador.

Prince Edward Island, where the law of 1999 on French-language services was never completely enacted or translated into French, chose to develop new legislation rather than attempting to render the former one consistent with current realities. In this regard, the province has adopted an approach which considers the following factors:

- The financial resources of the province;
- The degree of bilingualism of the provincial public service;
- The priorities of Francophone and Acadian populations;
- The geographical concentration of Francophone communities.

With this approach, the province seeks to promote cooperation and to avoid placing themselves in a context where claims could potentially arise. This example also demonstrates the widespread desire which exists in some provinces to work with communities and to involve them in the choice of health priorities.

*** Note: the new PEI French Language Services Act was enacted in December 2013.**

3.3 HEALTH: A PROVINCIAL JURISDICTION

Unlike many countries in the world that have a single health system, Canada has a national health insurance system encompassing thirteen distinct provincial and territorial systems, but which share certain common characteristics and basic protection standards. The principles governing the Canadian health care system are defined by the *Canada Health Act* and reflect Canadian values.

The Federal government and provincial and territorial governments share roles and responsibilities regarding health insurance. Under Federal health insurance legislation, the Canada Health Act (CHA), criteria and conditions are specified which provincial and territorial health care insurance plans must satisfy in order to qualify for their full share of the Federal financial contribution available under the Canada Health Transfer (CHT) for health services.[21]

Provincial and territorial governments are responsible for the management, organisation and delivery of health services for their residents.

3.4 Federal-Provincial-Territorial Accord on Health

Federal, provincial and territorial governments collaborate on several policies and programs related to health. In fact, even if health is under provincial jurisdiction, Federal funding and national standards and objectives of the national policy are established under a national agreement dating back to the late 1990s.

For example, the 2004-2014 Accord provided a new health care reform fund focused on primary health care, home care and catastrophic drug coverage for very expensive prescription drugs. It is within the framework of this fund that numerous initiatives of the *Santé en français* Networks were carried out.

This Accord expires in 2014. In January 2012, the federal government introduced the general terms of the new 2014-2024 funding program without the agreement having been the subject of negotiations with the provinces and territories. The Federal government has indicated its intention to adopt a neutral approach to the establishment of a health policy. The provinces must therefore consider the possibility of having to provide health services in the absence of national health agreement.

This new position represents a major turning point whose consequences could be crucial to a Canadian health care system which already stands out for its lack of comprehensive national strategies.

On the issue of French-language health services, the position could also have serious consequences at a time when the development of French language health services in minority communities is a growing field, and when achievements remain fragile and in need of Federal support.

[21] Canadian government web site *hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html*

3.5 MINISTERIAL CONFERENCE ON THE CANADIAN FRANCOPHONIE

The Ministerial Conference on the Canadian Francophonie (MCCF) is an intergovernmental organisation created in 1994; it is made up of Federal, provincial and territorial Ministers responsible for the Canadian Francophonie.

The MCCF Conference deals with various issues related to the Canadian Francophonie, providing direction for intergovernmental cooperation between the Federal, provincial and territorial governments and playing a unifying and influential role in support of the country's Francophonie[22].

All provinces and territories have an administrative structure or directorate responsible (see boxed list) responsible for the application of the law on official languages in their province.

These structures are essential and contribute to ensuring the vitality of the French language and of Francophone and Acadian culture in their respective environments. Certain amongst them also play a very significant role in support of the development of French-language health services.

The Canadian health system is deployed in a complex global and political context having many levels of authority. We provided a brief overview in order to better situate elements having an influence on its operations and on its capacity to provide linguistic access to official language minority communities.

Canadian Francophonie Network

- **AB:** Francophone Secretariat
- **BC:** Francophone Affairs
- **PEI:** Acadian and Francophone Affairs Secretariat
- **MB:** Francophone Affairs Secretariat
- **NB:** Francophonie and Official Languages
- **NLL:** Office of French Services
- **NS:** Office of Acadian Affairs
- **NU:** Division of Official Languages
- **NWT:** Francophone Affairs Secretariat
- **ON:** Office of Francophone Affairs
- **QC:** Secretariat of Canadian intergovernmental Affairs
- **SK:** Francophones Affairs Directorate
- **YK:** French Language Services Directorate

[22] *www.cmfc-mccf.ca/gov-involved-conference*

4 FACTORS OF INFLUENCE ON THE HEALTH SYSTEM

Health systems are extremely complex structures reflecting the organisation and values of the societies in which they are developed. The Canadian health care system is in evolution, changing from a curative approach to a primary health care and patient-centered approach.

4.1 Comparison – Canadian health system and other countries

In a comparative study of the structures and characteristics of different health systems, Snowden and Cohen (2011) describe the Canadian health care system as **State as owner-operator** model in comparison with a **State as guardian model.** Under the principle that all citizens have the right to access health services without regard to, among other considerations, their financial situation, Canada, Australia and England have adopted a system of "universal" health. Canada and Australia have also adopted a decentralized system giving the provinces (or States in Australia) responsibility for the organisation and delivery of health services[23].

A lack of consolidated strategies for the organisation and delivery of health services at a national level, the limited power afforded to Canadian consumers in the selection of their health services and the quasi-absence of competition amongst health service providers are among the factors which influence all dimensions of the Canadian health system. Snowden and Cohen (2011) point out that the Canadian health system tends to promote a sense of passivity amongst consumers who have little decisional power as regards the choice of their health care services and providers.

The following table, adapted from the Snowden and Cohen model, presents the main comparative characteristics of health systems.

State as owner-operator	State as guardian	Private mixed model
• Principles of equality and universality • Public insurance system • State Tax revenue • Private insurance • Co-payments • Direct patient contrivution	• Principles of solidarity • Social insurance system • Employer / employee contribution • Private insurance premium • Direct patient contribution	• Principles of high-quality, technology and specialist care • Private insurance system • State health system • Employer / employee contribution • Private insurance premiums • Direct patient contribution
• **Canada** • **Australia** • **United Kingdom**	• **France** • **Switzerland** • **Germany** • **Netherlands**	• **États-Unis**

[23] Snowden, A. et Cohen, J. *Strengthening Health Systems Through Innovation: Lessons Learned.* International Centre for Health Innovation, 2011.

European health systems generally place more importance on participation of the individual, family and community. The links between health and social aspects are also more obvious. In Belgium for example, social insurance principles are reflected in *horizontal solidarity* between those in good and poor health and a *vertical solidarity* primarily based upon level of employment income. The organisation of the health system is characterized by a high level of therapeutic freedom for the physician, consumer choice and remuneration based on payment per act.

Another important difference between Europe and Canada is the private insurance system. In Canada and the United States, private insurance plans play a complementary role to that of the public health system and are offered by private for-profit companies. In Europe, private insurance plans are mainly offered by non-profit companies (mutual insurance companies, unions, etc.) who act as partners of the State to ensure population access to health services. The government plays a regulatory role and establishes standards of quality, which represents a major difference with the Canadian and American systems.

Although Federal/ provincial/ territorial agreements have contributed to progress in specific areas, they do not allow the development of national strategies due to the very limits of their functioning. This situation limits not only the capacity for innovation on a national level, but also has a direct impact on uniform accessibility to health services in both official languages in Canada.

A major challenge to the sustainability of a Canadian health system focused on hospital care will be the ability to evolve towards innovative models for chronic disease management which promote feelings of self-determination and of community empowerment, particularly for the adoption of healthy lifestyles and for the well-being of citizens.

Many initiatives to increase linguistic accessibility implemented by the *Santé en Français* Networks and the Francophone and Acadian minority communities are oriented towards the promotion of self-determination for health among members of French-speaking communities.

4.2 IMPACT OF CULTURAL DIVERSITY ON THE HEALTH SYSTEM

Declining birth rates and an aging population are among the factors which threaten the vitality and economic situation of Canada. Population decline is offset by immigration that has accelerated over the past decade. The growing diversity of the population and of the Canadian labor force creates new opportunities for organisations, but also creates major challenges. Immigrants bring a renewed vitality to Canada while changing its social fabric.

The Ministerial Conference on Canadian Francophonie examined issues and opportunities in the areas of governance, recruitment and selection of Francophone immigrants and they support efforts directed towards socio-cultural and socio-economic integration of newcomers into their respective communities[24].

The Canadian health system is influenced by these transformations of Canadian society on two levels:

- Health system clients have increasingly diverse cultural backgrounds and may present with very complex health needs;
- The health system has a culturally diverse workforce frequently educated outside of Canada within very diverse educational systems.

[24] News release of the Ministerial Conference on the Canadian Francophonie, Francophone immigration : Essential for all Canadians! Chantal Alarie, February 2012

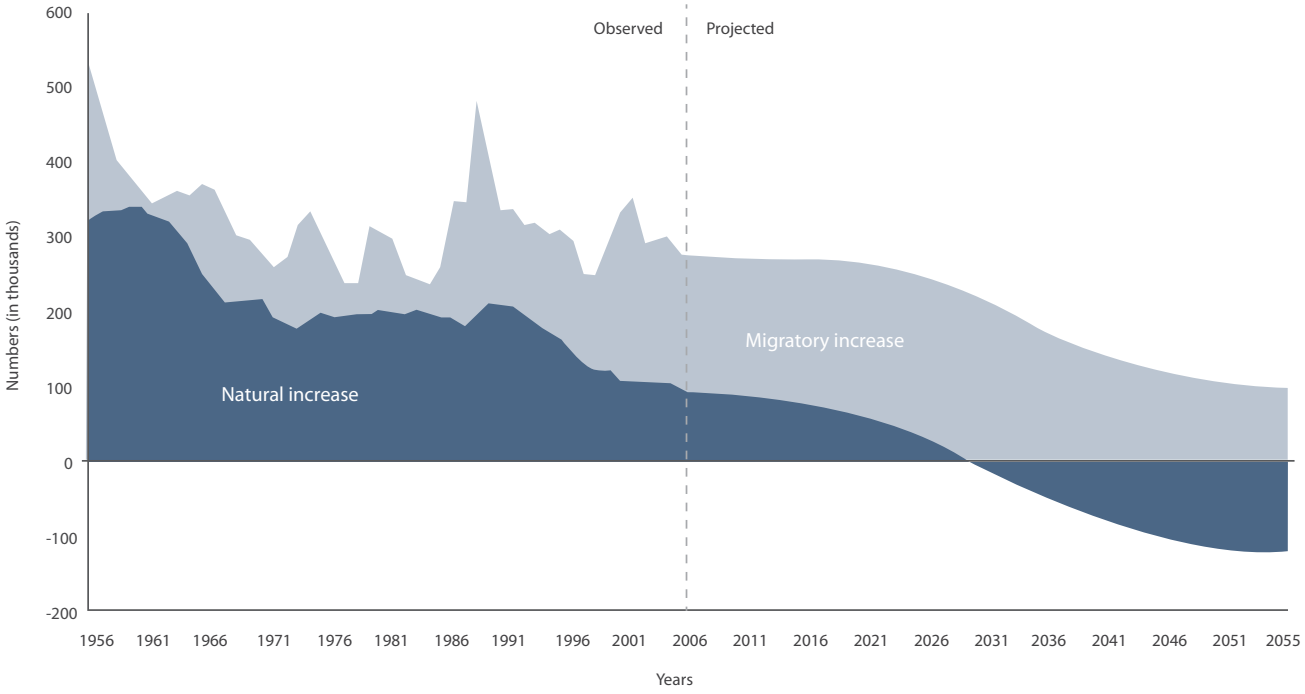
For health facilities, the traditional client population is now paired with an increasingly diverse client base, both in terms of language and culture. The same holds true for facility staff who are increasingly diversified, who must learn to work in multidisciplinary teams, understand the needs and attentively provide services to all client groups.

The issues related to acquisition of cultural competencies within health systems are the same everywhere. How to adapt to the rapid changes in the environment? How to respond appropriately to the needs and expectations of an increasingly diversified clientele? How to train a workforce which is responsive and sensitive to its environment? How to develop clinical and management practices as well as client services in light of this new reality?

Multiculturalism has a growing impact on models of service organisation and on the approaches adopted by health systems in certain provinces where immigration accounts for a very significant proportion of the population.

THE FOLLOWING TABLE ILLUSTRATES THE IMPORTANCE OF INTERNATIONAL IMMIGRATION IN COMPENSATING FOR CANADIAN POPULATION DECLINE.

MIGRATORY AND NATURAL POPULATION INCREASE IN CANADA 1956 TO 2056



Data sources: *Statistics Canada, 2005, Population Projections for Canada, Provinces and Territories, 2005-2031, Statistics Canada Catalogue number 91-520-XIE, scenario 3, and Demography Division, annual population estimates from 1956 to 2005.*

Figure source: *Statistics Canada, 2007, Canadian Demographics at a Glance, Catalogue number 91-003-XWE.*

IN 2017, MORE THAN ONE OUT OF FIVE CANADIANS (22%) COULD BE BORN OUTSIDE OF CANADA.

5 CONCEPTUAL FRAMEWORK FOR LINGUISTICALLY AND CULTURALLY ADAPTED HEALTH SERVICES

We propose a conceptual framework which establishes relationships between the different levels of influence on the health system in order to better situate practices which favor linguistically and culturally adapted services.

In the context of our study, we emphasized two types of approaches: those that have a global impact, are sustainable and have been integrated into the health system, and those promising practices and models which, despite being local or relatively new, have significant potential in terms of linguistic and cultural accessibility. However, the objective is not to review all existing approaches and programs.

This review of approaches and practices, categorized according to the conceptual framework, will allow us to highlight some general findings as well as criteria associated with best practices for linguistically and culturally adapted health services. It will also allow for an appreciation of the potential role of a normative framework within the Canadian environment.

5.1 A CLIENT-CENTERED APPROACH

According to the American *Institute of Medicine*, client-centered services are characterised by compassion, empathy and sensitivity to the needs, values and preferences of the patient as an individual (Aucoin, 2008). As also underscored by Betancourt (2006), these same elements are the basis of linguistic and cultural adaptation of professional and organisational practices. In other words, linguistic accessibility and cultural adaptation at a professional and organisational level are central to a client-centered approach.

Client needs and expectations represent the ultimate point of reference for defining the desired quality of services offered by a health organisation. For Francophone and Acadian communities, the model of a desired health system should minimally include a component of linguistic adaptation and, ultimately, a cultural adaptation component as required.

In his review of the literature, Aucoin (2008)[25] concludes that efforts for offering linguistically and culturally adapted health services should be situated on three levels:

1. Government and the health system;
2. Health organisations;
3. Communities, while taking into account their specific issues.

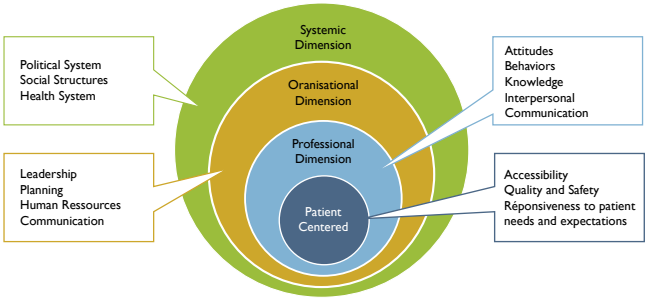
The integrative model we are proposing in this study takes these three levels into account while providing a distinct level for the professional dimension.

5.2 CONCEPTUAL MODEL

Levels of influence in the health system

Our study proposes a conceptual framework which establishes relationships between the different levels of influence on the health system in order to better situate practices which favor linguistically and culturally adapted services.

CONCEPTUAL FRAMEWORK



This graphic representation of the client-centered conceptual framework recognises the importance of acting upon each dimension of the health system in order to effect the changes required for linguistic accessibility and cultural competency within Francophone minority communities.

ALL INTERVENTIONS, FROM THE SIMPLEST TO THE MOST COMPLEX, HAVE AN EFFECT UPON THE SYSTEM AS A WHOLE, WHICH IN TURN HAS AN EFFECT UPON EACH OF THE INTERVENTIONS IMPLEMENTED.[26]

[25] Aucoin, Léonard. *Compétences linguistiques et culturelles des organisations de santé, analyse critique de la littérature. Société Santé en français*, March 2008.

[26] Campbell S. Systems thinking for health systems strengthening, Alliance for Health Policy and System Research, WHO 2009.

6 SYSTEMIC DIMENSION: DEFINITION, APPROACHES AND PRACTICES

In the following chapters, we briefly define each dimension and present approaches and practices that contribute to rendering health services linguistically and culturally appropriate in Canada.

6.1 DEFINITION

The systemic dimension encompasses the health system and the social system, including the populations within which these systems evolve. Many health determinants are external to health organisations: socio-economic factors, education, employment, etc. Health and social policies must therefore be considered with respect to their sensitivity to the linguistic and cultural characteristics of the communities involved.

AS IN THE PATIENT-CENTEREDNESS MOVEMENT, PIONEERS OF CULTURAL COMPETENCE RECOGNIZED THAT DISPARITIES IN HEALTH CARE QUALITY MAY RESULT NOT ONLY FROM CULTURAL AND OTHER BARRIERS BETWEEN PATIENTS AND HEALTH CARE PROVIDERS BUT ALSO BETWEEN ENTIRE COMMUNITIES AND HEALTH CARE SYSTEMS. HENCE, THERE WAS A NEED NOT ONLY TO TRAIN CULTURALLY COMPETENT PROVIDERS, BUT ALSO TO DESIGN CULTURALLY COMPETENT HEALTH CARE SYSTEMS.[27]

6.2 APPROACHES AND PRACTICES

The vast majority of current approaches to providing linguistically and culturally appropriate health services to Francophone and Acadian communities in minority settings in Canada are recent, anchored in the health system of the province, and meeting specific legislative and administrative requirements. These approaches are also based on the priority needs of the communities they serve. There is no normative framework or formal assessment process underlying these approaches to ensure that efforts are achieving their intended results. Research in this field is in its infancy in Canada and has not yet generated sufficient evidence to allow prioritizing one approach over another.

A key element of this dimension is the legislative aspect. The Table on page 18 provides an overview of the laws and regulations in support of French-language services in each provinces and territories. Without a legislative context, there can be no significant and sustained offer of health services supported by a government. Such a situation does not prevent community initiatives, but restricts their scope and long-term financing.

In the next sections, we mainly focus on the health system and systemic dimension of our framework. The approaches and practices described primarily seek to ensure linguistic access to health services for minority official language communities and to thus meet obligations relating to official languages.

The systemic approaches described in this chapter are:

I. Active offer;
II. Designation;
III. Access programs or plans;
IV. Provincial coordination mechanisms and positions;
V. Health Planning Entities;
VI. Provincial or regional linguistic access services (interpretation);
VII. *Santé en français* Networks.

[27] Beach, M. C.,Saha, S., Cooper, L. A. *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality.* The Commonwealth Fund, October 2006.

The following table lists the main approaches and modalities, by province, which will be described in this section.

Province	Approach	Length of time*	Modality
Alberta	Regional and provincial interpretation and translation Services	More than 5 years	Linguistic access
British Columbia	Provincial interpretation Service	More than 10 years	Linguistic access
Manitoba	Policy on active offer Designation of bilingual regions Coordination of French-language services Regional medical interpretation Service	More than 10 years More than 10 years More than 10 years	Linguistic access Cultural adaptation
New Brunswick	Hybrid approach (linguistic and territorial). Francophone and Anglophone Health Networks (2008)	Less than 5 years	Linguistic access Cultural adaptation
Nova Scotia	Access Program for French-language services Provincial coordination of French-language services	More than 5 years More than 5 years	Linguistic access
Ontario	Territorial designation and designation of establishments Provincial and regional coordination of French-language services French language Health Planning Entities of the Local Health Integration Networks (2011)	More than 10 years More than 10 years Less than 2 years	Linguistic access Cultural adaptation
Quebec	Access Program for Health & Social services in the English-language Designation of establishments	More than 15 years More than 15 years	Linguistic access
National	*Santé en français* Networks (2003-2004)	10 years	Cultural adaptation

** Approximate length*

I – ACTIVE OFFER

The concept of active offer maintains that services in French must be visible, available and easily accessible. **Manitoba** is the only province with an official policy on active offer that involves all government services. The policy seeks to create a climate in which people feel comfortable using the official language of their choice. An active offer in Manitoba has four main components:

- Bilingual greeting and services in the official language preferred by the client;
- Bilingual signage (including the wearing of badges or pins by staff who are bilingual);
- Bilingual documentation (including web sites);
- A quality of service comparable to that offered in the English language.

In general, the request for services in French increases considerably from the moment they are provided according to the principles of an active offer.

In **New Brunswick**, an active offer consists of informing the patient, from the first contact, that services are available in both official languages. A reference guide for managers of health facilities and health professionals[28] was developed by the *Réseau-action Formation et recherche*, to provide information to the regional health authorities of New Brunswick on the availability of services in both official languages. This guide provides practical examples and strategies to promote the offer of services in both languages. The guide is being revised following the reorganisation of the health system in New Brunswick in 2008.

When a service is offered to the public by a Regional Health Authority, there is a legal obligation to offer and provide the services in the official language chosen by the client. There are no exceptions based on a minimum number of residents.

In New Brunswick: regular and specialized services, normally offered under the law, include, without however being limited to:

- Signage
- Oral communication
- E-mail, Internet, voice messaging
- Correspondence
- Documentation, forms and documents intended for the public
- Services of judicial and administrative tribunals
- Services contracted with third parties

In those cases where interpretation services are required, they must be immediately accessible. Translation services must be available to translate forms, reports, correspondence and lengthy documents.

Ontario is also interested in the concept of active offer and favors its integration within the framework of the designation process.

II – DESIGNATION

Territorial Designation

Territorial designation refers to portions of the territory, regions or municipalities wherein minority official language communities obtain service guarantees. This approach is also used in Europe to define bilingual or minority language regions.

In **Ontario**, a region is designated bilingual if at least 10% of its population is Francophone or when it has a minimum of 5,000 Francophone residents. These basic criteria have allowed for the designation of 25 bilingual regions in the province.

In **Manitoba**, a designated region is one that is recognized by the Government of Manitoba and where the population can choose to receive services in French, given the concentration of Francophones in the region or the vitality of the Francophone community, as evidenced by the use of the French language in institutions.

Establishment Designation

The designation of an establishment or program is a legal recognition of the competence of an organisation or establishment to provide services in the official minority language of the province. Ontario, Quebec and Manitoba have an establishment designation process while New Brunswick has instead created two Regional Health Networks, one Francophone (Vitalité Health Network) and one Anglophone (Horizon Health Network), which share responsibility for health care and services on the territory.

Mechanisms for the designation of an establishment are usually accompanied by exhaustive administrative processes involving several administrative levels.

[28] *Delivery of Health Care Services in both Official Languages. Let's see to it!* Société Santé et Mieux-être en français du Nouveau-Brunswick, Réseau-Action formation et recherche.

In **Quebec**, a health establishment having 50% or more of its clients who are English-speaking may request recognition from *l'Office québécois de la langue française*, which then allows the establishment to submit a request for designation to the Ministry of Health and Social services, as an establishment designated to offer all of its services in both English and in French.[29]

In **Ontario**, following authorization by the Board of Directors of an establishment to undertake the designation process, the request may involve several distinct stages of approval and external decision-making levels, before being sanctioned by the Council of Ministers.

Designation criteria in Ontario are generic and have similarities to the CLAS standards in that they include factors of Francophone community representation and Francophone leadership. The Ontario designation criteria seek to:

- Offer quality French-language services on a permanent basis;
- Guarantee access to French-language services;
- Ensure Francophone participation in the organisation's Board of Directors and senior management team;
- Ensure accountability of the Board of Directors for the provision of French-language services by means of a written policy or internal regulation which defines the organisation's responsibility.

The greatest numbers of designated organisations are located in the North-East and Champlain regions.

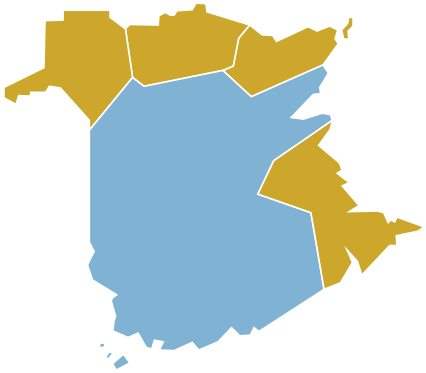
In **Manitoba**, certain organisations, establishments, programs, services and positions have been designated bilingual with the objective of promoting the delivery of French-language services in conformity with the concept of an active offer. The goal of the designation is to focus improvement efforts by targeting key points of service where the demand for services in French, as well as the capacity to offer them, is high. *The Conseil communauté en santé du Manitoba** is working with the Francophone Affairs Secretariat to develop a proposal for updating and rendering official the system of designation of Francophone and bilingual health and social service establishments, as well as the application protocol.[30]

*** Note: the Conseil Communauté en santé du Manitoba changed its name to *Santé en français* in 2014.**

Linguistic / territorial hybrid approach

In **New Brunswick**, the only officially bilingual province in Canada, the government seeks to guarantee access in the English and French languages to all provincial services, including health. The eight Regional Health Authorities were abolished in 2008 to be replaced by new structures which are both territorial and linguistic, that is:

- The Francophone Health Authority, the Vitalité Health Network (in yellow);
- The Anglophone Health Authority, the Horizon Health Network (in blue).



The division of the provincial territory between these two entities distinguishes the regions having a majority francophone population from those having a majority Anglophone population. Nevertheless, the Beauséjour Zone (Moncton area) is a joint responsibility. This hybrid structure avoids having the government find itself in a situation of linguistic duality in the area of health. However, these changes are not accompanied by any performance measures related to accessibility of services in both languages and are too recent to allow for a critical review.

The capacity to function and to offer services in the two official languages is progressing at variable rates within the two regions. The Vitalité Health Network has the highest rate of bilingualism whereas the Horizon Health Network must pursue its efforts in this regard.

[29] Website of Quebec Government *www.msss.gouv.qc.ca/ministere/saslacc/index.php?etablissements*

[30] Website of Conseil Communauté en santé *http://ccsmanitoba.ca/regions*

III – SERVICE ACCESS PROGRAMS OR PLANS

Access Programs and Plans specify the obligations of health and social service establishments with respect to the services which must be accessible to the official language minority population.

In **Quebec**, this program is sanctioned by the government and involves multiple phases, requiring that each of the Regional Health and Social service Agencies in the province develop and adopt an Access Program for health services in the English-language.

In **Nova Scotia**, the government and the Ministry of Health and Wellness work closely with the Acadian and Francophone community, in collaboration with the *Réseau Santé Nouvelle-Écosse*, in order to improve the level of services in French[31] The areas of primary health care, continuous care and support to health professionals are among the Ministry priorities. Each Regional Health Authority must submit a plan for access to French-language services and annual progress reports are published. Information on French-language services is available on the websites of the different Regional Health Authorities with updates translated on an ongoing basis.

An example

Approximately 70 ambulance paramedics in Nova Scotia are bilingual and offer emergency health care services in French.

IV – COORDINATION MECHANISMS AND POSITIONS - PROVINCIAL ROLE

In many provinces, structures or coordination positions were created within the different Ministries responsible for health or within health establishments in order to forge closer ties between the health system and the community.

For example: In **Nova Scotia**[32], the responsibilities of the coordinator of French-language services within the Ministry of Health and Well-being are to:

- Ensure a liaison between the Ministry of Health and the Francophone and Acadian communities;
- Participate in the ministerial, inter ministerial and provincial planning process in order to ensure integrated service delivery;
- Provide advice and feedback to the Ministry of Health, Regional Health Authorities and institutions on the implementation of new initiatives to improve the availability and the access to services in the French language;
- Provide assistance to the Ministry of Health, the Regional Health Authorities and the IWK Health Care Center for document translation and revision.

In **Manitoba**, a coordinator assumes defined responsibilities for the general implementation of French-language services in the health sector by virtue of the Policy on French-Language Services and the related guidelines.

In **British Columbia**, a coordinator of French-language Services assumes responsibly for the provision of information, project planning and liaison between the Francophone community, the Health Authorities and public health care institutions.

[31] *http://novascotia.ca/dhw/fr/default-en.asp*

[32] Government of Nova Scotia website *http://novascotia.ca/dhw/programs-and-services.asp*

V – HEALTH PLANNING ENTITIES - REGIONAL ROLE

In **Ontario**, the French-language Health Planning Entities represent an innovative approach to sustain the engagement of Francophone communities on issues related to health services in French and thus ensure that their needs are taken into account in the planning process of Local Health Integration Networks (LHIN's).

The six Health Planning Entities for French-language health services support one or more LHIN's and advise them on various issues, including:

- methods of engaging the French-speaking community in their area;
- health needs and priorities of the French-speaking community in the area, including the needs and priorities of diverse groups within that community;
- health services available to the French-speaking community in the area;
- identification and designation of health service providers for the provision of French language health services in the area;
- strategies to improve access to, accessibility of and integration of French-language health services in the local health system; and
- planning for, and integration of, health services in the area.

In 2011, the French Language Health Services Network of Eastern Ontario and the Francophone Wellness Network of Northern Ontario were designated as planning entities by the Ministry of Health and Long-Term Care to advise the Local Health Integration Networks (LHINs). These responsibilities are new and French-language Health Service Networks are beginning to assume the mandates assigned to them following agreements with the LHIN's. Although this approach seems promising, it is too early to assess its impact.

Note: the six French-language Health Planning Entities have since been designated.

VI - PROVINCIAL OR REGIONAL LANGUAGE ACCESS SERVICES (INTERPRETATION)

Medical interpretation services are designed to support health facilities and teams of professionals in their communication with patients and represent one of the basic methods of providing linguistic accessibility in the absence of bilingual employees. In Canada, these services are offered by different categories of organisations: government departments, non-profit organisations, private companies and community groups. The provinces of British Columbia, Alberta and Manitoba have established medical interpretation services integrated at the regional or provincial level.

In **British-Columbia**, the *Provincial Language Service* (PLS) is a program of the Provincial Health Services Authority. The program objective is to assist organisations in making their services accessible to linguistic and cultural minority communities by means of interpretation, translation, consultation and training services. This program assists Francophones by providing information to assist in identifying a health professional, to access information in French regarding health issues and to obtain information about the health system in British Columbia.[33]

> AMONG THE 95 051 REQUESTS FOR INTERPRETATION, 570 WERE FOR THE FRENCH LANGUAGE (AN INCREASE OF 100% WITH RESPECT TO 2009), OF WHICH 336 WERE FOR ON-SITE SERVICES AND 234 BY TELEPHONE
>
> 2010-2011 REPORT - PROVINCIAL LANGUAGE SERVICES

In **Alberta**, the translation and interpretation service of the *Alberta Health Services* (AHS), implemented many years ago, offers a variety of free language services to its employees in the Calgary region. These services, provided by certified interpreters, include:

- Face-to-face interpretation (Calgary region only)
- Telephone and videoconference interpretation
- American Sign Language (ASL) interpretation for the deaf and hard of hearing
- Document translation
- Language proficiency assessments

Most of these services are available in over 200 languages and dialects, including International and French-Canadian French. The purpose of this service is to meet the needs of Alberta's culturally and linguistically very diverse population rather than responding to elements pertaining to official languages. Interpretation in French or French-Canadian French is very rare (less than 10/1,400 per month).

[33] *www.phsa.ca/AgenciesAndServices/Services/Provincial-Language-Service/RessourcesFrancophones/default.htm*

In **Manitoba**, the Winnipeg Regional Health Authority (WRHA) offers complete medical interpretation program free of charge for all linguistic minority clients. The services are available by appointment either in person or by videoconference. Interpreters can also communicate messages to clients about appointments or simply as a reminder. The language access service is offered free to clients of any establishment funded by the WRHA, to the Action Cancer Society of Manitoba and to physicians under Fee-For-Service plan.

Several Canadian health institutions have also established internal medical interpretation services that are available to their staff. These services are not necessarily provided by certified interpreters and often consist of a list of employees who have knowledge of foreign languages.

VII – Santé en français Networks

Created nearly 10 years ago, the *Santé en français* Networks contribute to linking the health system with communities. Their relationships with the health care system and its stakeholders may be formal, informal or advisory, according to the needs and approaches favored in each province and territory.

The following are some examples of formal roles of the *Santé en français* Networks:

- The *Conseil communauté en santé du Manitoba* has been the official spokesperson for the French-language community in matters of health since 2004;
- The Réseau *Santé en français* Î.-P.-É (Prince Edward Island Network of French-language health services) is a government/community type Network model of French-language health services wherein the Network coordination is ensured by a government official since its creation in 2003-2004;
- The French Language Health Services Network of Eastern Ontario has had an official mandate for the designation of establishments for French-language services for more than ten years and has been officially recognized as a Health Planning Entity for two Local Health Integration Networks.

Other *Santé en français* Networks play an important role by actively participating in the efforts of their governments and Health Ministries to implement health services at the provincial and territorial level. *The Société Santé et Mieux-être en français du Nouveau-Brunswick* and the *Réseau Santé Nouvelle-Écosse* are recognized as key collaborators of the different Ministries involved in the area of health. The *Réseau-action Communautaire* plays a leadership role in health promotion in New Brunswick.

The systemic approaches described in this section are a cornerstone of culturally and linguistically adapted health services in Canada.

Systemic Approaches

I. Active offer
II. Designation
III. Access Programs or Plans
IV. Provincial coordination mechanisms and positions
V. Health Planning Entities
VI. Provincial or regional language access Services
VII. *Santé en français* Networks

However, despite a willingness to act upon systemic factors, major transformations currently underway in the health system can also have unforeseen effects on accessibility to French-language services. The following examples have been reported:

- Loss of designated status following a merger of establishments where one establishment is designated and the other does not meet the criteria for designation;
- Disappearance of bilingual positions following major administrative changes;
- The designated status of one group may lead to a lack of accountability among other groups for the provision or French-language services.

7 ORGANISATIONAL DIMENSION: DEFINITION, APPROACHES AND PRACTICES

7.1 Definition

The organisational dimension of the model affects both health establishments and the variables related to the management of these organisations: leadership of the Board of Directors and management team, strategic priorities, service planning, allocation of human, financial and technological resources, implementation of care processes, etc. Although health professionals are responsible for service delivery and quality of care, leaders and managers play a key role in the organisation of these services.

"The improvement of French-language health services and their adaptation to the values and needs of Francophone communities depend upon effective leadership and an appropriate organisation of services." [34]
(translation by authors)

Therefore, health organisations have the responsibility of putting into place an environment, policies, human, financial and technological resources, as well as continuing education programs, in order to offer services adapted to the language and culture of the communities they serve.

The organisational dimension is at the core of linguistically and culturally appropriate health services. American CLAS standards were written for health facilities and health professionals. In the U.S., initiatives that have furthered the use of standards are found mainly within the organisational and professional dimensions.

7.2 Approaches and practices

In Canada, health systems are organised according to a hierarchy of service delivery models corresponding to levels of service: primary care, secondary care and tertiary / university level care. The organisational dimension includes mainly Anglophone (occasionally bilingual) institutions governed by administrative and legislative structures which vary significantly from one province to another and which are not subject to national quality standards. For example, accreditation of health facilities is not mandatory in all Canadian provinces and territories.[35]

In this section we will examine five organisational arrangements:

I. Francophone University hospitals: Secondary and tertiary care;

II. Francophone Community Health Centers: Primary care;

III. Designated or bilingual establishments and organisations;

IV. Establishments created as a result of cultural community initiatives;

V. Modalities for linguistic adaptation of the offer of services in establishments.

I – Secondary and tertiary care – Francophone University hospitals (outside of Quebec)

Montfort Hospital, Ottawa, Ontario[36]

Founded in 1953, Montfort Hospital is a 300 bed teaching hospital offering a wide range of acute care services. At Montfort Hospital, the working language is French. However, all services are offered in both official languages.

Historical reminder

The Ontario Divisional Court and the Court of Appeal concluded that the Montfort Hospital is an institution essential to enabling the Franco-Ontarian community to flourish and that any recommendation seeking its closure is contrary to the fundamental unwritten constitutional principle of protection of linguistic minorities. The courts clearly indicate, for the first time, **that it is unconstitutional to close Montfort** given that is essential to community vitality.

After successfully ensuring its survival thanks to the tenacity and commitment of the Franco-Ontarian community, this francophone establishment now has its own Research Institute affiliated with the University of Ottawa – the Montfort Hospital Research Institute (MHRI). Montfort Hospital adheres to the

[34] Vézina, S. *Gouvernance, santé et minorités francophones. Stratégies et nouvelles pratiques de gestion,* Les éditions de la francophonie, Moncton 2007.

[35] Tremblay S., Prata G., *Cultural and linguistic competency standards in health: exploratory study of the American standards*, Société Santé et Mieux-être en français du Nouveau-Brunswick, 2011.

[36] Information from web site *www.hopitalmontfort.com/accueil.cfm*

vision of a *humanist hospital.* It realizes this vision by adopting best practices in the field of health, and in all of its spheres of activity, while using the most advanced technologies in the context of a philosophy of compassion and personalized attention.

Dr-Georges-L.-Dumont Regional Hospital, Moncton, New Brunswick
The Dr. Georges-L.-Dumont University Hospital Centre is the main establishment in the Beauséjour Zone of the Vitalité Health Network. This 302-bed hospital provides a range of primary, specialized and tertiary health care services, with the support of leading edge technology, in the official language of the patient's choice. A 45-bed residential care center is open to cancer patients from outside the immediate Moncton area.

The Dr. Georges-L.-Dumont University Hospital Centre is a provincial referral centre and a teaching and research facility. The Beauséjour Zone of the Vitalité Health Network is a francophone health sciences centre of excellence in the Atlantic Provinces.

It is also important to mention some innovative service delivery models serving Francophone populations, including:

- The New Brunswick **extra-mural** program which provides a wide range of home health services which would otherwise have had to be provided in a hospital setting;
- Some French-language general hospitals or long-term residential care centers in certain Ontario municipalities (Hawkesbury, Cornwall) where there is a significant Francophone population;
- Structuring initiatives in long-term care and in services for seniors are underway in Manitoba and Prince Edward Island.

II – FRANCOPHONE COMMUNITY HEALTH CENTERS – PRIMARY CARE

A community participation model of health service organisation emerges from the organisational modalities observed, namely the Community Health Centres (CHCs).

The Community Health Centre is a primary health care model implemented in several Canadian provinces. This is the equivalent of the Quebec Local Community Services Centres. CHCs are characterized by community governance, professional practice in inter-professional teams and a patient-centered approach. Teams of service providers include, amongst others, physicians, nurse practitioners, social workers, health promotion agents, community health workers, podiatrists, nutritionists, dietitians and volunteers.

In **Manitoba**, one of the pioneers, the *Centre de santé Saint-Boniface,* is a French-language primary health care center offering bilingual services to the French-speaking population of Winnipeg and Saint-Boniface. The Centre's programs and services are offered by an interdisciplinary team which works to promote health and prevent, treat and manage health problems. The *Centre de santé Saint-Boniface* is recognized as a model of excellence for its delivery of innovative primary health services promoting community health and well-being.

In **New Brunswick**, Community Health Centres provide health promotion and disease prevention services while ensuring efficient use of professional health care resources. They assist in transforming the health care system in New Brunswick by using a patient-centered approach.

The network of Community Health Centres in New Brunswick includes several Francophone centers that offer services in both French and English. The following are two examples:

- The *Médisanté Saint-Jean* Health Centre ensures the provision of quality primary health care to the Francophone community. It provides wellness and health promotion programs and services. Through the use of telehealth, Médisanté also has access to the programs and expertise of other centers.
- The Noreen-Richard Health Centre offers primary health care to Francophones of the Greater Fredericton area with a collaborative team of health professionals. Services of general practitioners and of other health professionals are offered by appointment. Health center staff works closely with these partners to meet the health care needs of the community.

In **Ontario**, the Association of Ontario Health Centres adopted the definition of health proposed by the World Health Organisation:

> HEALTH IS A COMPLETE STATE OF PHYSICAL, MENTAL AND SOCIAL WELL-BEING AND DOES NOT ONLY CONSIST OF THE ABSENCE OF ILLNESS OR DISABILITY.

Ontario has nearly 75 community health centers who are members of the Association of Ontario Health Centres. Of this number, 15 are Francophone or bilingual. They are all not-for-profit organisations with volunteer Board members. The CHC's provide primary health care with a focus on health promotion and disease prevention. In addition, the CHC's collaborate with the local population to improve population health.

In Edmonton **Alberta**, the Saint-Thomas Centre (Saint-Thomas Community Health Centre and Saint-Thomas Health Centre)[37] is the first community-based Francophone health center in the province. Created in 2007 as a result of the efforts of the Francophone community in Edmonton[38], it includes two distinct organisations which are part of Alberta Health Services: a community health center and a continuous care centre for seniors.

The Saint-Thomas Community Health Centre offers primary health care services, provided by an interdisciplinary team, to people of all ages and at all stages of life. The Center also offers Health and Wellness programs in order to keep individuals and community groups informed, particularly on issues of healthy lifestyles, injury prevention and the treatment of diseases.

Saint-Thomas Centre

A major challenge is to ensure that the criterion of choice of language is considered by regional placement committees as an important factor in assessment of the needs of seniors awaiting residential placement in order to allow Francophones who wish to be placed in a Francophone setting to do so.

The Saint-Thomas Health Center provides care for seniors according to the Albertan concept of *Aging in Place*, by which an elderly person can continue to reside in the same location while having access to the care they required. The Saint-Thomas Health Centre manages apartments and a continuing care center for seniors, including a section for persons with dementia.

Following five years of existence, the Saint-Thomas Centres are firmly rooted within their community. French-speaking staffing does not appear to present a problem for the Health Centre, partly because it was able to rely on the hiring of an immigrant labor force from French-speaking countries.

Other Francophone or bilingual Community Health Centers exist in **Nova Scotia** and in **Prince Edward Island**[39]. Variations in models for the organisation of primary health care services also exist which are articulated around community needs such as the health cooperative models in **Québec** and in **New Brunswick**. Finally, some establishments and residences for seniors serving Francophone populations in minority communities have emerged in some regions. For example, the *Foyer Maillard*, in **British Columbia** and the *Centre Action Marguerite* in **Manitoba** offer residential and community health services including home care, public health and mental health services.

III – BILINGUAL AND/OR DESIGNATED ESTABLISHMENTS AND ORGANISATIONS

In Canada, treatment requiring hospitalization or specialized services (cancer, mental health, rehabilitation, etc.) is in most cases provided in Anglophone establishments. Our review of the websites of several major Canadian health institutions revealed that many of them display their information in English only. It is extremely difficult, if not impossible, to find a reference to language services or to the possibility of using the services of interpreters.

It is important to highlight the efforts of Anglophone institutions in the Yukon and Northwest Territories who indicate on their websites that French-language services may be available depending upon the presence of Francophone professionals, or who offer support to meet the needs of their linguistic minority clients.

[37] *www.cscst.ca/index%20-en.htm*

[38] Colette, D. Les francophones d'Edmonton prennent en charge la santé de leur communauté, Revue le Point, Été 2007.

[39] Website of the Canadian Alliance of Community Health Centre Associations (CACHCA), www.cachc.ca

A certain number of Canadian hospitals define themselves as bilingual or are designated to provide all or a portion of their health services in French (or in English in Quebec). Also, some specialized programs are sometimes available in French. A study by Forgues (2011)[40] on the offer of French-language health services in a Francophone context enabled a better understanding of the reality of four such Anglophone or bilingual health institutions in Ontario, New Brunswick, Nova Scotia and Manitoba.

The results of this study highlight factors of influence which fall outside of the legal context surrounding the creation or designation of these establishments and which have a direct impact on the offer of services in French. These factors include:

- Board commitment and senior management leadership;
- Human resources:
  - The availability of resources to ensure the offer of language services, that is, bilingual employees (staffing, recruitment, posting, etc.);
  - Human resource management (planning, management, communication);
  - Labour relations;
- Rate of bilingualism in the organisation, the majority language environment and the perception of employees;
- Skills and language training;
- Supply and demand of French-language services.

One of the key factors of influence is senior management leadership. Without a strong vision, well communicated and supported by concrete actions, it is extremely difficult to make progress in the linguistic and cultural adaptation of services within a health facility. American establishments cited as models in the previously mentioned study of American standards have all demonstrated a strong and committed leadership.

Canadian health facility leaders must be sensitized to the issues of language and cultural barriers in health. In addition to problems currently experienced by French-speaking official language communities, issues will more frequently arise stemming from increasing cultural diversity within communities, inciting leaders to consider the impact of language and cultural barriers on the quality and safety of health services.

Despite binding legal frameworks, time-consuming designation processes and a lack of outcome evaluation data, Forgues (2011) notes advances in the area of language of service within the environments studied, while also recognizing that significant challenges are still present and that the balance is fragile between perception and reality. Access to health services in the French language remains a major challenge in many Canadian provinces.

IV – Establishments arising from the initiatives of cultural communities

Within the context of linguistic duality and bilingualism in Canada, it is often difficult to make the argument of language and cultural barriers in health. Yet the existence of language and cultural barriers is definitely present and some cultural communities have decided to take action by creating health facilities of a linguistic and cultural character. Two establishments are of interest in that they have allowed cultural communities to receive adapted health care and services. These establishments are now components of their provincial health systems, despite the absence of legislative parameters authorizing their creation:

- The Montreal Chinese Hospital in Montreal, Quebec;
- The Yee Hong Geriatric Care Centre in Mississauga, Ontario.

The Montreal Chinese Hospital, Québec

The Montreal Chinese Hospital[41] was incorporated in 1920 in order to provide medical services to the Chinese population in Montreal and other regions of Quebec.

According to Quebec laws, the Hospital must be governed by a Board of Directors of which three members are designated by the Corporation. The Corporation continues to own the land and the building and received official designation as owner Corporation from the Quebec Ministry of Health and Social services in 1996. Its mission is to preserve and safeguard Chinese language and cultural characteristics.

The mandate of the hospital is to provide health services and residential services to adults and seniors, particularly those of Chinese and South-East Asian origin. The hospital provides its services in an environment which is adapted to the values, customs and socio-cultural traditions of the patients it serves. The hospital also provides diagnostic services and medical consultation in its outpatient clinic as well as Day Center services which are reserved exclusively for elderly members of the Chinese and South-East Asian communities.

[40] Forgues, É., Bahi, B., Michaud, J. The offer of health services in French in minority context. Canadian Institute for Research on Linguistic Minorities, November 2011. *http://icrml.ca/en/site_content/91-eric-forgues*

[41] *www.montrealchinesehospital.ca/en/index_en.html*

The Yee Hong Geriatric Care Centre in Mississauga, Ontario

The Yee Hong Centre for Geriatric Care[42], officially opened in 1994, is a non-profit organisation serving seniors in the Greater Toronto area. They are responsible for planning and offering a continuum of culturally adapted services to seniors of Chinese or Asian cultural background (including the South Asian, Filipino and Japanese communities) to enable them to live autonomously, with dignity and in health.

The Yee Hong Center manages a total of 805 long-term beds shared between four long-term care facilities in the regions of Scarborough, Markham and Mississauga and offers its services to over 15 000 individuals from different ethnic communities. Services include community-based programs, rehabilitation services and senior housing. The majority of community services are financed by the Central, East Central and Mississauga Halton Local Integrated Health Networks. In October 2012, all four Yee Hong Centres received Accreditation with Exemplary standing for 2012-2016—the highest honour and recognition awarded by Accreditation Canada for an organisation's commitment to Quality and Excellence. They are a model of culturally and linguistically adapted services and have as a strategic objective to promote and facilitate the development of health services culturally adapted to the needs of ethnic communities.

V – MODALITIES FOR LINGUISTIC ADAPTATION OF THE OFFER OF SERVICES IN ESTABLISHMENTS

In Canada, there are no standard to provide a framework for linguistically and culturally adapted health services which would correspond to the American standards. Six recommendations from a Canadian study on the use of government services in French conducted by the Canadian Institute for Research on Linguistic Minorities (CIRLM)[43] are similar to several CLAS standards and thus support the relevance of having standards to guide practices.

The scope of application of the CLAS standards is that of health facilities whereas the recommendations of the CIRLM study are intended for provincial government services. Despite being written in the context of Nova Scotia, they are applicable to the other Canadian provinces and territories.

Recommendations of the CIRLM study[43]

- Ensure that government services are offered in French, both orally and in writing;
- Make road signs bilingual, as well as provincial posters and signage, making the French versions more prominent in Acadian regions;
- Propose that forms and information be written in a bilingual format, rather than in two separate versions in English and in French;
- Ensure the active offer of government services in French by advertising that the service exists, and by asking those service providers competent in French and English to wear special pins indicating that service can be provided in French and in English;
- Implement a recruitment and training strategy for civil servants who are bilingual and sensitized to the issues pertaining to the utilization of governmental services in French;
- Develop a provincial campaign to promote the French language and Acadian and Francophone culture.

In both cases (CLAS standards and the CIRLM study), we note that the essential linguistic accessibility factors target similar elements, that is:

1) Staff bilingualism;
2) The availability of interpretation services;
3) The visibility of the offer of services:
   a) Verbal and written information;
   b) The availability of written documentation regarding available services and language access rights;
   c) Signage.

[42] *http://yeehong.com/centre/index.php*

[43] Deveau, K; Landry, R.; Allard, R (September 2009). *The utilisation of French Language Government Services. A Study on the factors associated with the utilisation of government services in French by Nova Scotian Acadians and Francophones.* [Research report]. Canadian Institute for Research on Linguistic Minorities.

Staff bilingualism

Francophone or bilingual employees remain the preferred manner of ensuring language accessibility. The designation of bilingual positions predetermines the language skills required for a given position. Regional language services may make their expertise available to establishments to carry out an assessment of the language skills of candidates who apply for a position. In Manitoba, this service is offered by the *Conseil communauté en santé du Manitoba* which has issued guidelines in this regard. Language training programs are now addressing needs and allowing staff to access coveted positions.

Linguistic services and medical interpretation

Despite the fact that having Francophone employees remains the preferred approach in providing French-language services, medical interpretation is an essential element of a comprehensive response in direct support of professionals. In some regions of the country, it is not possible to make the full range of French-language health services continuously available to linguistic minority populations by relying solely on the presence of bilingual staff. However, the use of an interpreter is an option which must be circumscribed and coordinated.

The following Table presents a summary of the characteristics of a quality interpretation service according to Sarah Bowen[44].

The Winnipeg Regional Health Authority adopted a Code of Ethics and Standards of Practice in 2011 to ensure the neutrality and skills of interpreters. (Appendix II).

CLAS standards specify that we must avoid recourse to unqualified staff members, family members or other patients to act as interpreters unless requested by the client. The use of untrained persons to act as interpreters carries a number of risks such as:

- Lack of confidentiality;
- Distortion or censorship of certain information resulting from a lack of understanding of health concepts and medical terminology;
- Addition or suppression of information by the person acting as an interpreter.

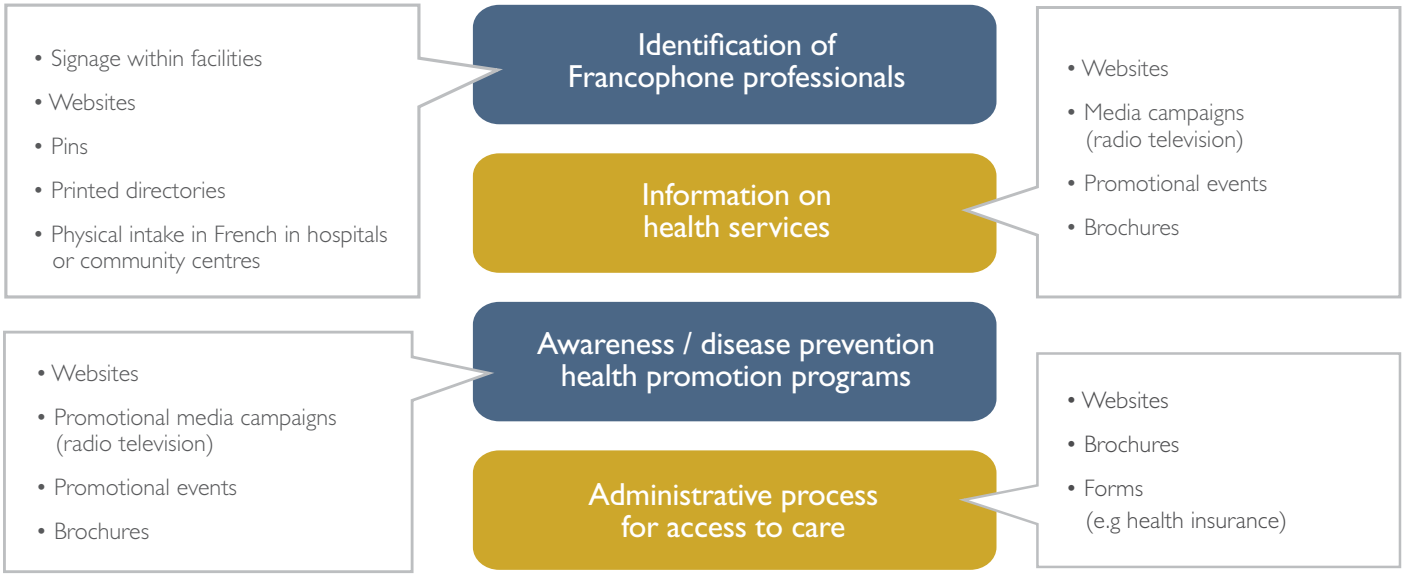
Current video conferencing technologies allow a Francophone patient to be connected to a Francophone health professional or allow for the participation of a medical interpreter to facilitate clinical consultation in the presence of language barriers. With the arrival on the market of intelligent communication tools, communication technologies could expand as a mode of language accessibility. These tools allow remote monitoring and facilitate the linkage between a patient and a French-speaking service provider, either in the same region or following interregional service agreements.

Characteristics of a quality interpretation service	Health system characteristics
• Standards for the recruitment, training, evaluation and professional practices of interpreters • Ethical and fair treatment of interpreters • Flexibility, ability to meet the needs of communities requiring services • Uniform services available 24/7 • Ability to place the client in contact with the interpreter at all points of care • Easy access for communities and the health system and ability to provide a response at the right time • Appropriate information technology systems • Visibility of the program/service to clients and health professionals • Monitoring and evaluation mechanisms	• Strong public support for these services at the highest organisational levels • Accountability at the highest organisational level • Appropriate organisational policies and procedures that support linguistic accessibility and the appropriate use of interpreters by health personnel. • Integration of interpretation services within the offer of health services • Integration of interpretation services in overall strategic planning and broader diversity initiatives • Strategies to ensure community contribution for the design and evaluation of interpretation services

[44] Bowen, Sarah. *Development of a Coordinated Response to Addressing Language Barriers within the Winnipeg Regional Health Authority – Final Report.* WRHA Language Barriers Project, July 2005.

Visibility of the offer of services

The visibility of the offer of French-language services allows an increase in efficiency of the health system as well as in the satisfaction of Francophone and Acadian communities who use these services[45]: This is a key factor in the concept of an active offer of services and of the American CLAS standards. Many elements contribute to making the offer of services visible. The following Table from the summary report *Setting the Stage* of the *Société Santé en français*, highlights the means of dissemination and communication which allow an increase in the visibility of the offer of French-language services.



Collection of language data on clients

American studies emphasize the importance of collecting data on client language to ensure an offer of health services adapted to client needs. In Canada, it is important to note the absence of a systematic data collection process allowing identification of Francophone clients as well as client language preference.

Data on language preferences would allow increased understanding of client needs, improved planning and adaptation of services, and would support research into the health of minority language communities. In addition, it was noted that the mere fact of questioning clients their language preference has the effect of highlighting the needs and, therefore, of providing a stimulus for health organisations to enrich the range of language access modalities offered[46].

[45] Société Santé en français, Setting the Stage: Summary 2004-2006.

[46] Lawson, E.H., et al. Collection of Language Data and Services Provided by Health Plans. American Journal Management Care. 2011., 17 (12): e 479-487.

8 PROFESSIONAL DIMENSION: DEFINITION, APPROACHES AND PRACTICES

8.1 Definition

The professional dimension of the conceptual framework refers to professional practices that influence the client/professional relationship including interpersonal communication, clinical decision- making, beliefs and behaviors of both client and provider and the relationship of trust between client and provider. **Language barriers contribute to the risk of errors in diagnosis and decrease the likelihood of compliance with treatments[47].**

Health professionals and clients each bring their own cultural perspective to the episode of care. The professional must understand the impact of his own values, culture, perspective and power in his relationship with the patient. In the relationship between the patient and the health professional, **language barriers displace additional power to the professional.** [48]

Health professionals have the responsibility of developing attitudes and behaviors which create a quality relationship with each client of a different language or culture. **The cornerstone of a high quality offer of service is the communication between the professional and the client.**[49]

Despite the fact that the Codes of Ethics of physicians, with the exception of Quebec, do not specify specific responsibilities in relation to linguistic accessibility, the provisions dealing with informed consent and non-discrimination are such that language barriers may compromise the ethical character of professional care. "*Three ways that ethical care is compromised are through:*

a) Failure to provide care to the same standard as received by other patients;

b) Failure to protect patients' confidentiality and;

c) Failure to adequately ensure patients' informed consent to treatment". [50]

8.2 Approaches and practices

In this section, we examine Canadian approaches to training, sensitization and professional support to assist professionals and health care providers in the acquisition of cultural and language competencies. In the United States, the creation of the *Office of Minority Health* had a catalytic effect at a National level thanks to, amongst others, online training modules that allowed the dissemination of knowledge and best practices to various professional groups.

We have grouped the modalities for professional support according to the following categories:

I. Promotion and awareness of culturally and linguistically appropriate practices among health professionals;

II. Language training and support of linguistic competencies;

III. Direct support of professional activities;

IV. Identification of professionals able to offer French-language services.

These different measures reinforce CNFS efforts for the training of Francophone health professionals, for French-language training, and for all of the support measures and tools developed in order to ensure the full integration of these professionals into work settings and within communities.

I – Promotion and awareness among health professionals of culturally and linguistically adapted practices

Guides, position papers, studies

Several studies, position statements or information documents have been prepared in recent years by various Associations and Professional Orders in the health sector to educate their respective members on the cultural and linguistic aspects of professional acts.

[47] *Beaulieu, Marielle. Formation linguistique, adaptation culturelle et services de santé en français.* Programme de formation linguistique et d'adaptation culturelle. SSF et CNFS. October 2010.

[48] *Francophones in Central Region: As Healthy as Can Be?* A Companion document to the Regional Health Authority - Central Manitoba Inc. 2009 Community Health Assessment, September 2010.

[49] Aucoin, Léonard. *Compétences linguistiques et culturelles des organisations de santé, analyse critique de la littérature.* Société Santé en français. March 2008.

[50] Bowen, Sarah. *Language Barriers in Access to Health Care*. Health Canada. November, 2001, p. 79.

These documents outline the challenges and needs which require the development of intercultural competencies and which emerge from the growth of ethno cultural communities in Canada. They distinguish between two complementary training objectives:

- Cultural diversity: *Improve relationships and interactions between culturally diverse team members;*
- Cultural Competence: *Improve the quality of care and services offered to patients of diverse cultural backgrounds.*

The following are examples of documents, guides and other tools to support the cultural competence of health professionals:

- *Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia,* Nova Scotia (2005);
- *Work Together with Francophones in Ontario: Understanding the Context and using Promising Practices,* Health Nexus and Healthy Communities, Consortium, Ontario (2009);
- *Les compétences culturelles chez les intervenants,* RIFSSSO, Ontario (2010);
- *Achieving Cultural Competence. A Diversity Toolkit for Residential Care Settings,* Ontario Ministry of Children and Youth Services (2008);
- *Embracing Cultural Diversity in Health Care: Developing Cultural Competence Guidelines,* Registered Nurses' Association of Ontario, (2007).

Measures to support an active offer – Manitoba

The Government of Manitoba has developed a series of tools to support the Policy on active offer which states that services in the French language must be clear, accessible, and comparable in quality to services offered in the English language. These tools include:

- A DVD on orientation to the active offer of services in the French language in Manitoba;
- A pamphlet on the concept of an active offer;
- An official poster on the offer of government services;
- A magnetic badge to identify bilingual staff.

In complementary fashion, the *Conseil communauté en santé du Manitoba* has developed specific tools intended for **health care providers**, including a workshop on active offer. These measures sensitize **health professionals** in order to have an active offer integrated into their professional practices.

Interactive workshop Acadie at a Glance – Nova Scotia 2011[51]

Acadie at a Glance: The Acadians of Nova Scotia and French-language Services is a one-day workshop designed to assist **public servants** in achieving a better understanding of the provincial government's commitment to developing and delivering French-language services. It seeks to increase awareness of the reality of the Acadian and Francophone community and explains how the historical, social, economic, and political contexts of the Acadian and Francophone community provided a foundation for *Nova Scotia's French-language Services Act* (2004) and the *French-language Services Regulation* (2006).

Following the success of this initiative, a second workshop on health professional practices has been developed, *Health Care in French at a glance.* The *Réseau Santé - Nouvelle-Écosse* and the CNFS are participating in this project and will be responsible for its implementation.

The Bonjour! Awards for Excellence in French-language services – Nova Scotia

The *Bonjour!* Awards for Excellence in French-language services recognize the exceptional contributions of **government employees** to the development and delivery of French-language programs and services. The awards encourage and inspire them to proactively respond to the needs of the Acadian and Francophone community.

These two examples serve to increase awareness amongst stakeholders acting directly at the legislative and operational levels while promoting the development of competencies related to Francophone and Acadian culture, thereby reinforcing the adoption of a systemic approach to issues of linguistic and cultural accessibility.

Reference framework: training for active offer – The CNFS 2012[52]

The CNFS developed a framework on training for an active offer of services to raise awareness among health professionals of the practices and values that underlie their interactions with customers. **Health professionals** are called upon to integrate an active offer into their practice using a client-centered approach. While acknowledging the systemic and organisational issues surrounding an active offer, professional capacity to communicate clearly and effectively with patients is recognized as essential.

Health education institutions will be called upon to train **students** so that they can acquire a profile of knowledge, skills and attitudes inherent to an active offer of services.

[51] Web site of the Office of Acadian Affairs *www.novascotia.ca/acadian/en/at-a-glance-workshop.htm*

[52] Lortie, Lise et Lalonde, André J. *Reference framework. Training for active offer of French-Language health services.* CNFS. July 2012.

Development of Francophone medical resources: Roadmap of the Association of Faculties of Medicine of Canada (AFMC) and partners

This joint project of the AFMC Resource Group for Canada's minority Francophone communities, the *Société Santé en français,* the CNFS and the Médecins Francophones du Canada (MdFC), offers a roadmap consisting of recommendations and an action plan to support the development and deployment of French-speaking **physicians** based on complementary strategies. Some seek to increase and improve the language and cultural competencies of students and professionals. Some examples of activities to implement are:

- Thematic networking activities among French-speaking **medical students**, or between students, residents and Francophone physicians;
- Workshops granting continuing education credits: medical terminology in French (CNFS Ottawa) or Cultural Competency Training (Saskatchewan);
- Continuing medical and interdisciplinary education sessions (Médecins Francophones du Canada).

II – Language training and support for linguistic competencies

One of the basic issues in increasing access to care and services in French for Francophone minority communities remains the availability of a sufficient workforce, with appropriate language and cultural skills, who work in various settings (schools, clinics, community organisations, etc.). The approaches presented here are intended primarily for employed **professionals and health care providers** who wish to develop their language skills in order to better serve their patients.

Health Canada language training programs 2009-2013

The l*anguage training and cultural adaptation project* (FLAC - Formation Linguistique et Adaptation Culturelle) is a component of the Official Languages Health Contribution Program under the *Roadmap for Canada's Linguistic Duality* 2008-2013. The FLAC project was developed in conformity with the broad guidelines of the *Société Santé en français* and the *Consortium national de formation en santé.* The FLAC targets the following results:

- Increase in the number of **health professionals** to meet the health needs of official language minority communities;
- Increase in the coordination and integration of health services offered to official language minority communities within institutions and communities.

This initiative has enabled the *Société Santé en français* to implement and support structuring projects and studies leading to the development and sharing of new knowledge. The initiative also enabled the development and implementation of many training approaches and retention initiatives across the country for Francophone and Anglophone professionals in minority settings.

Self-study Workbook for Health and Social Service Professionals: Triage Nurses[53] English language training Project

In collaboration with the *Ordre des infirmières et infirmiers du Québec* (OIIQ), McGill University developed tools for **triage nurses** which include self-study CDs and an animation guide. This OIIQ collaboration in the development of language training specific to sectors of nursing activity facilitates learning and the acquisition of effective and safe communication skills in a specific work context.

Bourse d'incitation au recrutement

Through the efforts of the *Conseil communauté en santé du Manitoba,* a work incentive bursary was created by the Nurses Recruitment and Retention Fund (NRRF) for nurses who fill a position requiring bilingualism. This bursary was in effect on April 1, 2012.
www.gov.mb.ca/health/nurses/bfrng.html

III – Direct support of professional acts

Medical interpretation services in support of acting professionals[54]

Language access by qualified interpreters is one of the means available to **health professionals** to enable them to communicate with their patients. At the Winnipeg Regional Health Authority in Manitoba, language access services have developed a large variety of tools to promote clear, safe and efficient communication in support of the use of qualified interpreters. These tools include, among others, cards for identification of desired language, guidelines to facilitate the use of services, and forms. These services are offered free of charge to health professionals who are encouraged to use them.

Campaign for Safer Health Care Now!

The Registered Nurses Association of Ontario has promoted the campaign of the Patient Safety Institute: *Safer Health Care Now!* This initiative seeks to improve the safety of care offered to patients in Canada by means of learning, sharing and implementation of strategies which have allowed for a reduction of preventable adverse events. It would be of interest to also add strategies related to language barriers.

[53] *www.mcgill.ca/hssaccess/fr*

[54] *www.wrha.mb.ca/professionals/language/index.php*

IV – IDENTIFICATION OF PROFESSIONALS ABLE TO OFFER SERVICES IN FRENCH

Human resources are the cornerstone of health systems. One of the best ways to understand the actual situation regarding official languages spoken by health professionals remains the identification of language skills by the professional organisations that represent them.

The language in which **health care providers** are able to provide services and interact with clients is not a variable that is systematically recorded. The Canadian Institute for Health Information (CIHI) maintains a national database of human resources in the health sector. To the extent that this data is captured at source by Professional Associations or Orders, it would be possible to include appropriate variables measuring the capacity of health and social service providers to offer services in French.

A study by the *Consortium national de formation en santé* (CNFS) and the *Société Santé en français*[55] confirms that detailed knowledge of the capacity of the workforce to provide services in the French language is essential for human resources planning and management based on population and community needs. Such data is even more important in a minority context.

In 2011, the *Société Santé en français* also undertook a tour of **national professional associations** to persuade them to record the language skills of their members in their registration forms. This awareness process will continue at the level of provincial or territorial associations.

Nursing care in French Project

Launched in January 2006 by the **Canadian Nurses Association (CNA)** and sponsored by Health Canada and the *Société Santé en français*, the *Projet soins infirmiers en français*[56] objective was to lay the foundations for increasing access to quality French-language nursing services for Francophone minority communities. Following this project, the addition of a language question in the application form for a license to practice allows provincial and territorial associations and colleges to identify francophone nurses across the country Networking tools for nursing care have also been developed.

Rationale for quality French-language health care services

In 2011, *the Conseil communauté en santé du Manitoba** completed an exploratory study on language skills at the time of hiring - *Étude exploratoire sur les compétences linguistiques à l'embauche* – which provided: a summary portrait of the reality of the main institutions responsible for providing French-language health services in Manitoba, a summary of Canadian jurisprudence, information regarding collective agreement positions on this subject and also the identification of human resource strategies. As a result of this study, an *Argumentaire pour des services de soins de santé en français de qualité* (2012) was developed. The objective is to provide arguments and tools to enable **health professionals, managers, members of Boards of Directors** and any other person interested in the development of French-language health services to demonstrate the importance and the impact of these services on the health of Francophone communities in Manitoba.

Directories of health professionals by the Santé en français Networks

The directories of health professionals developed by the *Santé en Français* Networks currently represent the only database on health professionals able to provide health services in French. Given that these directories are created as a result of a voluntary registration process, that they are not standardized and not systematically updated, they cannot serve as a reliable indicator of the offer of services in French in a given province or locality.

***Note: The Conseil Communauté en santé changed its name to *Santé en français* in 2014.**

[55] La santé des francophones en situation minoritaire : un urgent besoin de plus d'informations pour offrir de meilleurs services, CNFS et SSF 2011.

[56] AIIC. *Projet soins Infirmiers en Français : Rapport de Synthèse*. August, 2007.

9 FINDINGS AND ORIENTATION AVENUES

The description of practices that promote linguistically and culturally appropriate health services presented in the previous chapters is certainly not exhaustive, nor sufficient to allow a more detailed analysis or to systematize practices and widen their dissemination. However, it captures the broader context within which these practices are situated and identifies avenues to enrich and pursue further reflection.

In this chapter, we present some general observations and findings resulting from our study in order to highlight the characteristics of a linguistically appropriate offer of services in Canada. Finally, we will present some avenues for reflection on the potential role of standards on linguistic and cultural competencies in the health sector in a Canadian context.

9.1 GENERAL FINDINGS

General context

- In Canada, linguistic duality is a reflection of history, rights and laws. Each province or territory has adopted its own approach to linguistic accessibility;
- In the area of health, authority was decentralised to the provinces despite the existence of a national health insurance system. No constitutional provision was foreseen to guarantee the rights of official language minorities in the area of health;
- There is a direct link between the presence of a provincial legislative framework for French-language services and the development of approaches addressing linguistic accessibility.

Systemic dimension

- The approaches identified in this study focused mainly upon linguistic accessibility with few measures identified for cultural adaptation. In Canada, cultural competencies are most commonly addressed in association with newly arrived residents and Aboriginal communities;
- A legislative or regulatory framework for French-language services is required in order to ensure the sustainability of a significant offer of services integrated within each province. Certain initiatives may exist in the absence of laws or regulations, but the scope of the resulting offer of services is limited;
- There exist a variety of provincial systemic approaches designed to facilitate access to French-language health services. No single approach works in isolation. The combination of more than one approach contributes to a more significant offer of French-language services;
- In the absence of evidence-based data resulting from evaluation and research, it is difficult to evaluate the impact of the measures implemented.

Organisational dimension

- The existence of Francophone or bilingual primary health care establishments facilitates adaptation of health care for Francophone clients and contributes to the integration of French-language services within the health system;
- Challenges associated with linguistic accessibility for minority communities are amplified at the secondary, tertiary and specialised levels of health care (mental health, cancer, rehabilitation etc.). Options are more limited or simply not available in many provinces. Access to French-language services largely depends upon the availability and identification of professional staff able to offer services in the French language;
- Linguistic access and interpretation services do exist but appear to be infrequently utilised by Francophone communities in certain regions, a fact which may indicate that these services fail to meet the specific needs of these communities;
- The limited capacity of health systems to adapt to cultural and linguistic needs will likely be accentuated in the future as a result of demographic changes in Canada and may lead to the creation of parallel structures. Cultural communities have begun to organize themselves in Canada to enable access to more culturally and linguistically appropriate health services.

Professional dimension

- Generally speaking, no explicit standards exist which provide a framework for communication between linguistic minority populations and health professionals;
- The best services are those provided by bilingual or Francophone employees. Language training efforts are required targeting professionals who already have basic French-language skills. However, language training alone will not be sufficient to meet demand in the Canadian context;
- Sensitization to cultural diversity is an issue of increasing interest to governments, health establishments and professional associations. This sensitization takes the form of general training, professional development, continuing education, and training in the workplace;
- The lack of systematic data collection regarding the linguistic capacities of health professionals continues to be a significant problem for the planning and organisation of linguistically adapted services.

9.2 ACTIONS TO PROMOTE LINGUISTIC ACCESSIBILITY IN HEALTH

In general, access to a significant offer of services in the French language within a minority context, as observed in this study, is a reflection of a hierarchical approach wherein each step serves as a foundation for the following step:

- A legislative framework to render political engagement and intentions more concrete;
- Designation to focus efforts in areas where the Francophone population is sufficient in number;
- The application of systemic approaches to ensure a significant and sustainable offer of services;
- Sites where services are offered, committed leadership and qualified human resources.

The modalities and approaches presented at the systemic level are relatively recent, primarily target linguistic accessibility and have not generated the evidence required to allow assessment of their impact upon access to services in French in a minority context.

Despite its hierarchical nature, the health system tends to operate in silos. In order to ensure access to health services in French for official language minority communities, the development of trajectories or continuums of integrated services, remains both a solution and a major challenge at all levels of care.

Role of *Santé en français* Networks

This study also confirmed the important role played by communities in the area of health. The creation of the *Santé en français* Networks more than ten years ago was a key factor.

A direct link appears to exist between the growth of French-language services in the provinces and the actions of Networks and communities on the front line.

Even in those provinces where the offer of services remains weak, the initiatives and projects put forth by the *Santé en français* Networks are a reflection of community commitment to improve access to health services. However, the results remain difficult to quantify in the absence of data on language access.

This study attempts to provide an overview of the offer of health services in the French-language, by province and territory based upon systemic and organisational criteria. This overview confirms that three provinces have a relatively high level of adaptation of their offer of French-language health services (New Brunswick, Ontario, Manitoba). Other provinces, such as Nova Scotia, are in the process of enhancing their offer of service.

THE FOLLOWING DIAGRAM ILLUSTRATES THE HIERARCHICAL APPROACH INCLUDING THE INFLUENCE OF THE NETWORKS AND THE COMMUNITY.

9.3 Linguistic and Cultural Competencies – The Role of Standards

The present study demonstrates the pertinence of a normative approach to ensure the quality and safety of health care and services in a minority context.

The normative approach exerts powerful leverage in placing discussions on linguistic and cultural accessibility within a context reflecting the core values of health organisations and professionals – the quality, efficiency and safety of services.

Senior management leadership is a key factor in the organisational support provided for the implementation of standards. Health professionals are responsible for the implementation of standards in their relationships with clients. Lastly, the *Santé en français* Networks can act in support of establishments and health professionals in their efforts to provide health services adapted to the linguistic and cultural needs of communities.

The American CLAS standards

American standards for culturally and linguistically appropriate services (CLAS) have encouraged the development of modalities for linguistic accessibility within health establishments in the United States. These standards also define the notion of cultural and organisational competencies. The CLAS standards encompass, within a single framework, three themes which are essential for the improvement of services to minority populations and for the reduction of health disparities, namely:

- Culturally competent care;
- Modalities for linguistic accessibility;
- Key components of organisational support for cultural competency.

We find some elements of CLAS standards in many systemic approaches described in this report.

For example, the Ontario designation criterion "*ensure the presence of Francophones within the board of directors and senior management*" is related to CLAS standards n°2 and n°12 which specify that:

- *"Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area."* - CLAS standard n°2
- *"Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities."* - CLAS standard no12.

The criteria for an active offer of services in Manitoba (see page 27) correspond to CLAS standards 4 to 7 on access to language services.

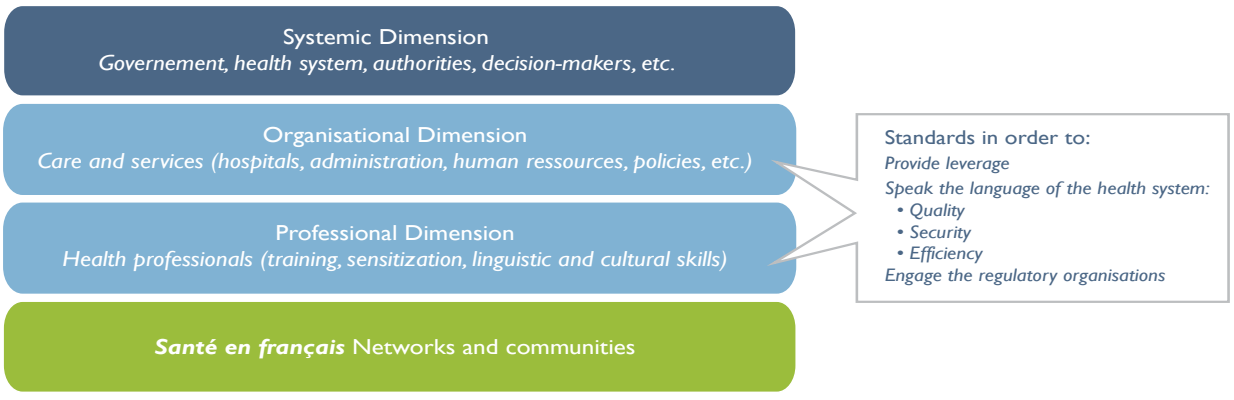
Accreditation standards and organisations

The CLAS standards served as leverage to influence the American national health sector accreditation organisations. They have gradually **adopted the principles** underlying the CLAS standards and **adapted their own standards** to take into account issues of communication and cultural and linguistic competence in health.

Drawing on the CLAS standards, the criteria of an active offer of services and the criteria for designation, discussions could be undertaken with Accreditation Canada, the Institute for Patient Safety and other stakeholders representing health professionals to ensure that existing standards are rendered more explicit regarding language competency and the reduction of language barriers in health. Such discussions were initiated in 2007 by the Prince Edward Island *Santé en français* Network and remain a promising avenue for action.

Another approach would be to consider the development of Canadian linguistic and cultural competency standards based upon the concept of an active offer of services. This would subsequently allow for the development of application criteria that could take into account the health sector environment in Canada as well as the provincial and territorial contexts.

The following diagram illustrates the impact of standards on the health system, principally at the level of the organisational and professional dimensions.



10 CONCLUSION

The study allowed the emergence of a global portrait of access to French-language health services for Francophone and Acadian official language minority communities in Canada.

To ensure the quality and safety of health services, governments, managers and professionals must take into account the linguistic barriers that represent not only an obstacle in terms of accessibility, but also opportunities for achieving gains in efficiency and effectiveness in the delivery of health services.

Santé en français Networks play a leading role in identifying solutions adapted to the Canadian reality. Over the past decade, Francophone and Acadian communities in Canada have demonstrated their ability to organize themselves, create partnerships and implement innovative solutions to actively participate in improving their health.

Different approaches have been developed and implemented in various provinces and territories to ensure a linguistically adapted offer of service. In the absence of such modalities or sites for providing French-language services, this offer of services remains limited.

The normative approach has proven itself in the United States and continues to advance understanding of the impact of language and cultural barriers in the health sector. The normative approach combined with different methods implemented in Canada to promote linguistic accessibility for official language minorities may prove to be a promising avenue to explore in the future.

In Canada, standards of cultural and linguistic competence in health represent an innovative approach. Their integration in an explicit fashion within national standards and codes of ethics for health professionals could have a positive impact on the quality and safety of health services.

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APPENDIX I - CLAS STANDARDS

THE FOLLOWING TABLE PRESENTS THE CLAS STANDARDS

Culturally Competent Care (Standards 1-3)

Directives which the U.S. Federal and State governments recommend be adopted.

Standard 1 *– Health care organisations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.*

Standard 2 *– Health care organisations should implement strategies to recruit, retain, and promote at all levels of the organisation a diverse staff and leadership that are representative of the demographic characteristics of the service area.*

Standard 3 *– Health care organisations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.*

Access to Language Services (Standards 4-7)

Mandatory standards for recipients of Federal funding (such as Medicare and Medicaid health insurance programs).

Standard 4 *– Health care organisations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.*

Standard 5 *– Health care organisations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.*

Standard 6 *– Health care organisations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*

Standard 7 *– Health care organisations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.*

Organisational support for cultural competence (Standards 8-14)

Directives which the U.S. Federal and State governments recommend be adopted.
It is recommended that Standard 14 be voluntarily adopted by health organisations.

Standard 8 *– Health care organisations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.*

Standard 9 *– Health care organisations should conduct initial and ongoing organisational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.*

Standard 10 *– Health care organisations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organisation's management information systems, and periodically updated.*

Standard 11 *– Health care organisations should maintain a current demographic, cultural, and epidemiological profile of the community as well a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.*

Standard 12 *– Health care organisations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.*

Standard 13 *– Health care organisations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.*

Standard 14 *– Health care organisations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.*

*Note: following completion of the present report, new enhanced National CLAS Standards were adopted in 2013
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

APPENDIX II - EXTRACT FROM THE WINNIPEG REGIONAL OFFICE OF HEALTH INTERPRETER CODE OF ETHICS[57]

CODE OF ETHICS FOR INTERPRETERS

Accuracy and Fidelity – Interpreters render the original message accurately and faithfully into the target language.

Confidentiality – Interpreters treat as private and confidential all information learned in the performance of their professional duties and adhere to requirements regarding disclosure.

Impartiality – Interpreters maintain impartiality, refrain from counseling, advising or projecting personal biases or beliefs and disclose potential or actual conflicts of interest.

Respect – Interpreters treat all parties with respect and support mutually respectful relationships among all parties.

Cultural Responsiveness – Interpreters are aware of cultural similarities and differences encountered in the performance of their duties.

Role Boundaries – Interpreters maintain the boundaries of their professional role and refrain from personal involvement.

Accountability – Interpreters maintain high quality in the performance of their professional duties and adhere to standards of practice, policies and legislative requirements.

Professionalism – Interpreters conduct themselves in a professional and ethical manner.

Professional Development – Interpreters continually further their knowledge and skills, through independent study, continuing education and actual interpreting practice.

[57] *WRHA* Language Access Code of Ethics and Standards of Practice for Interpreter, *Revised in January 2011*.

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