Assemblée de la francophonie de l'Ontario

Hearst, September 21, 2023

The Honourable Marc Holland
Minister of Health
Home and Continuing Health Care Unit, Health Canada
Jeanne Mance Building, 4th floor
200 Eglantine Driveway, Tunney's Pasture
Ottawa, Ontario K1A 0K9

C.c. The Hon. Kamal Khera, Minister of Diversity, Inclusion and Persons with Disabilities
The Hon. Pascale St. Onge, Minister of Canadian Heritage
The Hon. Seamus O'Regan Jr., Minister of Labour and Seniors
The Hon. Randy Boissonnault, Minister of Employment, Workforce Development and Official Languages
The Hon. Marc Miller, Minister of Immigration, Refugees and Citizenship

Dear Minister,

Re: A proposal to effectively integrate the Francophone minority community lens into the federal *Safe Long-Term Care Act*

Access to French language health care services is a growing concern for Ontario's Francophone minority communities. In the wake of the pandemic, the health care system is under pressure. At the same time, Francophones increasingly need health and long-term care services. Our population is aging more rapidly than the provincial average, a trend that highlights greater needs for accessible, equitable, safe and linguistically and culturally appropriate senior care services.

Francophone minority communities face major challenges in accessing health care services, including long-term care services.

- In 2018, long-term care beds identified by Ontario municipalities numbered 30,000. Among them, the number of beds designated under Ontario's *French Language*

Services Act was 1 per 3400 Francophones, a ratio 20 times lower than in the general population (1 per 170 Ontarians).[1]

- There are no defined standards for Francophone long-term care services that are accepted or recognized by Ontario's Ministry of Long-Term Care.
- Ontario's recently adopted Bill 7 prioritizes patients deemed to be in crisis for access to available long-term care beds, regardless of the patient's linguistic or cultural status or the bed's linguistic or cultural designation. This is beginning to negatively affect Francophone patients' access to beds that come with French language services.

The proposals put forward in this brief would improve equity and access to safe long-term care services for the Francophone minority language community, while also increasing the safety and fiscal responsibility of long-term care services.

As the Government of Canada is preparing legislation on safe long-term care, there is an opportunity to improve the accessibility and safety of services for Canada's official language minority communities (OLMCs). Our recommendations offer measures that aim to optimize the efficiency and security of long-term care services, so that OLMCs, and Ontario's Francophone community in particular, can fully benefit from them.

Recommendations

1. The federal and provincial governments should include in their public health policies and health care planning, at all administrative levels, an acknowledgment of the fact that living in a minority language setting impacts the health of individuals and constitutes a social determinant of health. It is imperative that this be taken into account when allocating federal funds to the provinces for health care, including long-term care to official language minority communities (OLMCs).

2. The Government of Canada should define standards of long-term care for Francophones that include:
    - Culturally and linguistically adapted care services;
    - Safety and quality of care; and
    - Culturally and linguistically adapted participation in the facilities' social life and leisure activities.

[1] Office of the French Language Services Commissioner, 2019

3. The federal government, through bilateral agreements on funding transfers to provinces, should ensure that Francophones have access, at the least in regions designated under Ontario's *French Language Services Act*, to beds in long-term care homes that meet the Francophone standard discussed in Recommendation 2, without competition with any other criteria which, by design, favour the majority language population to the detriment of the cultural and linguistic needs of Francophone minorities (e.g., Ontario's *More Beds, Better Care Act, 2022*).

4. The federal and provincial governments should jointly implement aggressive strategies to increase Francophone and bilingual human resources in the health care sector, including long-term care, by:
    - Increasing the number of health care training programs and positions funded and overseen by the *Consortium national de formation en santé* (CNFS) and distributing them equitably across the province;
    - Facilitating a process for recognizing diplomas obtained abroad that reflects real qualifications and ends the protectionism shown by certain professional associations in Ontario.

5. The federal and provincial governments should require the adoption of quality assurance standards across the entire long-term care sector by making certification mandatory. The standards for safe long-term care should include:
    - The general module;
    - The official languages module; and
    - The infection prevention module made available in French as well.

I thank you for the attention paid to these recommendations.

If you wish to obtain further information or if you have questions or comments, I invite your team to contact the AFO's Health coordinator, Anne-Elisabeth Noppens, by email at aenoppens@monassemblee.ca.

Yours sincerely,

Fabien Hébert
President

Assemblée de la francophonie de l'Ontario

Brief

Federal Legislation on Safe Long-Term Care

Assemblée de la francophonie de l'Ontario

Table of contents

1- EXECUTIVE SUMMARY

Official language minority communities (OLMCs) have demographic similarities that put them at greater risk of confronting health care challenges less successfully. The Franco-Ontarian community is more vulnerable to developing or aggravating health care problems that could have been better managed if the language factor had been dealt with at the onset. In that sense, language is a social determinant of health. Generally, the Franco-Ontarian community presents the following characteristics compared to the general population: a higher average age, higher poverty among seniors and a lower level of education. Also, among seniors, there is an above-average incidence of two or more chronic illnesses, as well as difficulty in accessing health care services (Bouchard et al., 2013).

The Franco-Ontarian community's access to care is made more difficult by the lack of health care and long-term care services specifically adapted to the language and culture of Ontario Francophones. In particular, long-term care services are sorely lacking: statistically, one bed with French language services is available per 3400 Francophones, compared to 1 bed per 170 citizens in the general population (Office of the French Language Services Commissioner of Ontario, 2019).

The inability to access health care services that are culturally and, most importantly, linguistically concordant, increases risks of not just discomfort and dissatisfaction, but also errors in treatment or medication, misdiagnosis, use of tests that can pose risks, a greater number of falls among seniors in long-term care and other adverse events (Hsu et al., 2022; de Moissac and Bowen, 2019; Seal et al., 2022). These are all human and economic costs. Yet despite such concerns, there are no standards that clearly define what constitutes proper care for Francophones in the long-term care sector.

However, increasing the offer of safe, quality services that are culturally and linguistically adapted to Ontario's OLMCs can only be possible if sufficient numbers of qualified health care workers are added to the workforce.

The COVID-19 pandemic has significantly impacted the populations of long-term care home residents, highlighting the need to establish standards of quality care in this sector, which should include, in the bilingual country that is Canada, the aspect of bilingualism.

In this regard, in late 2020 and early 2021, the AFO convened leaders from several sectors involved in long-term care to discuss the challenges faced by Francophones and make recommendations on long-term care to Ontario's Long-Term Care COVID-19 Commission. Earlier in the process, the AFO and its collaborators had a meeting with the commission and submitted a brief.

In its final report, the commission made four recommendations to the Government of Ontario.

- In order to protect the rights of Francophones:
    - Design and implement a provincial strategy to increase French language long-term care services and beds;
    - Adopt a clear definition of "bed occupied by Francophones";
- Make targeted efforts to recruit workers who are able to provide French language services;
- Provide an additional incentive to organizations that prioritize linguistically and culturally adapted health care services.

The AFO's recommendations:

1. The federal and provincial governments should include in their public health policies and health care planning, at all administrative levels, an acknowledgment of the fact that living in a minority language setting impacts the health of individuals and constitutes a social determinant of health. It is imperative that this be taken into account when allocating federal funds to provinces for health care, including long-term care for official language minority communities (OLMCs).

2. The Government of Canada should define standards of long-term care for Francophones that include:
    a. Culturally and linguistically adapted care;
    b. Safety and quality of care;
    c. Culturally and linguistically adapted participation in the facilities' social life and leisure activities.

3. The federal government, through bilateral funding transfer agreements with the provinces, should ensure that Ontario's Francophones have access, at least in regions designated under the *French Language Services Act*, to beds in long-term care homes that meet the Francophone standards discussed in Recommendation 2, without competition with other criteria which, by design, favour the majority language population to the detriment of the cultural and linguistic needs of Francophone minorities (e.g., Ontario's *More Beds, Better Care Act*, 2022)

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    a. Increasing the number of health care training programs and positions funded and overseen by the *Consortium national de formation en santé* (CNFS) and distributing them equitably across the province;
    b. Facilitating a process for recognizing diplomas obtained abroad that reflects real qualifications and ends the protectionism shown by certain professional associations in Ontario.

5. The federal and provincial governments should require the adoption of quality assurance standards across the entire long-term care sector by making certification mandatory. The standards for safe long-term care should include:
    a. The general module;
    b. The official languages module; and
    c. The infection prevention module made available in French as well.

2- INTRODUCTION

Why is the *Assemblée de la francophonie de l'Ontario* (AFO) interested in access to French language services in health care and long-term care?

At our last annual general meeting, our members unanimously adopted a resolution demanding that "the *Assemblée de la francophonie de l'Ontario* (AFO) make health care a key priority and devote the necessary resources to engaging proactively in advance of political decisions." As shown in the table below, access to health care, home care and long-term care services in French is an increasingly important concern in our community.

In the list below, indicate your top five priorities by order of importance, 1 being your most important issue.						
Priorities	1	2	3	4	5	**Total**
Increase access to French language primary care	36.89%	21.31%	14.75%	5.74%	6.56%	**85.25%**
Improve access to French language post-secondary programs	15.84%	15.84%	13.86%	5.94%	9.90%	**61.38%**
Ease the shortage of Francophone and bilingual workers	12.82%	17.95%	21.37%	15.38%	11.11%	**78.63%**
Complete the University of Sudbury project	12.20%	8.54%	3.66%	3.66%	2.44%	**30.5%**
Provincial funding for Francophone organizations	12.00%	8.80%	12.00%	13.60%	8.80%	**55.2%**
Increase services to Francophone immigrants	9.71%	3.88%	11.65%	9.71%	10.68%	**45.63%**
Improve French language education (elementary. intermediate and secondary)	8.51%	10.64%	7.45%	11.70%	3.19%	**41.49%**
Post-pandemic recovery of not-for-profit organizations	8.51%	10.64%	6.38%	12.77%	10.64%	**48.94%**
Improve access to Francophone home care	8.51%	9.57%	10.64%	13.83%	7.45%	**50%**
Other	8.00%	5.33%	0.00%	4.00%	6.67%	**24%**
Investments in Francophone arts and culture	7.92%	7.92%	6.93%	12.87%	19.80%	**55.44%**
Improve access to long-term care in French	6.48%	15.74%	14.81%	14.81%	10.19%	**62.03%**
Financial support for cultural centres	5.75%	5.75%	10.34%	5.75%	3.45%	**31.04%**
Capture the language variable in the Health card	4.60%	3.45%	3.45%	3.45%	10.34%	**25.29%**
Build more health infrastructure by and for Francophones	4.55%	4.55%	6.82%	11.36%	12.50%	**39.78%**
Survival of Franco-Ontarian media	2.33%	5.81%	6.98%	4.65%	10.47%	**30.24%**
Implement a Francophone university network	2.20%	9.89%	9.89%	5.49%	9.89%	**37.36%**
Improve access to Francophone early childhood education	1.10%	3.30%	6.59%	12.09%	12.09%	**35.17%**
Certification	0.00%	1.37%	0.00%	2.74%	5.48%	**9.59%**

3-METHODOLOGY

This brief was prepared "by and for" Francophones following literature reviews and **consultations** with many key partners in the field of French language health care and long-term care. This brief is a logical extension of the brief on integrating the Francophone lens in health care and long-term care services we published this spring and the information we gathered for the consultations on long-term care conducted by the Office of the Ombudsman of Ontario. This brief has also benefited from the input of our **health care advisory committee**, whose members include directors of long-term care homes, home care services, supportive housing, Francophone seniors' groups, hospitals, community health centres, the *Réseau de santé en français*, mental health services and

post-secondary institutions, as well as the group of experts who helped to prepare the AFO's submission to Ontario's Long-Term Care COVID-19 Commission.

We wish to thank everyone who took part in the wide consultation effort that led up to this brief.

4- AN OVERVIEW OF LONG-TERM CARE IN ONTARIO

Over time after Ontario's public health system was created in 1965, a number of elements have been put in place to help Francophones access French language health services, including long-term care services.

- Six French Language Health Planning Entities have been created.
- There are 17 long-term care homes designated under the *French Language Services Act*.
- In 2018, long-term care beds identified by Ontario municipalities numbered 30,000. Among them, the number of beds designated under the *French Language Services Act* was one per 3,400 Francophones, a ratio 20 times lower than for the general population (1 per 170 Ontarians).
- The modernization of the *French Language Services Act* in 2022 entrenched the principle of Active Offer directly within the Act, but it applies only to organizations that have been designated under the Act.

The following numbers indicate other difficulties that Ontario Francophones face in obtaining long-term care services in their language.

- Greater Toronto's Francophone population (127,000 people) has access to just 37 long-term care beds with bilingual services, that is, one bed per 3432 Francophone Torontonians (Reflet Salvéo, 2019).
- Francophone seniors represent 5.5% of the province's seniors (75+) (Ontario 2019), but just 1.9% of long-term care homes are designated under the *French Language Services Act* and 0.5% have a cultural designation.
- No standards define Francophone services, even in designated institutions.

In addition to the lack of beds to serve Francophones, we note a reduced proportion of Francophone residents within designated services in certain facilities, in part due to the *More Beds, Better Care Act, 2022*, which prioritizes patients with crisis status over the cultural and linguistic needs of Francophone patients (as told to us by administrators, directors of designated long-term care services and home-care coordinators). The result is more ostracization of Francophone seniors, as they are forced to accept services that are not linguistically and culturally adapted and therefore not safe services, this in spite of their request for services in an official language of Canada.

5- LANGUAGE OF SERVICE AND MINORITY LANGUAGE SETTING AS SOCIAL DETERMINANTS OF HEALTH

The federal government's *Official Languages Act (1969)* made English and French the country's two official languages with equal status. The Act was twice modernized in depth, the last modernization having been adopted this year. Articles 41.1 and 41.2 of the Act clearly define the federal government's responsibilities towards OLMCs and specifically its role in protecting and promoting French.

> **Progressing towards equality of status and usage of French and English**
>
> **Commitment — enhancing vitality of communities and fostering English and French**
> 41 (1) The Government of Canada is committed to
> (a) enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development, taking into account their uniqueness, diversity and historical and cultural contributions to Canadian society; and
> (b) fostering the full recognition and use of both English and French in Canadian society.
>
> **Commitment — protection and promotion of French**
> (2) The Government of Canada, recognizing and taking into account that French is in a minority situation in Canada and North America due to the predominant use of English, is committed to protecting and promoting the French language. (Canada)

Health is a wider and much more complex notion than simply the absence of illness. Health cannot be explained simply in genetic, biological, environmental and pathophysiological terms. The social determinants of health should be understood as the social conditions in which people live and work. The study of social determinants of health focuses on showing the impact of social context on health, as well as the mechanisms by which social determinants affect health (Lang, 2014).

Some material aspects of this concept have an obvious link with health, such as access to wholesome food, clean water or housing. Other more psychosocial aspects can accompany them, such as psychological stress caused by work that provides little opportunity for satisfaction, control or influence, coupled with physical stress due to grueling work. The number of social interactions provided by the environment, and thereby the emotional and practical support an individual can count on, also influence health (Lang, 2014).

However, a key factor in the social determinants of health, at every age of life, is the level of education and revenue. An individual's level of education is a foundational achievement in early adulthood. Education influences lifestyles and healthy behaviours. It leads to a profession and to a certain level of revenue, therefore to a social standing. To some degree, it is protective against unemployment and it is also predictive of the level of exposure to working conditions that are detrimental to health. Education also affects health in indirect ways, such as having a degree of control over one's own life (Lang, 2014).

In their 2013 study, Professor Louise Bouchard and her colleagues clearly demonstrated that Ontario's minority language population aged 65 and over at that time was more rural, economically poorer and less educated compared to similar Anglophone populations. Francophone seniors also exhibited a clear correlation between their educational and socio-economic status and their perceived health status, as well as multiple chronic diseases, compared to similar Anglophone populations (Bouchard et al., 2013). The demographics of the Franco-Ontarian community changed to some extent over the past ten years, but not enough to significantly diminish the importance of these findings.

Language is at the forefront of communications between health care professionals and the population and the impacts of language barriers on health are increasingly well documented. Going forward, in the Canadian context of two official languages, equitable health policies should take the minority language setting into account as a determinant of health (Bouchard and Desmeules, 2013).

This applies not only to Ontario's Francophones, but to all OLMCs. The profile of the Francophone minority outside of Quebec shows a greater proportion of people perceived to be in poor health, older, less educated, poorer, and with two or more chronic illnesses,

compared to the average Anglophone population. Quebec's Anglophone population, aside from Montreal, presents a similar profile (Bouchard and Desmeules, 2013).

Recommendation 1

The federal and provincial governments should include in their public health policies and health care planning, at all administrative levels, an acknowledgment of the fact that living in a minority language setting impacts the health of individuals and constitutes a social determinant of health. It is imperative that this be taken into account when allocating federal funds to the provinces for health care, including long-term care to official language minority communities (OLMCs).

The Government of Canada's website lists access to health care services as one of the main social determinants of health (Canada, 2023). However, for Ontario Francophones in minority settings, access to culturally and linguistically appropriate health care services that are equal in quality and safety to those available to the Anglophone majority remains substantially below average (Doucet et al., 2021).

It should therefore be recognized that members of Ontario's Francophone communities:

- are older than average compared to the general population;
- have less post-secondary education compared to the average for Ontario seniors;
- are poorer economically compared to the average for Ontario seniors;
- have greater difficulty in accessing culturally and linguistically adapted health care services; and
- live in a minority language setting.

All of these aspects are social determinants of health that negatively influence our community and therefore require health policy strategies and public investment from many levels of government in order to mitigate health inequalities for Ontario's Francophone minority communities.

6- THE IMPORTANCE OF LANGUAGE FOR HEALTH CARE SAFETY AND COMPLIANCE

The World Health Organization (WHO) defines patient safety as follows. "Within the broader health system context, patient safety is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in

health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur." (WHO b)

Receiving health care services in one's own language is a factor for safety of care. Communications between patients and health care workers, as well as obstacles they may face due to poor communication, greatly impact the quality, cost and safety of care and may result in misdiagnosis and inappropriate treatment (Betancourt et al., 2012).

Language concordance between patients and their health care workers significantly reduces the risk of adverse events. In their research on language concordance in an Ontario hospital published in 2022, Emily Seale, a medical student and researcher at *Institut du savoir Montfort*, and her colleagues noted that Francophones who received language-concordant care were at a significantly lower risk of harmful hospitalization or in-hospital death compared to Francophones who received language-discordant care. They also noted a higher number of rehospitalizations for patients who received language-discordant care, due mainly to poor understanding of medical instructions and poor care compliance due to poor comprehension.

Language discordance between patients (and their caregivers) and health care workers leads to these principal adverse effects:

- patient and caregiver dissatisfaction with services (Al Shamsi et al., 2020; Diamond et al., 2019)
- misdiagnosis (de Moissac and Bowen, 2019)
- misunderstood diagnostics (de Moissac and Bowen, 2019)
- errors in treatment or prescriptions (Al Shamsi et al., 2020)
- higher stress levels in interactions with health care workers (de Moissac and Bowen, 2019)
- delayed treatment (de Moissac and Bowen, 2019; Al Shamsi et al., 2020)
- poor understanding of treatment, resulting in poor compliance with treatment and instructions of health care workers (Seal et al., 2022; de Moissac and Bowen, 2019)
- poor knowledge of healthy behaviours due to lack of exposure to health promotion (Renzaho, 2007; Okrainec et al., 2015)
- poor quality consent process, which may mean no truly informed consent to procedures and treatment (Seal et al., 2022)
- lower quality health care services (de Moissac and Bowen, 2019)

- low trust in health care services (de Moissac and Bowen, 2019)
- more frequent rehospitalizations (Seal et al., 2022)
- longer hospital stays (de Moissac and Bowen, 2019; John-Baptise et al., 2004)
- higher incidence of falls (Hsu et al., 2022)
- more emergency room visits (Diamond et al., 2019; Okrainec et al., 2015)
- more frequent adverse events (Seal et al., 2022; de Moissac and Bowen, 2019; Diamond et al., 2019)
- more in-hospital mortality (Seal et al., 2022)
- more dissatisfaction among health care workers who provide services in these conditions (Al Shamsi et al., 2020)
- source of work-related stress for health care workers (Al Shamsi et al., 2020)
- increased precautions by health care workers due to poor communications (Seal et al., 2022)
    - more prescribed tests and diagnostic procedures (Seal et al., 2022)
    - more hospitalizations (Seal et al., 2022)

      This could appear to be an advantage, and in some cases, it is, but:
        - almost all diagnostics and procedures involve a degree of risk to the patient (Crownover and Bepko, 2013; Lippi et al., 2006);
        - the health system incurs unnecessary additional costs (for interpretation services (Al Shamsi et al., 2020) and unnecessary admissions, diagnostics and tests (Seal et al., 2022);
        - the risk of nosocomial diseases increases (Delgado-Rodriguez et al., 1990; Luong-Nguyen et al., 2020).

The many adverse effects of linguistic discordance between patients and health care workers highlight the importance of providing the entire Franco-Ontarian community with access to safe, linguistically and culturally adapted long-term care services. The problems that stem from linguistic discordance underscore the need to provide equitable access to quality long-term care services for all OLMCs and to guarantee that patients can communicate effectively with health care workers. By investing in linguistically adapted health services, Canada can not only improve the security of patients and the quality of care, but also reduce operating costs and improve staff satisfaction and retention in the health system. Guaranteeing that every individual receives appropriate care in either official language thus contributes to improving the overall population's health and well-being.

Linguistic concordance in long-term care is associated with lower levels of hospitalization in Ontario OLMCs (Batista et al., 2019). Moreover, in facilities where the French language is predominant, fewer Francophones show worsening symptoms of depression or are prescribed antipsychotics despite having no diagnosis of psychosis, compared to Francophones in facilities not designated under the *French Language Services Act* (Batista et al., 2021). Francophone residents in French language facilities also experience fewer falls than their peers in non-designated facilities (Hsu et al., 2022). The findings of these serious studies clearly demonstrate that residents experience more well-being, services are safer and of higher quality and costs to the health care system are lower when Francophones are cared for in long-term care facilities that provide a French language living environment and care services.

To ensure that seniors in long-term can be cared for in an environment where their language is spoken and the communal living environment is culturally adapted is to ensure well-being, especially if health care workers adequately meet their needs (Badger et al., 2012; Bouchard et al., 2012). When seniors receive care in their own language, their families have one less thing to worry about because they feel that their loved ones are getting better care. All in all, quality of life is greatly improved (Heikkilä et al., 2007; Khan and Pillay, 2003; Oliver et al., 2004).

The French language is not the only positive factor for safe, quality care and services to Francophones. The French culture and its distinct way of looking at life is just as important and sometimes even more important (Larocque et al., 2023).

> "Through language, one can express one's "logos," that is, one's raison d'être. In other words, language is not just the key vehicle of a culture, but also the means by which individuals can receive, decode and interpret material and intellectual realities."
>
> Bernard, 1990. *Le déclin d'une culture*. (Our translation)

As Roger Bernard states, the close link between language and culture explains why Ontario's Francophones have an identity that differs from the Anglophone majority. To flourish, they need long-term care and services that are decodable and interpretable in their cultural code and their language. Once a person has settled into a long-term care facility, language services are most often provided by visitors (e.g., family members, parents and friends) or volunteers, unless the resident is in a long-term care facility that

has a Francophone or ethnic designation (Hsu et al., 2022). In their 2023 study, Larocque and her colleagues gathered a number of quotes from Francophone caregivers and residents who experienced a transfer from an Anglophone to a Francophone long-term care environment. Here are excerpts that show why it is important for residents to have a culturally appropriate living environment (our translation):

- *My parents wanted to have a French-speaking place to stay so that they could live in French and hopefully maintain the cultural aspects of Ontario's Francophone community.*
- *One resident said: "English-speaking people don't have the same mentality." And her caregiver added that she "doesn't understand the ladies [in the Anglophone centre] very well."*
- *I don't want to lose my French, [...] in other words, I don't want to be assimilated [...] so I will always have and always value my language and customs [...], to keep reading in French, seeing French plays, culture, everything that is offered in French.* (Larocque et al., 2023).

In light of these considerations and research findings, it is of fundamental importance to define what standards of safe, quality care should mean for Francophones in a minority language setting. The standards should include linguistic and cultural aspects, both for levels of care and the living environment.

Recommendation 2

The Government of Canada should define standards of long-term care for Francophones that include:

- **Culturally and linguistically adapted care;**
- **Safety and quality of care; and**
- **Culturally and linguistically adapted participation in the facilities' social life and leisure activities.**

The language and the directives that define care for Francophones should appear not only in the act's preamble, but also in the standards.

Moving into a long-term care facility, even voluntarily, is a major life change that can sometimes be extremely distressing (Hodgson et al., 2004). Communication problems between care providers, family members and residents in long-term care facilities are widely recognized in scientific publications (Mold et al., 2005; Oliver et al., 2004), especially when residents lose the ability to speak their second language due to a serious illness or dementia (Heikkilä and Ekman, 2003; Verma and Howard, 2012). Therefore, the quality of communications can have a considerable influence on a person's state of health and the adaptation of services to their preferences, wants and needs (Larocque et al., 2023).

It should also be noted that a good number of Francophone patients in long-term care facilities have lost or will lose their ability to communicate in their second language (Bowen, 2015), which is generally English, due to neurodegenerative diseases such as Alzheimer's. One can imagine the anxiety and incomprehension felt by a long-term care patient who can't understand the language spoken by facility staff and health care professionals, be it in daily interactions or in an emergency.

For Francophone residents living in an Anglophone long-term care home, the language barrier is an isolation factor, as they are unable to interact with fellow residents or fully participate in the leisure activities and social life of their new living environment. Social isolation is also detrimental to residents' health, as clearly explained by the CDC:

- It significantly increases the risk of premature death from all causes at a level that can rival the risks of smoking, obesity and physical inactivity.
- It increases the risk of dementia by about 50%.
- It increases the risk of heart disease by 29% and stroke by 32%.
- It increases depression, anxiety, and suicide.
- Social isolation among heart patients was associated with a nearly 4 times higher risk of death, a 68% higher risk of hospitalization, and a 57% higher risk of emergency department visits.

7- ACCESS TO CULTURALLY AND LINGUISTICALLY ADAPTED LONG-TERM CARE

Statistics Canada provides the following numbers on the older segment of Canada's population in the 2021 Census:

- The baby boomer generation, now aged 56 to 75, continues to be the largest generation in Canada even though they are getting on in years. The 2021 Census counted 9,212,640 baby boomers, or 24.9% of Canada's population. (Statistics Canada, 2022)
- In 2031, the oldest members of this very large generation will be turning 85, an age at which physical limitations and loss of autonomy are more common. (Statistics Canada, 2022)
- The population aged 85 and older is one of the fastest-growing age groups, with a 12% increase from 2016. Currently, 2.3% of the population is aged 85 and older. (Statistics Canada, 2022, b)
- Over the next 25 years (by 2046), the population aged 85 and older could triple to almost 2.5 million people. (Statistics Canada, 2022, b)

It is obvious from these numbers that Canada will face growing needs for services to seniors, including long-term care. Canada's aging population is one of the country's most important issues and even more so in the Franco-Ontarian community.

- The average age of the Franco-Ontarian population is four years higher than the Ontario average (44 years, vs. 40 years for the general population).
- 57% of the Franco-Ontarian population is aged 45 and over.
- The average age of the Franco-Ontarian population is higher than the provincial average in northern and eastern Ontario, but similar to the provincial average in central and southwestern Ontario. (Statistics Canada, April 26, 2022)

Providing long-term care with French language services in Ontario is a challenge. The number of designated beds is low, which forces difficult choices upon many families. They must choose between placing a family member in an Anglophone facility nearby or in a Francophone or bilingual facility farther from the person's family and community... if they can find one.

In Ontario, there are 17 designated and 33 identified long-term care homes under the *French Language Services Act*. Among the designated facilities, there are also several LTC homes with a Francophone character under Regulation 79/10 of the *Long-Term Care Homes Act*. However, no definitive standards apply to their French language services and the system does not give Francophones priority in accessing these homes.

There are three main models for ensuring access to adapted long-term care homes for Francophones:

- homes "by and for" Francophones;
- Anglophone homes with bilingual staff and some practices that ensure an active offer of French language services;
- Anglophone homes with a Francophone wing.

However, the following numbers show the challenges that Francophones face in obtaining quality services in their language:

- In 2018, Francophones had access to 1 designated bed per 3400 Francophones, compared to 1 bed per 170 Ontarians in the general population (Office of the French Language Services Commissioner of Ontario, 2019).
- The *More Beds, Better Care Act, 2022* gives priority for placement in long-term care to residents deemed to be in a "crisis" situation, above all other criteria, including language and culture. Statistically, 94.5% of "in-crisis" residents will not be Francophones, yet they will have priority access to the few linguistically and culturally adapted beds that Francophones would normally count on.

Studies based on Ontario health administration data show that persons under the age of 65, with the lowest revenue and from ethnically and linguistically diverse populations, were among those who waited the longest to move into the facility of their choice (Um, 2016; Um and Lightman, 2017). Clearly, the wait times to access long-term care across Ontario are much longer for recent immigrants and for those who are waiting for designated beds or beds specific to a culture or ethnicity (including the province's facilities designated as offering French language services). (Hsu et al., 2022)

Recommendation 3

The federal government, through bilateral funding transfer agreements with the provinces, should ensure that Ontario's Francophones have access, at the least in regions designated under Ontario's *French Language Services Act*, to beds in long-term care homes that meet the Francophone standards discussed in Recommendation 2, without competition with any other criteria which, by design, favour the majority language population to the detriment of the cultural and linguistic needs of Francophone minorities (e.g., *Ontario's More Beds, Better Care Act, 2022*).

8- FRANCOPHONE AND BILINGUAL HUMAN RESOURCES AS A DRIVER OF ACCESSIBILITY FOR CULTURALLY AND LINGUISTICALLY ADAPTED LONG-TERM CARE SERVICES

The challenge of recruiting health care workers who can work in both official languages is the main cause of the lack of access to French language health and social services in minority settings. (Savard et al., 2021)

Therefore, it is crucially important to set targets across the health system to increase the number of designated health care and long-term care providers under the *French Language Services Act* per municipality and to put in place a Francophone and bilingual workforce plan to facilitate staff recruitment for health and long-term care services.

Increasing the pool of health care workers who can provide French language services will make it possible to increase the offer of long-term care services and thereby increase access to the system for Francophones. Another benefit related to this objective is an increase in work satisfaction, as workers would not have to work as often in situations of linguistic discordance with Francophone residents and their families and caregivers.

This measure would also reduce the excessive and unjustified costs the health system incurs when Francophones do not receive linguistically and culturally adapted care and services.

Recommendation 4

The federal and provincial governments should jointly implement aggressive strategies to increase Francophone and bilingual human resources in the health care sector, including long-term care, by:

- **Increasing the number of health care training programs and positions funded and overseen by the *Consortium national de formation en santé* (CNFS) and equitably distributing them across the province;**

- **Facilitating a process for recognizing diplomas obtained abroad that reflects real qualifications and ends the protectionism shown by certain professional associations in Ontario.**

In creating the *Consortium national de formation en santé*, Canada has acquired an organization and a process that facilitates and fosters the training of Francophone health care professionals across the country.

However, it is obvious that the number of trained professionals available in the labour market remains well below the needs of French language health care providers (Chartrand et al., 2017). This prevents those who would like to offer more French language services from expanding their programs, as they are unable to recruit and maintain Francophone or bilingual staff.

Another recent observation shared by French language health care and long-term care providers is that in areas where post-secondary institutions provide health education programs, it is easier to recruit from their cohorts, because young graduates seem inclined to remain in the area where they obtained their post-secondary education and placements.

Therefore, it is important that Canada and Ontario provide enough spots in Francophone and bilingual health education programs (Chartrand et al., 2017) through coordination with the *Consortium national de formation en santé* and the educational institutions. These spots should be distributed equitably across the province and in areas designated under the *French Language Services Act*.

9- ACCESS TO QUALITY, SAFE, STANDARDIZED LONG-TERM CARE

The WHO's People-Centred Health Care policy framework of 2018 presents a vision for the future in which "all people have access to health services that are provided in a way that responds to their preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality." The OMS framework focuses on using political levers to improve quality. (OMS)

However, in addition to the federal and provincial policies that ensure quality and access to health care, including long-term care, it is important to have mechanisms at the

supplier level to ensure, verify and improve the quality and security of care and services, that is, a quality management system.

Recommendation 5

The federal and provincial governments should require the adoption of quality assurance standards across the entire long-term care sector by making certification mandatory. The standards for safe long-term care should include:

- **The general module;**
- **The official languages module; and**
- **The infection prevention module made available in French as well.**

The COVID-19 pandemic clearly revealed deficiencies in some long-term care facilities' minimum quality and security standards (Ombudsman of Ontario, 2023), as well as inadequate mechanisms in public policies and some facilities' internal processes to ensure the provision of safe and quality care to their residents.

A mandated quality assurance certification (for example, through Accreditation Canada, DIN EN 15224) should include a periodic external review of procedures and standards by impartial experts, as well as self-evaluation and correction mechanisms. This is to ensure that in the future, long-term care services are more standardized across the province, with safe, quality care centred on clients' specific needs, thereby making them culturally and linguistically adapted to linguistic minorities and more efficient in terms of human and financial resources.

In the wake of the COVID-19 pandemic, the importance of quality control procedures for infection prevention has returned to the forefront. It should be kept in mind that all policies and procedures in this field need to be accessible and understandable in both official languages, so as not to exclude official language minority groups.

10- CONCLUSION

Because Canada's demographics are changing, with more people over 65 and projected increases in coming years, it is important to have national policies, procedures and structures to support this segment of the country's population.

Canada's linguistic duality must be respected, fostered and supported, including the services provided to seniors and others who need long-term care.

Policies, legislation, strategies and investments aimed at serving this segment of the population, which is by definition vulnerable due to age and fragile health, should include and attend to the particularities and specific needs of members of OLMCs. The laws, procedures, strategies and investments should ensure the quality, security and appropriateness of long-term care services aimed at members of OLMCs and specifically take into account their needs and barriers, their culture and language, in order to create an equitable system that effectively serves these communities' needs.

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