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Chair

Mr. Guy Lauzon

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● (0910)

[*Translation*]

The Chair (Mr. Guy Lauzon (Stormont—Dundas—South Glengarry, CPC)): Good morning, ladies and gentlemen. I would like to welcome all members as well as our guests. This morning we're pleased to welcome Ms. Louise Bouchard, Ms. Nicole Robert and Mr. Marc Laflamme.

We will proceed in the following order: Ms. Robert, Mr. Laflamme and then Ms. Bouchard. We will then have a question period.

Ms. Robert.

Ms. Nicole Robert (Director, French Language Health Services Network of Eastern Ontario, French Language Health Services Network of Eastern Ontario): Good morning, Mr. Chairman, members of the committee.

My name is Nicole Robert. I am the chair of the board of directors of the Réseau des services de santé en français de l'Est de l'Ontario. Allow me to introduce Mr. Marc Laflamme, from the University of Ottawa Heart Institute, who will speak to you in a few minutes about a wonderful project called FrancoForme.

The Eastern Ontario health system includes 20 hospitals, 66 community support services organizations, 26 mental health community organizations, 8 community health centres, 1,240 family physicians and 1,450 specialists. Of this number, 66 agencies are said to be designated or identified, meaning that they are compelled by the province to offer health services in French.

My intention in presenting these figures is not to draw easy inferences. Rather, I'm trying to show you the dynamic environment in which the Réseau de l'Est operates, in order to give you a better picture of the issues facing French language health care services, the impact of our network on access, and the relevance of an ongoing commitment to health care for official language minority communities.

The mandate of the Réseau de l'Est is to ensure access to the entire range of high-quality health care services, in French, to the 226,000 francophones in Eastern Ontario. Overall, the francophone population represents 20 per cent of the total population of the region, but our representatives in the House of Commons will quickly point out that this proportion goes up to 40 per cent in certain communities of Stormont, Dundas and Glengarry and up to 70 per cent in the counties of Prescott and Russell.

What this means is that access is particularly important for the francophone clientele and for the institutions that are members of the network and which provide service delivery in French. The network ensures that its mandate is fulfilled in cooperation with its partners through planning, development and evaluation of French-language services throughout its territory.

The network was established following a decision of the Ontario Health Services Restructuring Commission in August 1997. It was recognized as an independent advisory body in 2002 pursuant to a memorandum of understanding signed by Mr. Tony Clement when he was Minister of Health and Long-Term Care for Ontario.

The network is made up of 61 health care institutions and organizations as well as post-secondary educational institutions that offer health care services in French in Eastern Ontario.

In order to fulfil its mandate, the network put in place a cooperative structure bringing together various stakeholders in the field of health care, forming sectoral committees and working groups. The participants are mainly representatives of health care agencies, members of the francophone community and representatives of other sectors such as social services.

Moreover, the network is linked to three other French language health care networks in Ontario as well as 13 networks that operate in other provinces and territories through the Société Santé en français.

A significant portion of the network's mandate consists in supporting the development of French language health care services in the Champlain territory. For eight years now, the network has provided assistance and custom advice to hospitals and community health care organizations that are involved in the designation process pursuant to the Ontario French Language Services Act. To varying degrees, these agencies are working to ensure that French-language services are provided through activities such as recruitment and staffing of human resources capable of working in French; the organization of intake and direct delivery services; French-language communication; continuity of French-language services within the agency and with regard to other agencies throughout the system.

In concrete terms for the population of Eastern Ontario, these actions translate into the proactive provision of health care services for a francophone clientele, who can thus identify French-language services and make use of them.

The network has also piloted a public awareness project on health care careers among students in French-language schools, in order to facilitate the future recruitment of health care professionals. The network also supports health care organizations and francophone community in the development of initiatives and health care programs that involve primary health care among other things, in the county of Renfrew as well as in the region of Kingston and the Thousand Islands.

● (0915)

In 2003, the network managed a total of $1.4 million granted by the Primary Health Care Transition Fund, Health Canada and the Société Santé en français. Twenty-three projects were submitted in the region of which nine were approved.

In order to illustrate the tangible impact of the PHCTF's project initiatives and the enthusiasm it aroused among its partners, I would mention the example of the University of Ottawa Heart Institute, under the leadership of Dr. Wilbert Keon, who is also a senator.

I will now invite Mr. Marc Laflamme, Coordinator of Franco-Forme to present the results of the chosen project.

Mr. Marc Laflamme (Coordinator, Francoforme Project, French Language Health Services Network of Eastern Ontario) Thank you, Nicole.

Mr. Lauzon and members of the committee, thank you for having given us the opportunity to appear before you today.

Whenever my children ask me if they can purchase something, I always ask if the purchase meets our criteria. In other words, the item in question must be good, beautiful, inexpensive, and it must be necessary.

In 2005, the Heart Institute received funding for the implementation of a new program as part of the PHCTF projects. Here is a summary of it.

The problem is the following: cardiovascular disease is the main cause of disability and premature deaths in Ontario. The prevalence of cardiovascular disease, as well as its related risk factors, is much more widespread among francophone residents of the province than among anglophones. The FrancoForme project is intended to reduce the disparity between francophones and anglophones in the Champlain region as far as cardiovascular health is concerned. It targets francophones living in both urban and rural areas and aspire to improve their access to individualized prevention and cardiac rehabilitation services, which will result in their improved cardiovascular health. A need exists.

Let us now talk about the solution. The FrancoForme project is managed and directed by the University of Ottawa Heart Institute, in collaboration with community partners, including the Eastern Ontario Health Unit and the Eastern Townships Community Centre. The program promotes healthy living habits by encouraging physical activity, a healthy and balanced diet, stress management, quitting smoking and adequate control of cholesterol and glycemia. A counsellor calls each participant once a week over a three-month period. A person's cardiovascular disease risk is assessed both at the beginning and at the end of the program. In short, the FrancoForme project offers its participants an empowering opportunity that will guide them towards a healthier life style and will reduce their risk of cardiovascular disease. This is good.

Let us look at the results to date. An advisory committee was created to offer support and advice throughout the project. Furthermore, our community partners offered us considerable and permanent support throughout. The program is now set up and in operation at the University of Ottawa Heart Institute and at the Eastern Ontario Health Unit in Alexandria. Several participants have already completed the program. As expected, we have seen an improvement in the risk factors such as their cholesterol level, their blood pressure, their weight, their level of physical activity and their sense of well-being. These participants say they are very satisfied with their experience. That is beautiful.

Moreover, an appropriate assessment of our project has shown that not only is the initiative effective from a clinical point of view, but that this service delivery model is less costly than a traditional cardiac rehabilitation program. It is not expensive.

I would now like to make some recommendations to the committee. We care deeply about the health of francophones. Within the scope of the PHCTF project, we have identified the problem, we have targeted the population at risk and we have had a significant and sustainable impact on its state of health. We strongly believe that the FrancoForme program, developed within the framework of this project, could be implemented not only in the Champlain region, but that it has the potential to become a service delivery model for preventive and cardiac rehabilitation services for other francophone communities in Ontario, and in time, across Canada. The broadening of the program, through the addition of one or more access points, such as the one planned for Cornwall under the foundation project, will take place over the next few months.

Once the program is well established in the Champlain region, we recommend the establishment of other satellite sites in Northern Ontario as well as in other francophone regions of Canada. The viability of these satellites will depend on the available financial resources and an association with various local health care stakeholders interested in establishing and maintaining the program. In short, we propose to create an infrastructure in order to establish the service in other regions of Ontario and of Canada where there is a large population of francophones at risk. Initiatives like this are good, beautiful, inexpensive, and francophones need them.

Thank you.

● (0920)

Ms. Nicole Robert: Thank you, Marc.

I will move on to the subject of the importance of service planning in the region.

Over the years, the network has carried out many studies on French services and has taken on the planning of these services through its working groups and through activities such as community forums.

Furthermore, the network set about developing the 2005-2006 regional plan for health services in French, a responsibility it was given by the Minister of Health and Long-Term Care. It was in this context that the "Préparer le terrain" project, whose goal was to establish a plan to develop French language primary health care in Eastern Ontario, was managed by the network and integrated into the regional plan.

This important exercise generated a list of recommendations and priorities for French language health services, which were presented to the local integration of services for health care network for the region of Champlain in the fall of 2006. They are as follows: human resources, the organization of services, primary health care, accountability within the system and support of health care agencies in supplying French-language services.

The continuation of the regional plan deals with the development and implementation of courses of action, a stage we intend to tackle soon.

The Government of Canada has been a partner of the Réseau de l'Est from the outset. Through Heritage Canada as well as Health Canada and the Société Santé en français, it has directly contributed to our role as an advocate of French language health care services in the region, and has been from the beginning of our network.

As far as cooperation with provincial authorities is concerned, we have been following the development of the restructuring of the health care system launched by the Minister of Health with great interest for the last two years.

The province's regionalization of health care services, through the creation of local integration of service networks, has a very special impact on French-language services.

In fact, it is a matter of a real integration of French language health care services, within the provincial and local health care system. The same is true for the improvement of access to services and of accountability through legislation and its regulations.

Briefly, we welcome the provincial government's leadership with pleasure as far as health care in French and the francophone population are concerned, as well as the prospect of an even closer cooperation on the issue of French language health care services at the regional level.

In this context, the complementarity of jurisdictions between the provincial and federal governments in health care is something that could be considered. The French Languages Health Services Network of Eastern Ontario is in a position to play a decisive role through cooperation between the partners.

In this regard, we keenly wish to continue our activities toward only one goal, that being to improve access to health care services in our community and to contribute to the improvement of the francophone population's state of health.

I thank you for the invitation to appear before you today.

Thank you.

The Chair: Thank you, Ms. Robert.

Ms. Bouchard, I believe you have some comments to make.

Mrs. Louise Bouchard (Professor, Director of PhD Program - Population Health, University of Ottawa): Thank you, Mr. Chairman, Madam Clerk and members of the committee.

I also thank you for the invitation to appear before you today. I am speaking today as a professor-researcher, and mainly on the issues relating to my research.

First of all, I will tackle the state of our acknowledge: what do we know about health, about health issues in a minority environment? How do we find that knowledge? What issues are connected to the production of knowledge on these issues? And finally, what are the best means or why is it necessary to develop a research infrastructure that will allow the continuous documentation of the needs connected to this problem?

What do we currently know about the health of francophone communities living in a minority situation? We know that these communities are spread across the entire country, with a more significant concentration in Ontario and in New Brunswick. We also know that they present a diversified profile, according to their demographic or socioeconomic context. The data will reveal that members of francophone communities are generally older, have less formal education and are fewer in number on the labour market. Francophones living in a minority situation are more concentrated in regions where the economy is more unstable, making it more difficult to develop and access social resources.

The revision of the Official Languages Act in 1988 committed the federal government to support the development of English and French minority communities in Canada, and to promote the full recognition and use of French and English. The importance of language takes on a particularly significant dimension when it is a matter of health. The ability to understand and be understood is critical to the effective relationship between health care professionals and users of the system, and access to health care services in one's language is an essential component to the improvement of people's health conditions and quest for healthy living.

Several recent articles and reports have described the challenges and problems that the francophone population outside Quebec faces in terms of health. One Health Canada publication describes the negative effects of the language barrier on access to health care services, on the quality of the care and on health itself.

Despite universal access, users of the health care system who cannot communicate in their language do not have the same access or the same quality of care as their fellow citizens. The language barrier limits the use of preventive services, limits access to all services that require communication, particularly mental health, rehabilitation and social services, as well as adequate follow-up of patients, which in turn contributes to the increase in emergency services and the use of supplementary medical examinations to compensate for difficulties in communication.

For example, a study coordinated by the FCFA, the Fédération des communautés francophones et acadienne, showed that French language health care services are three to seven times less accessible to francophones living in 71 regions of Canada where they live in minority situations.

The few analyses undertaken on the group of Ontario francophones who participated in the National Population Health Survey in 1996-1997 support the hypothesis that there is a different state of health for francophones and that for this group, certain health care determinants play a bigger role. Even though the differences are not major, francophones in Ontario would be in fewer numbers to state that they are in very good health, but in larger numbers to state that their activities are restricted, that they have chronic health problems, to score higher on the stress scale and are apt to be taking more medication. Also, a significant percentage of users say that they cannot get the services they need.

Therefore, these disparities are poorly documented and have not yet been the focus of rigorous assessments of health care policies and programs.

In an effort to better understand—and you will see a few of the results I will be talking about on the slide show that will be presented—our team, which comes from a partnership between Statistics Canada and researchers at the University of Ottawa of which I am one, tried to establish if the fact of living in a minority situation can be considered a determinant of health. I am sorry, I did not say where I am from. I am also with the Institute of Population Health Research at the University of Ottawa.

● (0925)

We tried to establish whether living in a minority situation could be considered a determinant of health. With the cooperation of the Statistics Canada Health Analysis and Modelling Group, we combined the Canadian Community Health Surveys of 2001 and 2003, in order to have the largest sample possible, which often poses a problem when conducting secondary analyses.

Our objective was to assess the link between living in a minority situation and self assessed health satisfaction, a variable of perception that is closely linked with the objective situation. In research, this variable has a widely accepted scientific validity. Therefore, we can use it without concern about overly influencing the results. We introduced four blocks of variables related to lifestyle, socio-demographic data, in context to life and inabilities. We hypothesized that living in a linguistic minority situation, despite the principles of universality and accessibility of Canada's health care system, would negatively influence the perceived state of health. The results show that based on age, Francophones living in a minority situation were more inclined to declare poorer health than Anglophones in a majority situation, both for men and women.

These results raise an important point that has never been explored in the Canadian context of official languages. Health publications have amply demonstrated that age, sex and income are the main determinants of health, but living in a minority situation has never, until now, been documented. These results, in addition to observations and initial studies on the matter, which confirm a different health situation negatively affecting francophone minority communities, underscore the importance of probing deeper and better understanding all the determinants of health.

The results also reveal the increased importance of conducting contextual or environmental analyses of health, allowing a better understanding between contexts, local settings and health.

The rapport between minority and majority seems to translate into a social inequality and unequal access to resources which, combined with other social determinants of health—socioeconomic status, education, literacy, age, sex and immigration—contribute, in fact, to the disparities in health.

This again poses a fundamental question that has been raised a number of times by lobby groups, that of linguistic duality and the inclusion of a sixth principle in the Canada Health Act, in terms of access to health care in both official languages as another requirement for federal funding.

Currently, the reforms are particularly favourable for reflecting on the organization of the services, as indicated by colleagues active in the field. But it is also important to document these realities and, in that sense, research is a necessary tool for doing so. Currently a number of obstacles are preventing research in this area. The marginalisation of this field of study, the difficulty in obtaining meaningful information, dispersal of researchers across Canada, and their affiliation with small universities that are often less competitive and offer few programs of study, make it even more difficult for professors to conduct research.

For two years, the joint research commission at the CNFS, the Consortium national de formation en santé, and the Société Santé en français, have been working hard on creating an environment conducive to the development of research, the promotion of networking and the support of thematic teams, to correct the inadequacies in the information on health, social determinants of health and access to services. To do so, the commission undertook to raise awareness among subsidized agencies such as the CIHR, the Canadian Institutes of Health Research, or the SSHRC, the Social Sciences and Humanities Research Council, about the importance of strategic research on official language minority communities.

● (0930)

This initiative was successful and resulted in the development of strategic competitions over the past year. I receive a subsidy, along with my colleague, Ann Leis, from Saskatchewan. Not only should these initiatives be maintained, but they also need to be enhanced because they give researchers the true means to produce the top notch research needed for a reliable analysis of the determinants and needs in health in a minority situation. It is through research that knowledge becomes useful to the decision makers and planners; it is through research that students are taught about realities and truly learn the job they will perform, we hope, with as much clarity as possible.

It is crucial for subsidized agencies and their partners to acquire lasting funding for an issue as important as the challenges of official languages in our Canadian context, in order to ensure continued production of top notch knowledge; to support the teams, research networks, and the succession; to implement broader studies that are representative of Francophones in a number of provinces. In that vein, I must point out the major limitations of the administrative data on health, which do not provide insight into the official language communities because the linguistic variable is never entered into health records. This is a problem that can be easily resolved; this information is essential in research for understanding where the inadequacies lie. The same is true for the national health studies that, without provincial oversampling, do not allow for very good studies in the different provinces. For example, in the Community Health Survey, only Ontario was oversampled. Studies may be done in Ontario, but is extremely difficult to get out of the Ontario context. Provinces should ensure that minority communities can be studied in national studies.

In fact, these shortcomings could be overcome if research in this area were taken seriously and given the means to make progress. The development of research infrastructure is, in my opinion, the best way to truly develop the ability to research sociolinguistic minorities and health, and a real network of teams of researchers with increasingly greater ramifications. This network will, thanks to the recruitment of young researchers and students benefiting from the mentorship of experienced researchers, consist in the experience of centres of research, and support from the network as well as the trust gained from initial successes and the results achieved.

A research network will also help mitigate the disparities in the ability to even conduct research; bring together researchers from different disciplines and different institutions; develop research programming; provide convincing results for developing policies; and ensure and support the succession. Connections between academic institutions, the health care environments and community partners could thereby be enhanced. This infrastructure will also help transform the environment of research on the health of francophone minorities, to allow the research teams to be competitive and obtain funding during subsidy competitions.

The synergy created by the team of researchers and partners involved in health in Canada will contribute to creating a corpus of scientific knowledge that is extremely useful for understanding the disparities in health and implementing structured interventions to better serve the francophone populations living in a minority situation, particularly the most vulnerable among them.

There seems to be no hesitation when it comes to funding research in genetics or genomics and creating centres of excellence without much benefit or results in terms of improving public health. Why should social research have to prove its relevance and importance in crucial matters and problems inherent to the Canadian situation in order to get such a small share of the funding?

Thank you for your attention.

● (0940)

The Chair: Thank you to our three guests. We will now begin our round of questioning. The first round is seven minutes.

We will start with Mr. Simard.

Hon. Raymond Simard (Saint Boniface, Lib.): Thank you very much, Mr. Chairman, and welcome to our guests.

As you know, in Saint-Boniface, we have a French health care centre. I would like to gain a better understanding of your structure. My question is for Ms. Robert. First of all, I would like to know if you have more than one centre? Do you have centres in rural regions? Are they independent, or located in hospitals? Are they funded by the federal government, the provincial government or both?

Ms. Nicole Robert: The network itself, for which I chair the board of directors, includes all francophone organizations from several districts in Eastern Ontario, where 226,000 francophones live. The network is primarily responsible for planning and needs assessment. It is made up of 66 organizations.

We have various structures. We have hospitals, naturally, that receive their funding solely from the Ontario Ministry of Health. Then we have community organizations. We have community health care centres which also receive their funding from the Ontario Ministry of Health and Long-Term Care. These community health care centres are primary health care centres where we deal with mental health and where doctors meet patients. As members of the network, we also have mental health organizations that also members of community health care centres. They are funded in different ways, but generally, many of them are funded by the Ministry of Health and Long-Term Care. They are all under provincial jurisdiction since we are talking about health care.

However, the network is fortunate to receive funding from both the federal and provincial levels. We were lucky enough to maintain our network until it was officially recognized by the provincial government, as I stated in my presentation. So we are funded by the provincial government and by the federal government, in the latter case, through Société Santé en français and the Department of Canadian Heritage. The network does not provide services directly to the general public. Instead, it is an organization that brings together other health care organizations that offer services in French and that help hospitals in our region obtain designation under the French Language Services Act. Members of the network can then help others, thanks to their expertise, to meet the conditions for designation established by the Ministry of Health and Long-Term Care.

Hon. Raymond Simard: Is French the language of work in these centres?

Ms. Nicole Robert: The organizations in the network use French.

Hon. Raymond Simard: Is it a service in both languages?

Ms. Nicole Robert: We offer services in both languages. Many organizations are bilingual, but they also have a structure that is very francophone. Look at the example of Salus, which is an organization to help people with mental health problems find housing. The organization is bilingual in that it has a completely francophone parallel structure. The people in charge have applied for designation as a francophone organization, in other words, interaction, reception and service provision is all in French.

Hon. Raymond Simard: The farther we go from the centre of the country, the more trouble we have providing training for professionals: doctors, nurses, and others.

Do you encounter the same problems, or do you have enough training facilities here in Ottawa, for example, to serve your centres?

Ms. Nicole Robert: The answer is yes. Fortunately, we have the Montfort Hospital which has been recognized as a university training centre for our health care professionals, especially in the field of medicine. We also have the Cité collégiale, which trains our health care professionals, and the University of Ottawa, which is the university in the region that serves all of Eastern Ontario. So we are very lucky in that regard.

The problem, like everywhere else, is attracting people in the health care field and training them. All regions of Canada, be it in English or French, are facing a shortage of health care professionals in all disciplines: doctors, nurses, physiotherapists, occupational therapists, and so on.

● (0945)

Hon. Raymond Simard: When you talk about the links you have with the Société Santé en français, do you discuss such things as sharing staff?

We have a great deal of difficulty attracting young doctors back home, especially in rural communities. Are those the kinds of things you discuss?

Ms. Nicole Robert: The networks and the Société Santé en français do, of course, discuss possibilities, especially with telemedicine and all of the distance care that is created. As Ms. Bouchard indicated, we also promote exchanges so that research is done in this area. Research projects are currently under way in Alberta, Manitoba, and New Brunswick to explore possibilities for distance education.

I think that with the new technology, it will be much more advantageous, especially in rural regions. Our organizations in Eastern Ontario are in both urban and rural communities. Access is more difficult in rural regions, that is for sure, but we succeeded in establishing services in Renfrew, which is a completely anglophone centre.

Hon. Raymond Simard: My question is for Mr. Laflamme.

Earlier on, you talked about satellite projects. I know that back home in the country, in Notre-Dame-de-Lourdes, they want to build a French services centre, but they are also talking about a travelling service for the other small villages in the region.

Is that something that you advocate in your discussions?

Mr. Marc Laflamme: Good, beautiful, inexpensive!

In fact, we would like to be in a position to export the highly effective intervention model we designed throughout Canada, to Saint-Boniface or elsewhere. You want a cardiac prevention and rehabilitation service in Saint-Boniface? We provide you with the data base we use, we train your staff, we recruit a bilingual person and then provide support. So if you have a minor problem with the data base software, the Heart Institute will serve as a resource.

Here's how the program works. Let us look at Alexandria, where members of the team are very autonomous: once the staff is trained, they recruit patients themselves, they are in a position to follow them, they promote the program in pharmacies, they meet with doctors to encourage them to send at-risk patients. So, we can reach the at-risk francophone population in the communities.

Hon. Raymond Simard: Thank you very much, Mr. Chairman.

The Chair: Thank you, Mr. Laflamme and Mr. Simard.

Ms. Barbot, you now have the floor for the second round of questions.

Mrs. Vivian Barbot (Papineau, BQ): Thank you, Mr. Chairman.

Thank you for being here this morning. Mr. Laflamme, you said that these initiatives are a good deal. I like that expression. That is what I used to say to my children when they were little.

However, when we are dealing with the health of francophones living outside Quebec, according to what we have heard so far, it is not a very good deal for the money. Maybe, and this probably applies to well-defined prevention programs, once they are implemented—and you said so yourself— the expertise can be applied elsewhere and that is how the objectives are met.

However, when we take a look at the entire situation, particularly when it comes to research, it is obvious that the main factor in determining what can be done is money, in other words, how much we are willing to spend. But when the target population is dispersed, there is not enough information to allow for a clear correlation that would lead to concrete action later on.

In my opinion, the funding allocated to these communities is a very important factor. This applies to health care as well as to all other areas. That is why, when it comes to language, this committee is so determined to help people find a way out of these unfavourable situations.

Moreover, Ms. Bouchard, you provided information comparing the health of francophones and anglophones. Francophones, in general, are not as healthy; others have told us the same thing.

Without taking into account these comparisons, can you tell me, objectively, about the health of francophones living in Canada, outside Quebec?

● (0950)

Mrs. Louise Bouchard: I would like to clarify something. Before beginning these surveys, we had to decide how the groups would be divided: French-language respondents, respondents whose preferred language is French or respondents for whom the first official language that they learned is French. This was important because we were dealing with health services where, as I explained, communication is the key. Therefore, when I speak about surveying the francophone population, this also includes immigrants who speak French. That is an important point and I stress the importance of the language category because in the context of Canada's official languages, these infrastructures must reflect our Canadian reality.

It was difficult to find a reliable way to document this survey. First, because data relating to language cannot be found in the administrative data relating to health. Surveys have to be done. There are problems related to access to information and to ethics. The small surveys done by Health Canada do not provide a big enough sample to allow for a reliable study. This situation has to be corrected.

I worked with Jean-Marie Berthelot and his team at Statistics Canada. I thought that by combining a number of age groups I would have an accurate snapshot, but, in my opinion, being part of a minority group means having a different type of access to resources and services, something that must be documented. It is true that socio-economic status is the main health determinant, generally speaking. But this study does not take financial status into account, nor does it consider age, sex, all of the factors where differences apply. Even if you ignore all of those factors, there is still something that has a negative effect on health. It might look simple, but I thought that this finding was significant because of the relationship to a linguistic or sociolinguistic minority. So this is something that must absolutely be explored further.

Obviously, since I am a researcher, I will advocate more research, so that we might be able to document this phenomenon and provide better service to these communities. What the networks have done to provide training in the French language for professionals is of tremendous value. That said, research is still the best way to determine how these services should be provided to this population.

Ontario is currently regionalizing its services. It is an extremely valuable opportunity for sociolinguistic communities to put forward services plans that will meet their needs. These communities must avail themselves of the opportunity to take a closer look at the issue.

I have a student who is working on her Ph.D. on the health of populations and who is examining rural and linguistic aspect of Northern Ontario. She is taking part in the regionalization project. I asked her to write her thesis on the language issue and the organization of services in Northern Ontario's rural communities where there is a need for professionals and where professionals should be sent; but the situation must be documented to ensure that services are provided in both languages.

The Chair: I am sorry, Ms. Barbot, but your time is up.

Mrs. Vivian Barbot: That was short. It always seems to happen to me.

The Chair: Mr. Godin will ask the next question.

Mr. Yvon Godin (Acadie—Bathurst, NDP): Thank you. I am lucky, it never happens to me. I should get at least 20 minutes...

Thank you Mr. Chairman and welcome all.

When looking at our health system, we consider how things are done for the francophones, the francophonie, etc. You are lucky, here in Ontario, because Montfort Hospital was able to use the Court Challenge Program; otherwise, they would have lost their case.

After dealing with research and the Montfort Hospital, I would like to know what is happening in Sudbury, in Ontario, because there is a large francophone population there. They have Laurentian University, Collège Boréal, other institutions, but what do they have by way of health services in French? I heard no mention of Sudbury, but you did discuss Northern Ontario. Everyone thinks that Northern Ontario means Sudbury, but it extends even further, to Hearst, Kapuskasing, Longlac.

Are you working with them on developing agreements in this region.

● (0955)

Ms. Nicole Robert: I will begin. What you say is true. The Montfort case went a long way to protect French-language health services in Ontario. It is because of the four networks that we now have in Ontario, following the ruling in favour of Montfort Hospital that we now have legislation to create a new health care structure in Ontario, with a preamble dealing with services provided to francophones in all Ontario communities. The act also includes two very important clauses relating to the new structure. First, there will be a French-language provincial council to directly advise the Minister of Health and Long Term Care on the needs of francophones in Ontario. Member agencies will be represented by people with an expertise in health, management and clinical health. This 10-member provincial council will advise the minister who will also consult with the networks.

A second clause confirms the work done by the networks. Up until now, the eastern network was the only one to be recognized through a memorandum of understanding with the Minister of Health and Long Term Care. From now on, there will be planning groups in Ontario's regions, including the North. The northern region has its network; it will be recognized through upcoming regulations. Official regulations should be in force in about three months, but the network is already in the act. There is therefore also an official French-language health services planning group in Northern Ontario. It was set up two years ago, with a board of directors; it is an organization similar to ours, but less experienced because we have been operating for eight years now. The networks in all of Ontario's regions are working within a new structure known as the Local Health Integration Networks. That is the new provincial structure. There are 14 of these networks in the province, with four French-language services planning networks responsible for the planning of French-language services.

We hope that, with these new regulations, the government will take a closer look at the needs of francophones living in the northern, southern, eastern and western parts of the province, and that a needs assessment will be made so as to advise the minister. This new, official structure is designed to ensure that the services are provided.

Mr. Yvon Godin: Mr. Laflamme made quite an impression when he described the incentives as being a good deal. But Mr. Laflamme, you have to be careful when you say that, because within the Francophonie, bilingualism is expensive. It does cost money to provide these services and sometimes governments might think that the price is too high and use that excuse to provide nothing at all. As francophones, we have already paid the price. I like your way of doing things; it made us sit up and take notice. Bilingualism is expensive, but that is the price we have to pay. In some countries, people are fighting for religious freedom. Elsewhere, race is an issue. Here we want to live together peacefully. We want services in our own language. It is expensive, but there is no way around it.

When it comes to research or training that we would like to provide, French-speaking students don't always have access to learning materials in their language. So francophones are once again at a disadvantage. What would you suggest to provide francophones with the same advantages as anglophones?

For example, 62 per cent of francophones in New Brunswick are illiterate. That is unfortunate. Once again, the government wants to cut the budgets to literacy programs, but that is another story.

● (1000)

Mrs. Louise Bouchard: Literacy is key; there was a seminar on that very issue last year. I think Alberta, for instance, has taken some steps in that direction. Being part of a minority francophone group has allowed me to discover my country. I have only been in Ottawa for five years and this is the first time that I find myself in a francophone minority setting. I come from Montreal.

It is essential to provide training in one's own language in order to ensure comprehension. That presents two problems. First, with respect to training, I agree that textbooks must also be available in French. When it comes to scientific research, that is another problem. We know that English is the language that is commonly spoken, and our own papers must often be published in that international language.

I would hasten to add that all bilingual or trilingual countries should promote the use of their languages, particularly since English has become the international language. Language should be as basic as universality and accessibility. That is why I suggest that we consider adding a sixth pillar to Canada's health act, mainly, services provided in both languages, particularly where numbers are lower and more dispersed. I think it is a basic value that must be promoted.

The Chair: Thank you, Ms. Bouchard and Mr. Godin.

We are now going to go to Mr. Petit for the last question of this round.

Mr. Daniel Petit (Charlesbourg—Haute-Saint-Charles, CPC): Good morning, Ms. Bouchard, Ms. Robert, and Mr. Laflamme. This question may be for Ms. Robert and perhaps Mr. Laflamme. I'm not sure Ms. Bouchard is familiar with the subject I wish to raise.

I am from the province of Quebec, home of Canada's francophone majority. We, in the federal government, want to fix the problem of excessive wait times for health care. That is one of our five priorities. In Quebec, there have been some unique events: because of the difficulties we were having in providing timely care to patients in our hospitals, we sent some of them to the United States for cancer treatment. So they were sent to an English-speaking area.

Witnesses have told us, not so long ago, that when patients are fearing for their lives and they realize that the wait time is shorter for services in English — that is, to be treated in an English-speaking hospital rather than a French-speaking one — they choose the English-speaking one because their lives are at stake. The language issue suddenly becomes secondary. I'd like to know your position on that. After all, we have to provide funding to organizations like yours for them to be able to continue operating.

The Société Santé en français appeared before us. Its representatives impressed me because they brought up a large number of subjects. They told us about the work right there in the field. I do not know whether you are familiar with that organization. I see Ms. Bouchard indicating that she is. I would like to know whether you support its way of doing things, without getting into any criticism of that organization. Should we give money directly to organizations like that, in your opinion, or is there a need for a supervisory committee?

Perhaps Ms. Robert could answer, she talked about CLSCs a bit earlier. I sense that she has a lot of skill in the field of administration.

● (1005)

Ms. Nicole Robert: A number of projects have been submitted to the Société Santé en français. The network chose 23 of them, including Mr. Laflamme's. I will let him tell you about that after. But I think that the Société Santé en français has solicited submissions all across Canada, through its 13 networks, in order to come up with primary health care projects, projects in the field, to improve the health of francophones in their region. Considering the amounts of money allocated to each project, the results go well beyond investment, because with minimal amounts, they managed to get expertise and projects that will be useful to the French-speaking population, like Mr. Laflamme's project. I think the money was well spent on those projects. It is important, for the good of francophones to gather expertise, and priority care increases with each new amount of money that is provided. So, to answer your question, I think you do have to keep funding organizations directly.

With small amounts of money, francophones are accomplishing great things. Of all of the projects that have been set up, including nine in the field in the eastern region — and I am sure that the same thing goes for other regions — the results have been very beneficial. That money was well spent, because the ideas were local ideas, the needs were identified locally, it was not national, it was not lofty thinking, the ideas were practical and were implemented in the field.

I think I will let Mr. Laflamme pick it up from here, because he knows what it means to do a lot with very little.

Mr. Marc Laflamme: It always comes back to the good deal principle.

It is too bad Mr. Yvon Godin is not here, because I would like to provide an update on that. We received $200,000 for our project. We have been working with that amount for over a year: I am a physiotherapist, and that paid my salary for one year; we hired two nurses from the Alexandria health unit who both worked part time; there was also an administrative assistant, we had documents and our database translated. All that with $200,000.

A voice: We will hire you in Quebec.

Mr. Marc Laflamme: That is called fiscal responsibility. I managed the budget. When making any acquisition, I always asked myself whether it was a good deal, every time. We spent every last cent, there was nothing left on September 30. I am proud of that. We managed the money well and it was a good investment.

As for the Société santé en français, it played a huge role in this result. It is a very important organization. Do we need another organization to oversee it, to supervise the Société santé en français? Absolutely not. No, because the Société has already administered the funds for the PHCTF project, the Primary Health Care Transition Fund. It then acted proactively in choosing 23 projects from among the 71 PHCTF projects. Then, all that was left was for Treasury Board to meet with Health Canada to sign the agreements by April 1, 2006. The agreements were signed last week. A lot of money was lost because of that.

So, if the direct administration of those funds had been left to the SSF, we would have had our money for the project as of April 1st. Now, we have funding for four months, instead of one year, to continue the project, which is too bad.

The Chair: Excuse me, Mr. Petit, but your time is up.

Ms. Bouchard, you may comment briefly.

Mrs. Louise Bouchard: Yes, the strategy of the Société santé en français is fabulous because with its networks, it reaches all across the country. There is an extraordinary mobilization. I go from group to group and it is quite fabulous. However, the money has to keep coming.

Of course, if we disperse and create new structures, we are going to waste our time and money. So, yes, effective structures need to be maintained. The Société santé en français has proven its worth and is fabulous. So I support that model, which is quite original, by the way, and very successful.

I would like to come back to the issue of specialized medical care, the case of francophones sent to the United States or who choose an English-speaking environment because the waiting lists are apparently shorter. I think Quebec has to define its priorities. In a context of limited resources, is it important to have a CHUM, the Centre hospitalier de l'Université de Montréal, and a McGill University Health Centre? I think the resources could be shared and provided in both languages, especially in Quebec. That said, let us move on.

The other important aspect is this regionalization effort. In Quebec, the CLSCs were set up 30 years ago. That is now being done in Ontario. It has been done in Manitoba. The idea is to be close to the public and to meet the needs. So let us encourage that.

● (1010)

The Chair: Thank you.

We will now go to a five-minute round, beginning with Mr. Jean-Claude D'Amours.

Mr. Jean-Claude D'Amours (Madawaska—Restigouche, Lib.): Thank you, Mr. Chairman.

I'd like to thank all three of you for appearing before the committee this morning. I have a few questions. For the first, I'd like a relatively short answer.

Ms. Robert, you mentioned earlier the situation, when my colleague Raymond Simard asked the question about the training of professionals. You said, among other things, that Franco-Ontarians were lucky to have the Montfort Hospital to provide them with a certain number of professionals. You also mentioned that one of the challenges was retaining those people. I'm from New Brunswick, and we have the same challenge. I also think that it will probably remain a challenge for some years, even decades.

Take the Montfort Hospital, for example. If the hospital no longer existed today, for reasons we all know, would it be difficult to have access to a pool of professionals?

Ms. Nicole Robert: The answer is yes.

Mr. Jean-Claude D'Amours: That's exactly what I wanted, a short answer. As for my second point, when I listen to you talk, I almost get the feeling that you have more support from the province of Ontario than you are able to get from the federal government. That may be an impression on various levels, but it's the kind of feeling I understand to a certain extent.

In relation to that, I'm a bit surprised because you advocate for all health care in French in Ontario. Looking at the plan of this committee, it could be said that there is even one member of the committee who is Conservative and Franco-Ontarian, but who does not advocate the same philosophy of support for official languages, as for the Court Challenges Program.

Had this program not been in place or restored after the cutbacks, Montfort would not exist. If Montfort did not exist, that would, as you answered earlier, have caused a problem. Today, we would be in a situation where your data base or pool of available professionals might have been affected. That's the situation in a province that appears to be, listening to you, proactive. I clearly heard you say that the province gives you substantial support. So, if that had not been the case, perhaps, to some extent, you wouldn't even be here today. You might like to comment on that.

Ms. Nicole Robert: The Montfort decision was definitely very important in terms of the availability and continuation of health care in French for Franco-Ontarians. There is no doubt about that. I think the Montfort support group was fighting not just for Franco-Ontarians, but for all francophones in Canada. I think it's a very important decision because we have two official languages and it has to be equitable for francophones when it comes to health care.

Health is largely a matter of provincial jurisdiction, and to make any headway in this area, you need very solid provincial support. The people on the ground—in our case, Franco-Ontarians—have to be constantly there, in front of the Minister of Health and Long-Term Care. That's how you get what you want, even without federal support. I think there's a lot of funding or the majority of funding that comes from the provincial government. I think that answers your question. I know there are changes and I don't want to get into a political debate about transfers of money, etc. It's important for the province to support the efforts made by the public. I would hope that in all of the other provinces, there would be the same kind of support from Health ministers.

● (1015)

Mr. Jean-Claude D'Amours: True, health comes mainly under provincial jurisdiction. The money is invested by that level of government. When you look at the situation, sometimes you have to equip yourself with tools in order to be able to do certain things. It's all well and good for the current government to say that it wants to comply with all existing legislation and behave properly in that respect, but without some financial and especially moral support to guarantee you some assistance or ability to defend your rights if necessary, the situation becomes problematic if the support comes up short. I understand that you don't want to get into a political debate, and I accept that, that's our job. But it does become, to some degree, a problem. If you have financial assistance on one hand, but you don't have support if, and I hope this doesn't happen, an Ontario minister decided to cut funding, there's a problem.

The Chair: Excuse me, but the time is up. I think there will be no answer to that question. Mr. Lemieux, you have five minutes.

Ms. Nicole Robert: With your permission, Mr. Chairman, I'd like to say this.

I think the two official languages of Canada are important, and not just in health, but also in education. I am a firm believer, a native-born Franco-Ontarian and I believe it's very important.

The Chair: Excuse me, but I asked Mr. Lemieux to put a question.

Mr. Pierre Lemieux (Glengarry—Prescott—Russell, CPC): Good morning. I'm very pleased to welcome you here as witnesses. You are members of organizations that give a good indication of the vitality in our part of Ontario. Your organization plays an important role for Franco-Ontarians. My riding is the riding of Glengarry—Prescott—Russell, just beside Ottawa. As you know, 65,000 Franco-Ontarians live there. So services in French are very important.

Mr. D'Amours tried to invent connections that don't actually exist. You try to promote services in French in health care, and we support your effort. I myself support your efforts.

I have a few questions. You worked on setting up a single-window in French in Renfrew. I'd like to know the details. Can you discuss the advantages? And do you intend to do the same in other places?

Ms. Nicole Robert: The single-window is very new, very recent. It was a project of the network in cooperation with community health organizations in Renfrew. Renfrew was part of the region that our network serves, and it was quite difficult, because the French-speaking population of Renfrew is not very big.

We brought together the organizations that wanted to serve the population. We had allies like the CCACs, the Community Care Access Centres, and we also had mental health allies, like Bernadette Wren, who heads a mental health organization. There were also other people at the table. The single-window needed to be consolidated and it had to work well, so that people would have a place to call and someone to talk to who could tell them where they could get adequate service in French.

Will that occur elsewhere? Yes, there will be a single-window for francophones in the Ottawa area too, and the same project will surely happen in other regions. This project was important because francophones want us to tell them immediately where they can be served in French. That was the goal.

I think access is one of the priorities of the new Champlain District Local Health Integration Network. Access to these services has to be fast; you shouldn't have to make 3,000 phone calls to get an answer. The single-window meets that need. Given that there are fewer points of service in French, the person will be referred, served in French and know where to go to get services in French. That will also facilitate active offer in establishments like the Renfrew Hospital and other services like the CCACs, where there will be services in French.

● (1020)

The Chair: You have 30 seconds left, Mr. Lemieux.

Mr. Pierre Lemieux: Do you work closely with the clinics as well? In our region, we have hospitals in Hawkesbury and Alexandria. You work with the hospitals regarding those that will be designated to offer services in French, but do you also work with clinics, places where doctors offer services together?

Ms. Nicole Robert: Since our main role under the legislation was to designate organizations that would offer service in French, we therefore evaluated the CASC of Eastern Ontario in Cornwall, which serves Casselman, Hawkesbury, Alexandria and Winchester, and we worked with these bodies. Any organization that wants to obtain a designation sends us a plan. A network counsellor works closely with the people in the organization. We always suggest they establish a committee on French services to facilitate things. We work to ensure that they get the designation. We tell the organizations what the main principles required are: access, reception services, clerks at the information centre, the number of individuals required to provide service in French.

The Chair: Thank you.

It is Mr. Malo's turn.

Mr. Luc Malo (Verchères—Les Patriotes): Thank you, Mr. Chairman.

Good morning and welcome to the committee meeting.

You touched on the issue I was going to raise a little earlier, but you did not go into depth on it. My question is to Ms. Robert.

Does the fact that Eastern Ontario is located close to the United States and Quebec means that you have different challenges or that there is an impact on your service delivery?

Ms. Nicole Robert: I will try to answer that question. I'm a health care professional. That is the other hat I wear. In fact, I run a mental health clinic.

In my opinion, the fact that we are located close to Quebec has been an advantage in the past, because health care professionals in Ontario were better paid than those in the Outaouais, for example.

So when the Hôpital Montfort and community organizations were looking for French-speaking health care professionals to staff certain positions, as did my organization, which also serves the francophone population, it was easier to recruit these professionals. The situation has now stabilized in the Outaouais. Fewer health care professionals are leaving Quebec to go to Ontario, but Quebec is experiencing a shortage of these individuals as well. So it has become more difficult.

The fact that Eastern Ontario is located close to the United States has not been a factor. The issue is more national in scope. The pay and benefits and working conditions of health care professionals have not always been good. That caused an exodus of these people to the United States. That did not happen just in Ontario. Human resources staff in institutions such as hospitals work very hard to improve the benefits and working conditions of health care professionals to prevent this exodus to the United States.

In addition, our universities and colleges, throughout the country, not just in Ontario, wake up to the fact that decisions made 5 or 10 years ago about recruitment or about the number of available positions in universities and colleges for future health care professionals were really out-of-date. We have now corrected this situation. So we should be seeing more health care professionals, and the fact that we have better working conditions for them now will help correct the situation further. However, it was not unique to Eastern Ontario.

● (1025)

Mr. Luc Malo: At the beginning of your remarks, Ms. Bouchard, you described the francophone minority community as older, with lower-than-average education and located in regions where the economic situation is poor.

Have you been able to do any comparative studies with majority community populations meeting the same criteria to determine whether language was actually a factor?

Mrs. Louise Bouchard: I made some comparisons with the anglophone minority community in Quebec to try to determine whether the fact their people are part of a minority community can have an impact on their health care.

If we exclude the Montreal region, it appears that the same situation exists, namely that there is some link to resources.

Does the anglophone minority community have the same characteristics as the francophone minority community regarding age, aging, and so on? I will have to do more research on this. I cannot guarantee that my information is 100 per cent accurate, but it does appear that the fact that people are part of a minority community is a genuine factor for both official language communities.

That is what I can tell you. I need to do more research to further interpret these data.

Mr. Luc Malo: Thank you.

The Chair: Thank you, Mr. Malo and Ms. Bouchard.

Mr. Luc Malo: I had a question for you, Mr. Laplante, but unfortunately my time has run out.

The Chair: Perhaps you could ask it on the next round.

Mr. Godin.

An hon. member: That does not cost much.

Mr. Yvon Godin: You will never forget that one. I would like to make a comment before asking Mr. Laflamme a question.

There is reason for concern when a government undertakes a reform. When the government decided to review the health care system in New Brunswick, to make some changes and rationalize it, the francophones really suffered. In the Acadian Peninsula, two hospitals were closed down and replaced by clinics. This had a terrible impact. The population was divided. Communities were fighting each other, and the links have never been restored. The government must work in consultation with the public, and not simply dictate its decisions as if they were the only acceptable ones. That is not the right way to operate. I think we experienced this first hand in New Brunswick.

Earlier you were talking about something that had been done, Mr. Laflamme, that was not expensive—only $200,000. Could you tell us how you can pay nurses, doctors and cover other expenses with $200,000, including costs related to the building. Something must not have been included in the calculations, because the building alone must cost more than that. Perhaps it is the fact that for francophones, the government generally spends less.

Mr. Marc Laflamme: Thank you for your question.

It is true that infrastructure costs are high. Fortunately, I work in a hospital, the Cardiology Institute, which has been around for 30 years. So it is true that we did not really include the infrastructure costs in our calculations.

However, I did manage to establish an office in the hospital, and that was not very expensive. Setting up the office and the computer cost about $1,500. The Alexandria Health Care Office also provided the premises. They relocated the entire health care office in Alexandria in order to make room for the FrancoForme Program.

Mr. Yvon Godin: In an existing building?

Mr. Marc Laflamme: Yes.

● (1030)

Mr. Yvon Godin: So you did not have to build new buildings?

Mr. Marc Laflamme In this program, all the work is done by telephone, with the exception of the initial evaluation. During it, the waist measurement is taken, the blood pressure and the weight of the client. So all we need is a small private room. We also need a very simple work space and a computer with Internet access and a telephone. So this program could easily be reproduced anywhere in Canada.

Mr. Yvon Godin: Earlier you were talking about discussions you would have with Quebec. This question is to any of our witnesses. Do you also speak with people in charge of the health care network in New Brunswick?

Ms. Nicole Robert: There is a network.

As I mentioned earlier, the Société Santé en français has networks throughout each of the provinces. In Ontario, there are four, and in New Brunswick there is one.

The networks in New Brunswick have also introduced projects such as the one Mr. Laflamme was speaking about in their municipalities and regions, in order to introduce certain programs. Since I am not on the health care services of Société Santé en français, I do not know that much about it, but those individuals could tell you about their projects.

Mr. Yvon Godin: I know there are networks in place, but I was wondering whether you and your New Brunswick counterparts share information.

Ms. Nicole Robert: Yes. The networks communicate through conference calls. In addition, all the networks take part in the annual general meeting of the Société Santé en français.

Mr. Yvon Godin: As you know, the New Democratic Party is completely opposed to the privatization of health care services. Do you think privatization could result in problems?

Many doctors think that some services should be privatized. Personally, I have trouble believing people who would want to make money from other people's illness. I completely disagree with this idea. What is your view about opening up private clinics, and so on in Ontario?

Ms. Nicole Robert: The network respects the national principles of health care, which do not include privatization. We do have a government that agrees with a certain type of privatization. For example, there are negotiations regarding the management of our infrastructure. That was suggested in the case of the Royal Ottawa Hospital, the mental health facility in Ottawa. There is an agreement, a partnership with the company that could build the building and probably manage the infrastructure. That is a type of privatization, but it is not privatized health care.

Mr. Yvon Godin: If people want an MRI, they can pay $600 and get it today, but if they do not want to pay, they will have to wait six months.

The Chair: Your time is up, Mr. Godin.

Mr. Yvon Godin: Is that so?

The Chair: It is up already. Five minutes go by fast when you are having fun.

Mr. Yvon Godin: I think your batteries are over charged.

The Chair: The thing is that Mr. Murphy is in a rush to ask his question.

You have five minutes, Mr. Murphy.

Mr. Brian Murphy (Moncton—Riverview—Dieppe, Lib.): Thank you.

I'm not out. I do not understand the word "*hâte*", but it means something different from the English word "out".

I apologize for missing part of the testimony, but the main question is this: Are some people healthier than others? As I understand it, we do not know for sure. We do not have accurate data from surveys or studies for New Brunswick, my province.

My concern, of course, is my own region. If we agree that it is very important to improve the quality of health care services for francophone minorities in New Brunswick, and perhaps for the whole country, is it very important to determine whether the quality of services for the francophone minority in New Brunswick is the same as that for the anglophone majority? Do you deal with this in your research?

Mrs. Louise Bouchard: I think we have to work to achieve equal access to services for both sociolinguistic communities. So I'm trying to understand what the situation is in each province. Each have slightly different regionalization models and different resources available, but there is no doubt that we must try to understand and document these facts.

If a hospital is closed down and services are regionalized, will the sociolinguistic communities be further ahead or further behind? That is a very important question. So we have to look at it closely.

The first studies done in New Brunswick clearly showed a health differential between the official language communities. However, it is also true that the socioeconomic situation is also very important. Poverty has a very negative impact on health, regardless which language a person speaks.

What I understand from New Brunswick is that there are regional boards that provide services in French, but that the problem of small communities spread around more anglophone regions has not been solved. Apparently there are some important challenges regarding these groups in particular.

● (1035)

Mr. Brian Murphy: I know this is a problem for the people from the other ridings, but I am from Moncton, from the centre of the Acadian region. I can say that because the other New Brunswickers are not here.

So we do have a problem at the moment: Where will the new cardiac catheterization laboratory be located? In Moncton, of course, because it would be the second one in the province. The first is located in Saint John, in the heart of the English-speaking part of New Brunswick. We are sure that the second will be located in Moncton, but where exactly? Will it be at the regional Georges-L.-Dumont Hospital or at the Moncton Hospital, which provides many bilingual services? If both institutions were equally acceptable, would it be reasonable to choose the francophone hospital for the reason we are discussing here?

Mrs. Louise Bouchard: I would be inclined to say yes, but I will ask Ms. Robert to answer the question.

Ms. Nicole Robert: I think it is very important for francophones, whether they live in Ontario or in New Brunswick, to be able to speak their language when they are ill. That is what they want, but in many cases, if they are offered service in English rather than French, they immediately go along with this.

In my opinion, the active offer of service is one of the best solutions for our francophones. People need to speak to them in French, and they must know that the service is just as good in French as in English. If people speak to them in English, they reply in English, because they are bilingual. I think that is a mistake. However, if someone speaks to them in French, if it is clearly indicated the service is available in French, francophones opt for service in French. That was the objective of the designations program in Ontario, particularly in the Ottawa region.

I chair the committee that studies the designation plans. I therefore meet with organizations that want to indicate that they offer services in French. When there is an active offer of service, francophones use the services in French, but they must be made aware that the service is available in French.

The Chair: Thank you, Mr. Robert and Mr. Murphy.

We will now go to Ms. Boucher.

Mrs. Sylvie Boucher (Beauport—Limoilou, CPC): Thank you for appearing before us today. I am learning a lot about the services available to minority communities.

Ms. Bouchard, you said earlier that the francophone minorities were aging. I'd like to know more about the pilot project on the health care needs of the senior francophone minority community. Unless I'm mistaken, the fact this is a pilot project suggests that the expectations are somewhat limited. Please tell us what approach of this type could demonstrate.

Mrs. Louise Bouchard: Allow me to make a clarification. Ann Leis, my colleague from Saskatchewan, and myself received a grant from the Canadian Institutes of Health Research, the CIHR, to set up a network of researchers across Canada. We received a $150,000-grant spread out over five years, which is not a huge amount when one thinks about it. We decided to try and develop research for our most vulnerable linguistic communities, for seniors and young people. Our goal is to eventually set up research projects to monitor the situation of the elderly living in a minority setting.

Unfortunately, I do not have specific data to present to you today. What our group can do, is fund small pilot projects which could be substantially funded at a later date. Indeed, it is obvious that we cannot restrict ourselves to pilot projects when doing research.

● (1040)

Mrs. Sylvie Boucher: This research could perhaps be used to create an interactive health atlas. You mentioned this earlier. Can you talk to us about the usefulness of such an atlas and who would be able to use it.

Mrs. Louise Bouchard: I have been mulling over this project for a long time. I simply do not have the funds necessary to carry it out. The Public Health Bureau of Montreal developed an absolutely wonderful tool for researchers and decision-makers. The tool makes interactive health data accessible, when there is data. Therefore, we must have access to census data and administrative data on health. We must also have results on studies carried out on the population and make sure that those particular data are incorporated properly.

You, members of Parliament, may be wondering what is the situation of francophones. With this project, it is possible to obtain administrative health data. For example, in the footsteps of the Public Health Bureau of Montreal, we can understand how people interface with health care services, and how often. This tool is not costly, but money is needed to get it up and running. To obtain additional funding, we have to compete for financing, which is very difficult and competitive. The success rate is not higher than 20 per cent. To obtain funding, researchers must have a very solid reputation.

That is why I am an advocate of a national research institute on sociolinguistic communities living in a minority setting, and research on health. The institute would provide *bona fide* data on all of these needs and make the useful tools accessible.

Mrs. Sylvie Boucher: We are talking about minorities. Their health is of importance to us.

Are francophones in poorer shape? Are we more prone to illness? Is it because of societal behaviour, when one is living in a minority setting? Does the same apply for the anglophone minority in Quebec? I'm not talking about anglophones in Montreal but smaller anglophone communities living in other regions of Quebec.

Are francophone minorities' behaviour very different?

Mrs. Louise Bouchard: It ties in closely to living conditions. Living in a remote minority setting means having less access to resources. Living in regions where the economy is depressed puts people in a very much less favourable condition.

One important concept in health care could perhaps be explored. I'm referring to the concept of linguistic insecurity. This does not necessarily translate into morbidity, but pose an identity dilemma for certain individuals.

I would like to explore this issue with young people. For example, does linguistic insecurity bear any relation to high-risk health-related behaviour, etc?

In my opinion, many problems must be documented.

● (1045)

Mrs. Sylvie Boucher: Thank you very much, Ms. Bouchard.

The Chair: Thank you, Ms. Bouchard and Ms. Boucher.

[*English*]

We have a special guest at this committee, Mr. Tilson, the chair of another committee, who has a very brief question—apparently a thirty-second question and a thirty-second reply.

The reason we're doing this so quickly is we do have some future business to discuss.

Mr. David Tilson (Dufferin—Caledon, CPC): It's a pleasure that you're going to give me thirty seconds, Mr. Chairman. I appreciate that.

Some hon. members: Oh, oh!

Mr. David Tilson: About a year and a half ago, I had an opportunity to be part of a delegation to the Council of Europe. While there, I met a doctor from France. Of course, in Europe there are no boundaries. There's French, English, German, and Spanish. He is French; that's it. Somehow we communicated with my lack of French, but we did talk about it.

He said that because of the linguistic problems in France, routine examinations were less frequent. Therefore, this would be a problem with determining detections of illnesses and conditions.

So now in Canada we have francophone, anglophone, and...multi-languages in Montreal, Toronto, and Vancouver. This doesn't apply to French-English.

So my question to you, Professor Bouchard, is whether you have looked at this topic in your research. If you have, is it possible to assess the effect of this problem on the linguistic minority situation of French and English?

[*Translation*]

Mrs. Louise Bouchard: I will respond in French.

Of course, immigrants living in Canada would have to choose to speak one of the two official languages. We know that—

[*English*]

Mr. David Tilson: If I could interrupt, forget that—just French and English. Just zero in on French minorities in English communities and English minorities in French communities. Forget the other part.

[*Translation*]

Mrs. Louise Bouchard: Fine.

My work has shown that living in a minority situation, whether it be anglophone or francophone, seems to have a negative effect on an individual's perceived health status. It goes beyond one's financial situation, level of education or sex; there is something else at play. Also, it seems more prevalent among men than women, according to our analysis model.

That is what I have accomplished to date. It is essential that we continue to explore this phenomenon so as to better understand it. With that in mind, it is important to include the networks so that we can determine what is happening in the field and find the best way to plan services to face this situation.

The Chair: Thank you very much, Ms. Bouchard.

[*English*]

And thank you very much, Mr. Tilson.

[*Translation*]

Unfortunately, we have to move on to another subject. I would like to thank our guests. I would ask committee members to remain seated because we have a few more matters to deal with; it should take about 10 minutes.

Thank you to our guests.

There are two things that we must discuss. First, upcoming business. Minister Solberg will attend our meeting next Tuesday, October 24; he will be here for one hour, from 10:00 to 11:00 a.m. We will hear a witness at 9:00, who will speak to us about health care issues. The minister will be here from 10:00 to 11:00 a.m. on the 24th.

On October 26 and 31, we will also hear witnesses on health care. Minister Cannon will appear on November 2nd, he will be here for two hours. We will be travelling on November 6.

We will hear witnesses on health care and immigration on December 14. Ministers Oda, Verner and Clement will be appearing subject to availability.

Mr. Godin, you have the floor.

● (1050)

Mr. Yvon Godin: If I understand correctly, on November 6, we will be travelling East, and the trip West will be on—

The Clerk: It will be from December 4 to 8.

Mr. Yvon Godin: It will be from December 4 to 8.

Can we discuss the possibility of inviting other witnesses to appear?

The Chair: It's already—

The Clerk: I have invited local witnesses to appear, at least until November 2nd, because if the committee travels you will be able to hear witnesses in those locations. Perhaps when you return, if there are points that you have not had time to develop sufficiently, we could call witnesses on immigration and health, since both are being examined jointly.

That is the situation as it now stands. If you would like to provide me with names... I know that I have one, and we can hear that person in Moncton.

The Chair: Mr. Godin was first.

The Clerk: Why are the bells ringing?

Mr. Yvon Godin: It is either a quorum call or a vote.

We have to be careful. We are not travelling to discuss health but rather to meet with a number of organizations. We must be careful not to fall into a trap. Here, in Ottawa, our witnesses are asked to deal only with health-related issues, and others are not invited. When we travel, we must not limit our discussions only to health care.

The Clerk: We are examining health and immigration. Would you like to deal with something else? For the time being, the committee is scheduled to spend only one day in each city.

Mr. Yvon Godin: That was the reason for my comment. The committee is not travelling to explore health-related issues. If they want to discuss health, then witnesses should be invited to appear before the committee here.

We are travelling to some locations to see how our program money is spent and what it is accomplishing.

If we are only in Moncton for one hour, we should not spend our time talking about health care without going into the reason why we are there in the first place.

Le président: I would like to clarify something. There is a list—

Mr. Jean-Rodrigue Paré (Committee Researcher): I believe there is a slight misunderstanding. Let's be clear about something. The starting point, the main reason for this trip revolves around the action plan. The action plan deals first with education, then, with health. It also includes immigration. So there are different aspects, including the public service, but it won't be necessary to deal with that when we travel. That is the action plan.

Mr. Yvon Godin: I agree on that.

We have decided that health will be a priority. So, when we are in Moncton, I don't think we should spend all of our time discussing health, since we have a forum for that here, in Ottawa, where witnesses may be called to appear.

It is hard to get very much done in one hour. In fact, we have just spent two hours discussing only health care.

● (1055)

The Chair: Do you have any comments on that, Ms. Boucher?

Mrs. Sylvie Boucher: I agree with Mr. Godin. We mentioned that at the outset: health care is discussed here. Of course, we can meet with people from outside Ottawa.

We have just spent two hours discussing health matters. I think that it is important for people from outside Ottawa to meet with us here, since everyone is already here. However, when we travel, we can only meet with one or two people. Nevertheless, we should not spend the entire week discussing health care.

The Chair: The clerk has taken note of your comments. Is that okay with you?

A voice: I agree with you, Mr. Godin.

The Chair: You always agree with him!

I will be appearing before the Liaison Committee at 1:00 o'clock this afternoon to request leave for the committee to travel. I hope it will work, because all of the whips are aware of it and, so far, they seem to be in favour of our plans.

Ms. Barbot.

Mrs. Vivian Barbot: Could we have a copy of the action plan? It all seems rather confusing. It would be helpful if we had a list of the people whom we have already met as well as the subjects that were discussed, and who we will be meeting with. That would help us to get a handle on things.

It feels to me like we are skipping from one subject to another, and we are losing track. I'm sure our researcher knows what is going on, but I would like to see it in writing.

Mr. Jean-Rodrigue Paré: You mean a work plan.

I can draft something, but it may not be accurate because once a week, and sometimes more often, we have to update the issues and priorities.

There already seems to be a misunderstanding. I thought that members would take this opportunity to look at the action plan, but that their priority would also revolve around health and immigration, while they were at it. But that is not the case. So we will have to rework the entire plan. All is not lost, however, because we will meet with some people here instead of at those locations.

Mrs. Vivian Barbot: That is why it is important for us to have a plan to which we can refer. Otherwise, people will just keep tinkering with it. A plan would help us to concentrate on what has already been established.

Mr. Jean-Rodrigue Paré: Very well. I will prepare a plan. I have no problem with that, since I have a plan already. I am well prepared because I suspect that you will want to draft a report. So I have a plan that I would be happy to provide you with, if you so wish.

Mrs. Vivian Barbot: And we should commit to following this plan. I understand that, from time to time, there may be a priority, but we must not constantly stray from our objective, otherwise we will feel that we have wasted our time. That is how I see it, anyway. There you have it.

The Chair: The researcher has taken note of your comments. Anyone else?

Ms. Boucher.

Mrs. Sylvie Boucher: Do we know who will be travelling?

Mr. Jean-Claude D'Amours: Mr. Chairman, you will be meeting with the Liaison Committee at 1:00 o'clock this afternoon. As soon as the House gives its consent, we will know who is on the list to travel.

The Clerk: Members have already asked me that question, but it is really up to you. For example, the group travelling East will not have much choice because you will have five cities to cover. That means that you will be leaving on Sunday night in order to begin in the first city on Monday morning.

With respect to the trip West, you will be visiting four cities, but they are farther apart. Would you prefer to leave on Sunday night and return late on Thursday? That is probably impossible to do. So you would probably have to leave on Friday or on Monday, when there is nothing to do. You will have Tuesday, Wednesday, Thursday and Friday, but you will probably only be able to return home on Saturday.

The Chair: Mr. D'Amours.

Mr. Jean-Claude D'Amours: So what you are saying is that it is rather complicated.

I would still like to raise the point. If at all possible, I would like us to seriously consider beginning on Monday morning in Vancouver. We have to travel in order to be in Vancouver for Monday morning, in any case, since that is where our first meeting will be held.

Then, on Thursday, we should try to see if each of us can return to our respective riding, since it will be the beginning of the Remembrance Day long weekend.

● (1100)

The Clerk: No, that trip will be in December.

Mr. Jean-Claude D'Amours: In another committee? No, Remembrance Day weekend is in November.

I was talking about the trip West. I would suggest that we begin on Monday morning in Vancouver and that we try to wrap up on Thursday so that we can each return to our riding, since it will be the beginning of the Remembrance Day long weekend.

The Chair: No, it is in December. The trip West will be in December.

Mr. Jean-Claude D'Amours: I'm sorry, I understand. Now I see what you mean.

One way or another, I would like to be able to return to my riding.

The Chair: Ms. Barbot.

Mrs. Vivian Barbot: That's it. However, I would like to travel on Monday, rather than on Sunday. I would prefer to meet only on week days, but if that is not possible, then so be it. Moreover, I would like to leave from Montreal rather than from Ottawa.

The Chair: Anyone else?

The Clerk: We will be in touch with each member. The trip to Vancouver will be on commercial flights. However, if you intend to only leave on Monday, you may arrive late, because the others want to leave on Sunday in order to begin on Monday morning.

Mrs. Vivian Barbot: I'm not saying that I want to do something that the rest of the group isn't doing. That is my preference if it is possible but I will do what the other members choose to do.

The Chair: Mr. D'Amours.

Mr. Jean-Claude D'Amours: I understand your reasons. However, given how far away Vancouver is, we may not begin before Tuesday. Therefore this would be a bit difficult.

Mrs. Vivian Barbot: Whatever is possible.

The Chair: The meeting is adjourned.

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