



Improving Access to Health Services in French: The Power of Networking and Knowledge Mobilization, a Proven Canadian Model

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Public Policy and Citizen-Based Practices That Support Social and Health Services for Official and Co-Official Language Minority Communities. An International Perspective: What Has Really Been Achieved and Where Are the Gaps?

Politiques publiques et pratiques citoyennes soutenant les services sociaux et de santé pour les communautés minoritaires de langues officielles et co-officielles. Une perspective internationale : ce qui a été accompli et ce qui reste à faire

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Article abstract

Language barriers have a detrimental impact on access to health services and compromise patients' safety. The purpose of this article is to describe and evaluate how the *Société Santé en français (SSF)* and the 16 *French Language Health (FLH) networks* used networking and knowledge mobilization for improving access to health services in French for Francophone and Acadian minority communities (FAMC). Method: Data was extracted from the 2013-2018 program's reports and evaluation. Results confirmed that networking effectively mobilized key partners for better access to health services in French regardless of location. This access increased incrementally as a function of the customized level of support provided to the system by the SSF and the FLH networks and, to a lesser extent, when FAMC represented over 3.5% of the total population in the region, province or territory. Networking and knowledge mobilization contribute to augmenting access to safe, quality health services in French for FAMC.

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Abstract

Language barriers have a detrimental impact on access to health services and compromise patients' safety. The purpose of this article is to describe and evaluate how the *Société Santé en français (SSF)* and the 16 *French Language Health (FLH) networks* used networking and knowledge mobilization for improving access to health services in French for Francophone and Acadian minority communities (FAMC). Method: Data was extracted from the 2013-2018 program's reports and evaluation. Results confirmed that networking effectively mobilized key partners for better access to health services in French regardless of location. This access increased incrementally as a function of the customized level of support provided to the system by the SSF and the FLH networks and, to a lesser extent, when FAMC represented over 3.5% of the total population in the region, province or territory. Networking and knowledge mobilization contribute to augmenting access to safe, quality health services in French for FAMC.

Résumé

Les barrières linguistiques nuisent à l'accès aux services de santé et compromettent la sécurité des patients. Le but de cet article est de montrer comment la *Société Santé en français (SSF)* et les 16 *réseaux santé en français (RSF)* ont fait appel au réseautage et à la mobilisation des connaissances pour améliorer l'accès aux services de santé en français des communautés francophones et acadienne minoritaires (CFAM). Méthode : Les données proviennent des rapports de la programmation 2013-2018 et de son évaluation. Les résultats ont confirmé la mobilisation des partenaires-clés pour améliorer l'accès aux services de santé en français, peu importe l'endroit. Cet accès a augmenté graduellement en fonction du niveau de soutien personnalisé, donné au système par la SSF et les RSF et quand les CAFM représentaient plus de 3,5 % de la population totale dans la région, province ou territoire. Le réseautage et la mobilisation des connaissances sont les outils essentiels d'un meilleur accès à des services de santé de qualité et sécuritaires.

Over the past decades, mounting evidence has shown that language barriers have a detrimental impact on access to health services, quality of care, respect of human rights, health service user and worker satisfaction, and treatment outcomes (Martin, 1992; Bowen, 2001; Johnstone & Kanitsaki, 2006; Bartlett, Blais, Tamblyn, Clermont, & MacGibbon, 2008; Chen, Fang, & Rizzo, 2011; Schwei *et al.*, 2016). According to the Canadian and the international literature, it is well known that linguistic minority groups do not receive appropriate, tailored information; they often delay consulting a primary care professional and are at risk of non-compliance with treatments (Green, 2007; Bailey, Sarkar, Chen, Schillinger, & Wolf, 2012; Falla, Veldhuijzen, Ahmad, Levi, & Richardus, 2017). They also experience errors or delays in diagnostics, longer hospital stays, reduced mental health interventions and palliative care (Bowen, 2015). This linguistic discordance also results in greater anxiety, low satisfaction with care, and poor chronic disease management (Govere & Govere, 2016; Zhao, Segalowitz, Voloshyn, Chamoux & Ryder, 2019). Frequently, the protection of informed consent rights and confidentiality is lacking for users with a limited knowledge of English (Bowen, 2015).

One Federal Health Care Act and 13 Independent Health Care Delivery Jurisdictions

In a bilingual country such as Canada, where both English and French languages have official status at the federal level, the distribution of populations over the 10 provinces and 3 territories has resulted in a Francophone and Acadian minority outside Quebec and an Anglophone minority in Quebec; New Brunswick is currently the only officially bilingual province.

In Canada, health is not a legislative power included in the *Constitution Act, 1867*.¹ It is rather a sector that comes under two levels of government: federal and provincial or territorial, in the exercise of their respective legislative powers (Lajoie & Molinari, 1978; Hogg, 2007). With the establishment of the *Canada Health Act*, in 1985,² shared responsibilities for the health care insurance system were determined for both the federal government and 13 provincial/territorial jurisdictions. Five conditions were adopted in the Act to ensure the respect of the Canadian values of solidarity and equity: the public administration of the health care insurance system, comprehensiveness, universality, portability from one province/territory to another, and accessibility of care.

More specifically, the *Canada Health Act*, while recognizing provincial jurisdiction in health, establishes “criteria and conditions in respect of insured health services and

1. (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, n° 5.

2. RSC 1985, c C-6.

extended health care services provided under provincial law that must be met before a full cash contribution may be made”³. The universality and accessibility conditions attached to certain health-related contributions and payments by the federal government to the provinces means that health care is expected to be provided in both official languages across the nation, including official language minority communities in Canada. Unfortunately, it has not been the case. A number of studies carried out in Canada have shown that, in practice, universal access to health services in the official language of one’s choice is far from being a reality (Michaud, Forgues & Guignard Noël, 2015), and that the minority Francophone population is up against major obstacles in terms of equitable access, quality health services and health outcomes comparable to the majority (Negura, Moreau & Boutin, 2014; Simard *et al.*, 2015; van Kemenade, Bouchard, & Bergeron, 2015). This is why the late Mauril Bélanger, in his Bill C-202, *An Act to Amend the Canada Health Act (linguistic duality)*, proposed adding linguistic duality as a condition that provincial health insurance plans would have to meet to qualify for the full cash contribution.⁴ Bill C-202 never became law. Consequently, nearly 1.2 million Francophone and Acadian Canadians in minority communities do not experience access to an equitable provision of health services in French in their community. The harmful effects of language barriers on access to health care and people’s satisfaction reduce the quality of the services received, placing individuals at risk and affecting the wellness of Francophone and Acadian minority communities (Bouchard *et al.* 2009; Bélanger *et al.*, 2011; de Moissac & Bowen, 2019).

The Establishment of Société Santé en Français (SSF)

As a follow-up to the Montfort Hospital crisis (Gagnon, 2017) and the lobbying efforts of the Fédération des communautés francophones et acadienne du Canada (FCFA), a federal consultative committee, under the health minister of the day, was established to review the situation and make recommendations to the government regarding equitable access to health services for official language minority communities (CCFSMC, 2001, p. 23-24). In 2002, Société Santé en français (SSF) was created under the partnership model of the World Health Organization’s Towards Unity for Health (WHO, 2001), to better respond to the health needs of Francophone and Acadian minority communities (FAMCs). As a not-for-profit organization, Société Santé en français⁵ is the current national leader, working with 16 provincial, territorial and regional health networks, called French Language Health networks (FLH networks), to improve equitable access to quality health programs and

3. *Canada Health Act*, R.S.C., 1985, c. C-6, s 4.

4. Bill C-202, *An Act to amend the Canada Health Act (linguistic duality)*, 2nd Sess, 37th Parl, 2002 (defeated at second reading 20 March 2003).

5. The work of Société Santé en français is funded by the Action Plan for Official Languages 2018-2023: Investing in Our Future (Government of Canada).

services in French, so that Francophone and Acadian minority communities enjoy their health in French and receive healthcare in their own language.

To maximize impact, Société Santé en français and the FLH networks chose to focus on networking and knowledge mobilization as levers for action.

The purpose of this article is to a) describe how networking is the cornerstone of Société Santé en français and how knowledge mobilization enables action, b) evaluate how networking and knowledge mobilization have both fueled major advances in strengthening access to health services in French and how systemic barriers have been reduced in some jurisdictions, c) briefly discuss future strategic directions and initiatives.

Method

This is a deductive qualitative case study design (Baxter & Jack, 2008). The phenomenon under study is the improvement of access to health services in French for FAMCs through the actions of Société Santé en français, more specifically networking and knowledge mobilization. Sources of information stemmed from emerging research literature on the social determinants of health of marginalized and ethnic minority populations, reports completed for SSF over time, the evaluation results of its 2013-18 programming, and a review of best practices in the regional, provincial and territorial FLH networks affiliated with SSF.

Networking as the Cornerstone for Improving Health Access in French

Since its creation in 2002, Société Santé en français has adopted a collaborative approach based on the World Health Organization's model Towards Unity for Health—Challenges and Opportunities for Partnership in Health Development (TUFH) (WHO, Boelen, 2000; Boelen, 2012)

The “partnership pentagon” illustrated in Figure 1 demonstrates the intent to make individuals and communities full partners in decision making to better meet their needs. The aim of this approach is also to break the isolation of health care providers, so that they can engage with patients and service organizations, to achieve the common goals of increasing access to health services in French, and positively impacting FAMCs wellness. Networking is the common thread connecting all partners to implement sustainable strategies and initiatives. The TUFH model was reproduced within each newly formed provincial, territorial or regional French Language Health network. Over time, FLH networks have become the main interlocutors of the community, as local agents of mobilization for improving health services in French, catalysts for innovative initiatives and experts in the area of health in French. With 15 years of knowledge and skills development, as well as leadership building

under their belts, the SSF and FLH networks made networking the cornerstone of their work. The importance of creating and maintaining strong partnerships with and between the five types of partners—policymakers, health system organizations and managers, health professionals, communities, and post-secondary educational institutions—is central to their core business of achieving lasting change.

Figure 1
Towards Unity for Health (TUFH) Model



Source : <https://www.santefrancais.ca/en/healthbound/>

The 16 FLH networks—members of Société Santé en français—are independent bodies working in the heart of the action. Given that they are in the field, they understand their communities' real needs and priorities and aim to find ways to improve access to health services at the local level, in cooperation with their partners. These provincial and territorial FLH networks are seen as hubs for the management of FAMCs health concerns, and each operates in a different demographic, political, legal and systemic environment. Moreover, they are at different stages of development and intervention. As such, an asymmetrical approach was required to progress at the national level (CCFSMC, 2007). Some of them find themselves in a situation of having to raise awareness of the basic needs of their Francophone community with their pentagon partners, while others are in a structuring or building phase. As the legal and political environment in which FLH networks operate varies from one province or territory to another, they must adapt their strategies and actions to their respective realities. For example, some networks have obtained an official recognition or a formal role in their health system and are called on as planners, consultants or representatives of their communities. These FLH networks are able to recommend

substantial actions for increasing access or expanding the provision of services in French by health professionals. For example, in Ontario, the three FLH networks work directly with health authorities to increase the number of designated health services organizations under the *French Language Services Act* of Ontario⁶ and to implement initiatives and projects such as increasing the number of long-term care beds for Francophones. In this context, the improvement in the services offered in French is observable. For other FLH networks, the priority is raising awareness among health system's decision makers of the importance of access to health and social services in French for the communities in their catchment area. In Alberta, for example, Réseau santé albertain has created a project for recruiting *health allies*, who are volunteers engaging with managers and professionals to make their community's needs known. Increasing access is a longer-term commitment in this case. Despite the diversity of settings and structures, learning experiences and best practices can be shared among the networks and through the prevailing role of Société Santé en français as a national leader and facilitator.

A number of other challenges exist, as health funding, governance and administration fall under provincial jurisdiction. The 16 FLH networks must collaborate with 9 provincial and 3 territorial unique health systems, each with different organizational characteristics, priorities, and varying degrees of centralization. This situation also means 12 health systems to monitor, analyze, understand and influence. Such diversity in the Canada's health systems implies that actions put forward must constantly be adapted and tailored to the province or territory where they are to be implemented. A solution that is applicable to Saskatchewan's health system is not necessarily applicable to Nova Scotia's, for example.

In addition to the uniqueness of each health system, one of the greatest challenges relates to the many partners, with whom to establish relationships. The participation and engagement of these key partners at local, regional, provincial, territorial and federal levels are paramount to reaching sustainable results. As an example, between the 2013-2018 period, the SSF and FLH networks were able to launch several approaches designed to a) raise awareness about the impact of language barriers, and b) specifically equip and support English-language health institutions in their efforts to make health services accessible in French to FAMCs. One of these projects was developed in partnership with *Réseau franco-santé du Sud de l'Ontario*. Their health human resource strategy⁷ is designed to meet the needs of anyone in the system interested in developing expertise in bilingual human resources. It consists of a complete online platform describing how health organizations can recruit and retain bilingual staff. More specifically, it outlines where to start, what to do, and how to equip health managers in their roles. The completion of this online human resource strategy

6. *French Language Services Act*, RSO 1990, c F.32.

7. See: <https://hhrstrategy.ca/>

module gives credits recognized by the Canadian College of Health Leaders. The online guide is free of charge, and a researcher in Wales who became aware of this resource said:

I was particularly taken by the Framework (HHR Strategy) because it meant so much to us in Wales... It made an awful lot of sense to us in Wales because it's the kind of steps that we are taking to look at the big challenge that we have in terms of workforce planning and workforce development, which of course is such a huge aspect of active offer. Unless we have the workforce there, we simply cannot make that active offer.⁸

In short, networking includes an entire array of activities, which have sustained the efforts of Société Santé en français and the provincial/regional/territorial FLH networks, and which have had lasting impacts coast to coast. It has helped FAMCs to face limited resources and confront ignorance regarding their access to health and social services, by allowing many of their communities to become better informed and equipped to navigate the health systems. It has also increased their influence on decisions made by policymakers, institutions and health facilities. Networking has addressed work fragmentation and reduced the isolation of Francophone health and social service professionals. It has made stakeholders more socially and fiscally accountable for responding to the challenge of better access to health services in French. Société Santé en français was invited to present the networking model and its impact both nationally and internationally. For example, a number of communications have been given at the International Union for Health Promotion and Education conferences in Thailand and Brazil, and the SSF networking model has been highlighted several times at TUFH conferences in Tunisia, Ireland, Australia and Morocco.

Knowledge Mobilization Enables Action

Inspired by the model developed by the *Agence d'évaluation des technologies et des modes d'intervention en santé du Québec* (Fournier, 2011), the definition of knowledge mobilization adopted by Société Santé en français is anchored in actionable knowledge. In the same vein but more recently, the *Social Sciences and Humanities Research Council of Canada* (n.d.) proposed an action-oriented definition of knowledge mobilization, as “the reciprocal and complementary flow and uptake of research knowledge between researchers, knowledge brokers and knowledge users—both within and beyond academia—in such a way that may benefit users and create positive impacts within Canada and/or internationally”. As such, knowledge mobilization is a dynamic and iterative process by which knowledge from various origins is brought together for the purpose of a common action. As suggested by Lomas, Culyer, McCutcheon, Law and Tetroe (2005) and others later (Ward, 2017), the knowledge

8. Quote from Mrs. Gwerfyl Roberts, Senior Lecturer, School of Healthcare Sciences, Bangor University, Wales. Online: <http://francosantesud.ca/en/best-practices/framework-for-recruitment-retention-of-bilingual-human-resources-in-the-health-sector/>

at the base of a mobilization process comes from several sources and must include community values and experiences. Scientific research is considered the primary source, and the knowledge produced is based on explicit, systematic, reproducible methods. The second source includes contextual components, i.e., based on organizational capacity, attitudes, funding, economic forecasts and ethics. Finally, the third source of knowledge, called colloquium evidence stems from “evidence about resources, expert and professional opinion, political judgment, values, habits and traditions, lobbyists and pressure groups, and the particular pragmatics and contingencies of the situation” (Lomas *et al.*, 2005, p. 1). The weight given to each of these types of data varies depending on the focus. The deliberative process by which this knowledge is co-created results from the ongoing cooperation between producers and users to enact change. In their “Promoting Action on Equity Issues: A Knowledge-to-Action Handbook Guide”, Bowen, Botting and Roy (2011) recommend, as a first step toward change, the creation of a partner coalition, if achieving lasting change is desired.

Accordingly, Société Santé en français has developed a knowledge mobilization strategy, which was updated following the publication of the “Knowledge translation planner” (Health Canada, 2017) by the SSF team (Roberge, Laframboise, & Vézina, 2018). It is grounded in four types of strategic activities: a) capacity building in knowledge mobilization within the FLH networks and Société Santé en français to become leaders for FAMC health; b) planning, adaptation and implementation of knowledge mobilization related to programming and audience needs; c) identification and use of sound data for informed decision making; d) support for the application of knowledge with partners and Francophone communities. This knowledge mobilization strategy is intended to foster coordinated evidence-based actions with stakeholders.

As a leader, SSF engaged some of its national partners, such as the Mental Health Commission of Canada, Accreditation Canada and Health Standards Organization (HSO) to address nationwide issues and mobilize action. For example, as early as 2010, SSF participated in one of the roundtables organized by the Mental Health Commission of Canada on the Francophone minority situation and, subsequently, SSF became one of the signatory organizations of the Mental Health Strategy for Canada. As a follow-up, numerous documents, tailored to the context of the FLH networks, were also produced (*Société Santé en français*, n.d.; *Réseau TNO Santé*, n.d.). The critical importance of data capture related to the language of patients was also discussed at length with HSO, to meet the quality and security standards of health services. HSO agreed to proceed with the development of a linguistic standard and called upon the broad expertise of an advisory committee that included experts from Canada, Wales, the Basque Country and United States. The standard CAN/HSO 11012.2018 – Access to Health and Social Services in Official Languages was completed and approved by the Standards Council of Canada, in July 2018. Afterwards, a few selected sites pilot tested the new standard, assessing the feasibility of incorporating

it into the accreditation process of health care institutions; this process is still ongoing. As a final example of the strategy, some FLH networks were identified as being a resource to other FLH networks, based on their skillset, strengths and capacity. This designation has thus facilitated mentorship and knowledge mobilization through the sharing of resources and best practices.

A Rigorous Evaluation of Impact Demonstrates Concrete Change

In November 2012, SSF created a 5-year plan entitled “Destination Santé 2018”, (SSF, 2013), which consisted of a coordinated intervention model promoting equitable, effective access to quality health services, which are linguistically appropriate for FAMC needs. Four priority areas grew out of consultations with communities and FLH network partners: a) organization and adaptation of services for better accessibility; b) consultation, enhancement and skills building of human resources, to ensure quality and security of health services in French; c) action on health determinants to improve wellness in French; and d) knowledge mobilization based on research and evaluation for achieving the best quality of services. To action these priorities, seven fundamental key strategies were implemented and resulted in significant transformations through well-coordinated structuring actions.

One of these strategies involved an arms-length evaluation of the program Destination Santé 2018. An outside consulting firm was tasked with assessing the extent to which SSF programming targets had been reached over the period and whether networking between partners had played a key role in achieving greater access to health services in French.

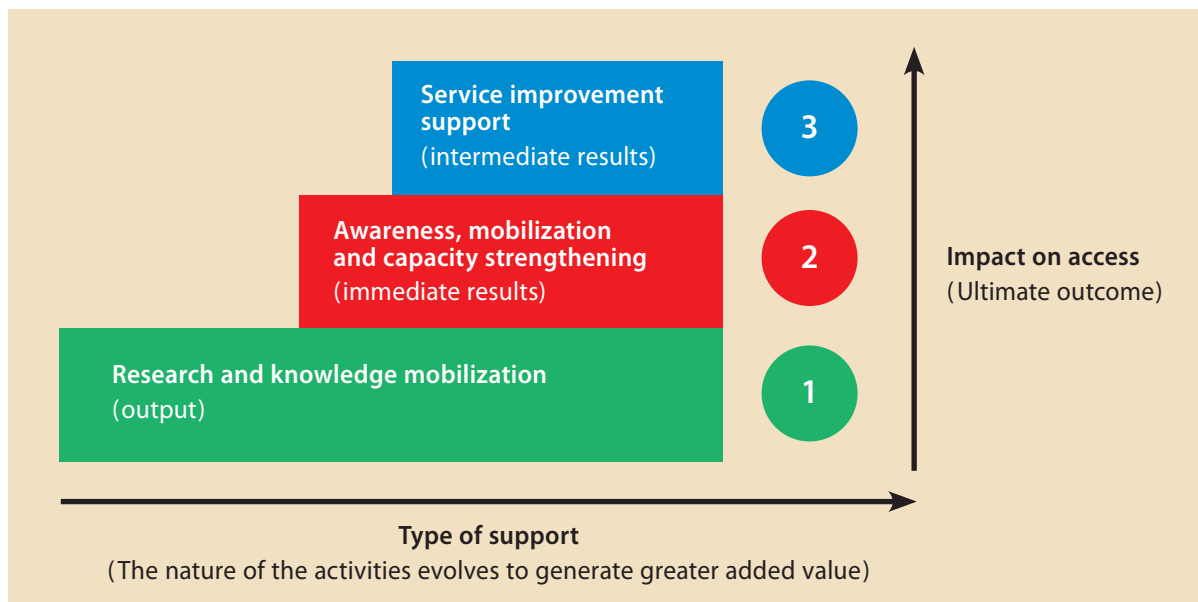
The consultants gathered data through the regular bi-annual reporting of the 16 FLH networks and other documents produced by SSF and its partners (secondary data), and they cross-referenced their findings with new data created specifically for the purposes of their evaluation (primary data).⁹ More specifically, an impact survey and individual interviews were conducted among the five categories of partners of Société Santé en français and of the FLH networks.

The results highlighted the critical importance of networking, which was described as an effective mechanism of trust building, influence, support, and ultimately mobilization of the health care system itself for improved access to health services in French. Interestingly, the data confirmed that the networking model has enabled SSF and the FLH networks to support their partners within their specific context, engagement level and readiness to change and has created mutually beneficial alignments, with positive repercussion in terms of access to health services for FAMCs. As illustrated in Figure 2, at the basic level, networking

9. Primary data included two (2) surveys conducted with networks and partners in April 2016 and April 2018, with a total of 256 respondents; and fifty-seven (57) interviews were carried out in 2016, 2017 and 2018.

activities based on research and knowledge mobilization lead to outputs such as improved awareness and information sharing, but the impact on service delivery remains limited. The next level of support intensity given to partners is about strengthening the capacity of the system to offer health services in French. To reach this level, networking and mobilization is necessary to support actors in the system who are able to provide services to FAMCs, but who will still rely on encouragement, capacity and skills building, tools and incentives. At the highest level, the support provided by the FLH networks is embedded in the health care systems themselves, which have often started to provide some services to FAMCs through institutional leadership, or because of higher concentration of Francophones and compliance with their legislation. At this highest level, networking and partnerships will lead to a skilled bilingual workforce dispatched at the right place and will increase the availability and appropriateness of a variety of health services in French for FAMCs: this is the ultimate outcome of the 2018-23 *Parcours Santé* programming.

Figure 2
Tri-Level Value-Added Service Model¹⁰



The evaluation demonstrated a relationship between context-dependant support along with the intensity level of support provided through networking, and the increased ability of partners to engage and meet the desired outcomes of FAMCs. In other words, greater access to health services offered in French was observed when the FLH networks provided

10. Source: SSF (n.d.). Évaluation finale de la programmation Destination Santé 2018—Rapport final, November 2018, p. 58

customized support to help their partners to that effect and, to a lesser degree, when FAMCs represented over 3.5% of the total population in the region, province or territory.

Several successes were highlighted. For example, Prince Edward Island was recognized as the first province to have included the language variable in residents' health card at the time of renewal; other jurisdictions have shown interest in following suit. Another large-scale project, which was initiated in Eastern Ontario (OZI), was the establishment of a data collection system related to organizational behaviour with regards to active offer. Work force's characteristics such as profession and language are now collected systematically to allow the health care system to ascertain who in their organizations is able to offer services in French and where; thus, an overall picture of Francophone human resource capacity by organization is catalogued within a region or province. The goal is to better align the supply and demand of health services in French. This online application is now being implemented everywhere in Ontario and could be used in other jurisdictions.

As for the expected outcomes of the Destination Santé 2018 programming, networking and knowledge mobilization made it possible to achieve 60% of the expected outcomes with a high performance level, 20% with a moderate (or less compelling) performance level, and 20% with a satisfactory but weaker performance level. The most significant outcomes, directly attributable to the work of SSF and the FLH networks were directly related to the networking and mobilization of the five partnership groups.

Future Strategic Directions and Initiatives

As SSF and 16 FLH networks forge ahead with a new cycle of funding and programming supported by Health Canada (n.d.), networking and knowledge mobilization will continue to be part of core business. Community capacity building and engagement remain central to the work, in order to continue strengthening the vitality of FAMCs. The involvement of Francophone communities in taking charge of their health and participating in their own health-related decisions is an essential step toward their specific health needs being recognized. It is also paramount to provide the knowledge and necessary support to enable health systems to make informed decisions and implement appropriate measures for meeting the needs of Francophone and Acadian minority communities. It will depend on systematically identifying the language variable to determine who should be served in French in the provinces and territories, thus creating compelling data for planning and informed decision making. In response to federal and provincial priorities, some projects are forging ahead, with a focus on issues such as elderly care, home care and mental health. Many new projects, undertaken in partnership with health authorities, reinforce the integration of active offer within the systems and explore new frontiers, such as navigation and interpretation services

as well as the creative use of technology and online platforms. A stronger documentation of the outcomes through rigorous research methodology is also necessary.

Conclusion

Networking and knowledge mobilization have proven to be excellent means for establishing meaningful, lasting relationships between the five key stakeholders of the TUFH model. Connection and cooperation will generate a better assessment of Francophone and Acadian minority community needs, resulting in solutions that are appropriate, tailored and effective. In summary, Société Santé en français and the 16 FLH networks have created a national Health in French movement, which is increasingly noticed and listened to by health authorities and governments across the country. It is important for FAMCs to continue to demonstrate the utility for active offer of health services in French. Communities should also participate in the organization of the health services offered to them and get involved in health governance. All these actions will help to achieve tangible results that are structuring and sustainable, so that FAMCs have access to safe, quality health services in French and ultimately enjoy better health.

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