

TOWARD AN IMPROVED HEALTH SYSTEM IN FRENCH IN NEW BRUNSWICK

Report presented to the Premier of New Brunswick,
the Honourable Shawn Graham

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Background

The provincial health reform of 2008 substantially transformed the administration and governance of the health system in New Brunswick. As we shall see, that reform is part of a continuum of actions imposed by governments across Canada that, since the 1980s, have sought to maintain control over the gradual increase in spending on health care while prioritizing the provision of quality services expected by the public. The most recent health reform in New Brunswick generated a wide range of reactions. Some saw it as a move toward a more integrated system province-wide with less duplication, while others expressed concern regarding the capacity of the Acadian and francophone community to continue to manage its francophone spaces and institutions in the health field. It is those latter concerns that prompted the preparation of this report, commissioned by the New Brunswick government.

A number of views have been expressed on the reform publicly, some proposing concrete, constructive solutions to the problem and others simply denouncing the change. Certain persons chose the media or political forums to make themselves heard, while others chose the courts, as in the case of the group *Égalité Santé en français*. One thing for certain, the health reform has galvanized all of civil society, because health care remains a priority for all citizens of New Brunswick.

Access of francophone citizens to these public services in their language is a right clearly set out, but when it comes to health care, the question of people's safety comes into play. Furthermore, the recognition that francophones have the right to manage certain institutions necessary to their development is not only seen as a legal principle, it also constitutes a fundamental value for the Acadian and francophone community. It is in fact

the articulation and the implementation of these rights and these principles that are at stake here.

During the last decade, the community identified this sector as a priority and invested major resources in establishing new associations in the health field. It is only natural that, in developing community health spaces, the emphasis was placed on services, awareness, training, and education. Unfortunately, little energy was devoted to the articulation of a model making it possible to reconcile the principles of autonomy and ownership by the Acadian and francophone community, on the one hand, and the principles of collaboration and sharing of common spaces within a provincial system that serves all citizens. I frequently found myself caught between these two realities during my numerous discussions with the stakeholders with whom I met. The challenge is to plan and protect the development of francophone spaces in the health field while ensuring quality services centred on New Brunswickers. Those services, ultimately, must be delivered by two networks of facilities within a provincial system characterized by limited means and human resources, without falling into the untenable trap of duplication of certain services. Lastly, the articulation of a new health governance model has, as its backdrop, decades of inequities between the north and the south, between urban and rural areas, and between the province's two official linguistic communities.

It is therefore not surprising that there is a great deal of uncertainty surrounding the 2008 health reform, and we hope that our recommendations will clarify the place that French must occupy in the provision of health services and, no less importantly, the role of the new Regional Health Authority A as a francophone institution and as a governance structure in which New Brunswick's Acadian and francophone community participates.

A reform of such scope can create enormous challenges along with new opportunities. Our mandate does not claim to tackle the numerous issues involved in the global challenge of developing and managing a sustainable, effective health system that is capable of responding to growing needs. Instead, it is limited to issues that have an impact on the governance of Regional Health Authority A by the Acadian and francophone community, the functioning of this Health Authority in the French language, and, lastly, access to services in French within the health system. As was the case in the field of education 30 years ago, the community has to get down to work by innovating and defining the parameters of a new francophone system in the health field.

Our focus on health and wellness in French in New Brunswick brought us to the area of language rights and constitutional law. Some of the people we spoke with felt intimidated by the substance of the legal jargon and the sometimes highly specialized vocabulary of this debate that, ultimately, revolves around the health system and its organization within the provincial public administration. The fact remains that these vested rights are key elements of the community's development. It is no exaggeration to say that the *Act Recognizing the Equality of the Two Official Linguistic Communities in New Brunswick* constitutes a fundamental element of the New Brunswick political pact. This report is concerned mainly with these dimensions of language and governance for the Acadian and francophone community. Nonetheless, even if we were not tasked with reflecting on the issue of the health of the francophone population as such, the 2008 reform must also seek to contribute to improvement of the health and well-being of francophones and the provision of quality services.

Throughout the world, health is considered a fundamental dimension of a society's development and an indicator of the quality of life and dynamism of

its citizens. I wish to thank the key stakeholders in the field of health and wellness in French in New Brunswick, such as the *Société Santé et Mieux-être en français*, the *Centre de formation médicale du Nouveau-Brunswick*, and the *Mouvement acadien des communautés en santé*, which reminded me on more than one occasion that, even though my mandate dealt with important issues in terms of structures and services, I should never lose sight of the patient or the population that must remain at the centre of the process at all times. The political scientist in me recognizes the importance of accountability mechanisms and structures and the need for a minority community to manage its community spaces in order to direct its destiny. As a father and grandson, I recognize that we must also tackle health from the perspective of the well-being of our families and of our communities in general.

Moreover, upon rereading my meeting notes, I was surprised to find that, despite the very clear indication given to the persons with whom I met that my mandate was concerned mainly with elements of a linguistic nature and the governance structures of the Acadian and francophone community, most of the stakeholders also wanted to discuss the health challenges of our francophone population. In particular, they wanted to talk about the population decline and our aging population, the shortage of francophone professionals in the field of health and wellness, as well as the overly curative and not sufficiently preventive approach of our system. Others wanted to share the issues surrounding nursing homes, youth obesity, the growing costs of the system, or the wait time for treatments. Those issues naturally go beyond my mandate, but I decided to mention them to show that anyone who wants to take the time to talk about health in New Brunswick will find a population that is attached to its system and is trying to help identify the solutions that we will have to identify in the near future.

Objective

I agreed to prepare this report with full knowledge of the facts. When the Premier approached me in December 2009, health was a hot-button topic within the Acadian and francophone community, and an adversarial process instituted by recourse to the courts was at its height. I entered into a conflict situation willingly, and I was conscious that I was taking a risk in the hope of bringing about a possible resolution of the impasse. Apart from a few efforts by a very small group to inform on those who were seeking solutions, everything went quite calmly. In the field, in every region of New Brunswick, I found an undeniable desire to propose solutions in order to improve the current structure of our health system.

Here is the objective of the process as presented by the Department of Health:

“The objective of this dialogue is to identify potential solutions in consultation with key stakeholders in the field of health in French in New Brunswick and to present the New Brunswick government with solutions designed to improve the health system following the 2008 reform. This process could possibly serve as an alternative to the legal proceeding initiated by Égalité Santé en Français Inc., but that is not its primary goal. Any express efforts aimed at resolving this dispute is therefore not our responsibility but rather that of the lawyers engaged by the opposing parties in the dispute.”

Mandate

The mandate is succinct and revolves around two types of issues, the first related to governance of the Acadian and francophone community and the second to access to services in French. At the risk of repeating myself, this report is not a reflection on the 2008 reform as a whole. The health system is increasingly complex and continues to consume a larger and larger share of the provincial budget. When I accepted the mandate to prepare recommendations for improving the health system for the Acadian and

francophone community, it was important to clearly determine the parameters of the mandate and clearly identify the issues, because the limited period of time allowed for carrying out the mandate (70 days) required great precision in how the problem to be studied was defined. I came to an agreement with the New Brunswick government that, by means of targeted meetings, we would engage leaders and stakeholders from the Acadian and francophone community in an effort to identify alternatives making it possible to improve the new structures put in place in 2008. The themes to be explored included the structure of the regional health authorities, their functioning, and the range of services offered to the population.

This exercise would have been impossible without the generous participation of the members of the support committee. Those persons are not in any way connected with the content of this report. The title given to the committee aptly conveys the role it played: support. The words and recommendations presented in this report are mine, and I assume full responsibility for them. But the support committee was essential when it came to exchanging ideas and identifying persons to be met with, documentation to be consulted, and research pertaining to our problem.

I wish to thank the persons who accepted the invitation to sit on the support committee and share their expertise in the field of health in French in New Brunswick:

- Barbara Losier, Executive Director, *Mouvement acadien des communautés en santé*
- Gilles Vienneau, Executive Director, *Société Santé et Mieux-être en français du Nouveau-Brunswick*
- Jean-Marie Nadeau, President, *Société de l'Acadie du Nouveau-Brunswick*

- Stéphane Leclair, Executive Director, Centre communautaire Sainte-Anne, and member of the advisory committee for the Centre de santé Noreen-Richard (Fredericton)
- Dr. Jeannot Castonguay, retired physician and Chair of the Board of Governors of the Université de Moncton
- Euclide Chiasson, former president, *Société nationale de l'Acadie*
- Sylvain Vézina, Professor, Department of Public Administration , and researcher with the *Groupe de recherche et d'innovation sur l'organisation des services de santé* (GRIOSS)

I broke the mandate down into four questions that guided my conversations with more than a hundred stakeholders in all parts of the province. In order to obtain comments that were as candid as possible, given the delicate nature of the subject, I promised to keep what the participants said confidential. On the basis of the partnership pentagon proposed by the *Société Santé et Mieux-être en français du Nouveau-Brunswick*, we met with stakeholders from five key health sectors: health professionals, academic institutions, communities, health managers, and policy makers.

The four themes, and corresponding questions, that guided the meetings are as follows (it should be noted that a number of sub-questions arose from these).

1. Governance (board of directors)
 - What are the essential characteristics enabling Regional Health Authority A to be an institution representing the Acadian and francophone community?
2. Functioning of Regional Health Authority A (its administration)
 - What are the essential characteristics enabling Regional Health Authority A to be an institution where the administration functions in French?
3. Improvement of services in French (narrowing of gaps between the RHAs and improvement of French-language service in RHA B)
 - What are the inequities between RHA A and RHA B, and how can the gaps be narrowed?
 - How can we ensure improvement of French-language services within RHA B?
4. Training of health professionals
 - What role can the training of health professionals in French play in the attainment of greater equality of health care in New Brunswick?

This report is thus the product of a process of reflection that follows 10 weeks of targeted meetings and discussions with key players in the field of health in French in New Brunswick. Within a relatively short period of time, we have come up with some recommendations that, in our view, will make it possible to improve the major reform of the health system implemented in 2008.

Challenges of Minority Linguistic Communities

When it comes time to organize their political voices and express their development priorities in the political arena, national minorities¹ face significant challenges. Linguistic minorities in Canada, including New Brunswick Acadians, benefit from legal recognition and community infrastructure promoting the carrying out of social action and participation in the shaping of their development. The implementation of those rights remains to be defined and is reflected in an ongoing process of co-management and dialogue between the legislator (the State) and the community. The actualization of real equality is a constantly evolving undertaking and requires a common ground for sharing and planning. Today, any development project put forward by the Acadian community must be subject to accountability measures and to the sound utilization of public funds. Any implementation of a francophone space and an autonomy agreement must occur within the accountability parameters of the Legislative Assembly of New Brunswick or the federal Parliament.

Recognition of the language rights of francophone minority communities has advanced considerably since the adoption of the *Official Languages Act* in 1969. With the increasingly generous reading of the scope of these rights by the courts, francophone minority communities themselves have had to rethink the development of their community and imagine how to actualize these new opportunities. Across Canada, several joint committees composed of representatives of the federal government and francophone communities have been set up in sectors as varied as francophone immigration and economic development in French. The same cannot be said for the New Brunswick government and the Acadian and francophone community.

¹ We are referring here to the concept of national minorities, as expressed in Will Kymlicka, *La citoyenneté multiculturelle: Une théorie libérale du droit des minorités*, Paris, La Découverte, 2001.

Common grounds for dialogue are few and far between and tend to exist on an ad hoc basis. It is a sad irony that, at a time in its history where the Acadian community has a multiplicity of structures and community action capacities at its disposal, neither it nor the New Brunswick government has been able to institute a common ground for planning and implementing development.

It is easier to identify the government's spokesperson or representative than it is to identify a minority community's legitimate representative. However, in the case of Acadians, the federal and provincial governments have recognized the community voice established several decades ago. Through its network of associations, from the former *Société Nationale des Acadiens* at the start of the century to the *Société des Acadiens du Nouveau-Brunswick* of the 1970s and the *Société de l'Acadie du Nouveau-Brunswick* founded just recently, Acadian civil society has always sought to acquire community representation tools in order to influence and defend its collective interests in political debates and the development of public policy. But the tools available to a linguistic minority do not have the scale or the scope of those of a government, and the relations between this community and its governments and its neighbouring societies must rely on mechanisms of accommodation and management.

The recent health reform brings into play the most fundamental challenges associated with the development and construction, by government, of places permitting the expression of linguistic and cultural diversity. When the New Brunswick government states that it desires real equality between francophones and anglophones, it is postulating de facto that it must take measures to protect and promote the language and institutions of the francophone minority. It is the language of the francophone minority that is threatened by surrounding linguistic and cultural pressures, not that of the

anglophone majority. Government must establish measures promoting the minority's influence without basing the entire public space on ethnic or linguistic criteria. It has to plan, invent, and find compromises through dialogue and discussion between societal groups.

New Brunswick's political space and public institutions must seek to establish a balance between recognition of key places essential to the protection of the minority's language and culture and the need to establish a common ground for anglophones and francophones that transcends ethnic and linguistic differences. New Brunswick's genius lies in the numerous accommodation formulas invented right here and exported throughout the Canadian francophonie. The school-community centre model for highly minority communities, an idea that was conceived here, merges a place of education (school) with the need to expand this into a space for socialization, community development, and empowerment for the entire community (community centre). Duality within the Department of Education is a management model unique to New Brunswick that serves this Department well and that is, quite clearly, essential to the maintenance of language and culture in New Brunswick. The establishment of the *Association des enseignants francophones du Nouveau-Brunswick* (AEFNB) and the New Brunswick Teachers' Association (NBTA) as professional development bodies that are separate but that form one entity, the New Brunswick Teachers' Federation (NBTF), when advocating for union interests, is another formula for accommodating linguistic and cultural diversity.

When it comes to the health field, the same planning issues emerge:

- How can we reconcile the need to create institutions that are managed by the francophone minority but that function within a common provincial system?

- How can we create spaces where French is the language of daily operations while having an obligation to serve both linguistic communities?

The concept of “vivre ensemble” [Living together] implies that, in societies that recognize specific rights for minorities, the members participate in the political community not only as individuals, but also through their group. Their rights therefore depend in part on their membership in a group, and governments must understand that this is a question of collective recognition and that the ensuing development must be viewed globally. That basically sums up the importance of this “vivre ensemble” concept that should govern all western societies. New Brunswick is, in several respects, a model of accommodation between linguistic and cultural groups, and what remains to be done is to transpose those concepts to the health sector.

Toward a Vision of Empowerment

I agreed to contribute to the discussion on the organization of French-language health services in New Brunswick because I consider this discussion to be no less important than the one held 30 years ago on the organization of the French-language education system, where the model adopted embraced duality and homogeneous school boards. But that duality model, where each linguistic community has its own school system, cannot be applied to the hospital system, the main reason being the exorbitant costs associated with duplication of facilities. The Acadian and francophone community is almost unanimous in affirming that duplicating facilities throughout the province is not the solution to the important discussion under way on the management of a francophone space in health. In the case of the health system, the Acadian and francophone community once again has to innovate and reflect upon what the governance of a francophone health space could look like.

Even though certain New Brunswick regions have benefited from French-language health services since the late 19th century, it was only a few decades ago that the Acadian community truly began to invest in the issue. A great deal of progress has been achieved to date thanks to the mobilization of community players. The historical background that follows is intended to highlight the development of French-language health services in New Brunswick and certain continuing inequities.

Genesis of French-Language Health Services in New Brunswick

If New Brunswick's Acadian and francophone community felt threatened by the health reform initiated by the provincial government in 2008, it is first and foremost because it fears that its gains in terms of access to French-language health services may be lost. Moreover, it also fears government inertia in reducing gaps in health services between the province's francophone and anglophone regions. The organization of French-language health services in New Brunswick goes back to the second half of the 19th century, thanks in particular to the sustained efforts of religious congregations. Between 1868 and 1888, these pioneers laid the foundations of the province's first francophone hospital system by founding the Hôtel-Dieu institutions in Tracadie, Saint-Basile, and Campbellton. During this time, the southern part of the province also had hospitals whose language of daily operations was mainly English. The social functions of these first hospitals of the 19th century were very different from those of the contemporary hospital environment. Before the start of the 20th century, hospitals consisted more in shelters for the destitute and sick than treatment centres for the whole population. Scientific and medical progress, as well as societal requirements, helped to transform the role and functioning of the modern hospital and to increase the utilization of hospitals by all classes of society.

The development of the francophone hospital system in New Brunswick continued until the mid-1960s, with religious congregations founding new hospitals in Moncton, Bathurst, Edmundston, Dalhousie, Saint-Quentin, Lamèque, Caraquet, Grand Falls, and Sainte-Anne-de-Kent. These facilities were not only established by the religious congregations but managed by them as well. By the mid-20th century, New Brunswick's health services system could still be described as ineffective, characterized by "a lack of cooperation and coordination between these institutions."² Local hospitals operated in an isolated manner, without being part of an integrated provincial network.

Government action in the health field stepped up during the postwar period, in conjunction with the rise of the welfare state, in order to provide a certain level of welfare for the entire population. Health services in New Brunswick saw significant progress thanks to the establishment of federal-provincial agreements in health, such as the hospital insurance cost-sharing program and the universal medicare program. However, there were significant regional disparities within the province with regard to health care and hospital services. Rural regions, in this case most of the province's Acadian and francophone communities, were clearly disadvantaged. The Equal Opportunity Program, launched by Louis J. Robichaud's government in 1967, led to the centralization of several public services, including health services, and the standardization of health care standards. County health councils were subsequently abolished and regrouped into five administrative regions in order "to provide a more efficient and coordinated system of care which permitted equality of services for all citizens."³ Beginning in the 1970s, the New Brunswick government took over the management of private hospitals.

² *Health Care in New Brunswick 1784-1984*, Fredericton, Department of Health, 1984, p. 12.

³ *Ibid.*, p. 15.

The next major reform of health services was carried out by the McKenna government in the early 1990s. That reorganization was in line with a wave of fiscal consolidation and improvement of the hospital system's efficiency. It resulted in reduction of the number of hospital corporations from around 50 to 8. The 1992 reform did not directly respond to the north-south inequalities. Of the eight hospital corporations, three served regions with a majority francophone population, i.e., the Northwest, Restigouche, and Chaleur/Acadian Peninsula, while the other five served regions where francophones were in the minority. The Beauséjour Hospital Corporation, which served southeastern New Brunswick, was in a minority setting but functioned in French. In 2002, the Lord government replaced the hospital corporations with regional health authorities. The number of health authorities remained at eight until the Graham government's reform in 2008.

Health and Wellness in French in New Brunswick: Growth of Knowledge and Community Mobilization

Since the 1980s, the New Brunswick Acadian community, through the organizations that represent it, has certainly contributed to the advancement of knowledge concerning health in French in the province. The *Société de l'Acadie du Nouveau-Brunswick* (SANB)⁴ commissioned a major study on the health of francophones. *Objectif 2000: vivre en santé en français au Nouveau-Brunswick*, a three-volume work by Jean-Bernard Robichaud, was published in the mid-1980s.⁵ That study highlighted the gaps between the province's francophone and anglophone regions in relation to health care. It showed that the anglophone hospitals in the southern part of the province, given the population served, were better equipped in terms of human and financial

⁴ We recognize that the organization has had different names over the last few decades, but we are using its current title.

⁵ Jean-Bernard Robichaud, *Objectif 2000: Vivre en santé en français au Nouveau-Brunswick*, 3 volumes, Moncton, Éditions d'Acadie, 1985-1987 (v. 1 La santé des francophones; v. 2 Le système de services de santé; v. 3 Le point de vue de la population).

resources. Moreover, the study also pointed to unfavourable gaps in the francophone hospital system with regard to availability of and access to services, especially specialized secondary and tertiary services. The northern region, which is predominantly francophone, proved to be far behind the south when it came to accessibility and availability of medical/hospital services.

Starting in the 1990s, access to health services in French became an issue for minority francophone communities across the country. The *Fédération des communautés francophones et acadiennes du Canada* (FCFA) coordinated the realization of the very first national study on the situation of French-language health care for francophone minorities, in which the SANB participated.⁶ Published in 2001, this report revealed major disparities in terms of access to French-language health care across the country and affirmed the crucial role of language in the efficient delivery of health care. In New Brunswick, during that time, the SANB made health in French a priority issue, organizing a series of consultation and dialogue forums on the topic. In 2003, a new large-scale study on the health of francophones in Nouveau-Brunswick, carried out under the direction of Léandre Desjardins and sponsored by the SANB,⁷ appeared. That study showed that the province's francophone hospitals, including the Dr. Georges-L. Dumont Regional Hospital, were still behind their anglophone counterparts with respect to access to specialized programs and to physicians, particularly specialists. Catch-up measures were recommended to correct the persisting inequalities between francophones and anglophones.

⁶ FCFA du Canada, *Santé en français – pour un meilleur accès à des services de santé en français, Étude coordonnée pour le Comité consultatif des communautés francophones en situation minoritaire*, Ottawa, June 2001.

⁷ Léandre Desjardins (sous la dir. de), *La santé des francophones du Nouveau-Brunswick: étude entreprise par la Société des Acadiens et Acadiennes du Nouveau-Brunswick*, Moncton, Éditions de la Francophonie, 2003.

During this period, New Brunswick's Acadian and francophone community acquired tools and means for advancing health and wellness services in French. A broader vision of health emerged, one that incorporated prevention and well-being. In 1996, the efforts of community organizations, such as the SANB and the *Association francophone des municipalités du Nouveau-Brunswick* (AFMNB), contributed to the introduction of the Healthy Communities concept in New Brunswick's Acadia. That concept encourages the assumption of ownership of health by local communities and populations through a collective approach to well-being. It led to the founding of the *Mouvement acadien des communautés en santé du Nouveau-Brunswick* (MACS-NB) in 1999, a dynamic network for the mobilization and support of local Acadian and francophone communities and populations in taking ownership of their well-being.

The establishment of the *Société Santé en français* in 2002 contributed greatly to the organization and mobilization of francophone communities in minority settings. This national network seeks to promote the development of health in French for minority Acadian and francophone communities and currently groups together 17 regional, provincial, and territorial networks, including three member networks of the *Société Santé et Mieux-être en français du Nouveau-Brunswick* (Réseau-action Communautaire, Réseau-action Organisation des services, and Réseau-action Formation et recherche). The New Brunswick network is the only one in the country that incorporates a common vision of wellness and health as pillars of its structure. Inspired by the World Health Organization, the governance model of *Société Santé en français* is based on engaging five partners: policy makers, health professionals, health managers, academic institutions, and communities.

In 2004, the *Société Santé et Mieux-être en français du Nouveau-Brunswick* (SSMEFNB) initiated a far-reaching project aimed at identifying the needs of

the Acadian and francophone community and planning primary health services. Called *Préparer le terrain*, this initiative targets two avenues of intervention: increasing access to French-language health services (which includes developing health promotion and disease prevention programs aimed at enhancing health status and ownership of health among individuals and in communities), and increasing the availability of health professionals capable of speaking French. The mobilization of community players contributed to significant achievements in recent years, in particular the opening of French-language community health centres in Fredericton and Saint John.

The increase in the number of francophone health facilities during the 20th century resulted in an increased demand for Acadian and francophone professionals in the health field. New Brunswick has in fact been grappling with a shortage of francophone health professionals for several decades. New Brunswick's Acadian and francophone community took another major step in September 2006 with the official opening of the *Centre de formation médicale du Nouveau-Brunswick* (CFMNB) on the Moncton campus of the Université de Moncton. That delocalized Université de Sherbrooke medical education site now enables Acadian and francophone students to receive medical training in French that is based in the province's communities and adapted to their needs.

The opening of the CFMNB is the result of several years of collaboration between the New Brunswick and Quebec governments. In 1981, the two provinces entered into the New Brunswick Francophone Medical Education Program (NBFMEP), which targeted French-language training for the province's doctors in the faculties of medicine of three Quebec universities (Sherbrooke, Montreal, and Laval). The program's objective was to increase the number of francophone physicians in the province's predominantly

francophone regions in order to overcome the shortage of physicians in these mostly rural areas. Students were exposed very early on in the curriculum to the option of doing their clerkships in the regions and returning there to practice once their studies were completed. The provincial government began to strengthen its ties with the Université de Sherbrooke beginning in 1992 with the designation of the Dr. Georges-L. Dumont Regional Hospital as a teaching hospital affiliated with the Faculty of Medicine and Health Sciences of the Université de Sherbrooke. A few years later, in 1996, following consultation with the New Brunswick government, the predominantly French RHAs, and the director of the NBFMEP, it was decided that the Université de Sherbrooke would repatriate three quarters of the 24 francophone New Brunswick students enrolled in medicine in Quebec. Since 2003, each year the Université de Sherbrooke has accepted 24 francophone students from New Brunswick out of a total of 30 possible enrolments. Today, those 24 students receive their training in New Brunswick, including rotations in several of the province's francophone communities. The delocalization of medical education constitutes a first among the Canadian minority francophonie.

The *Consortium national de formation en santé* (CNFS) was an essential partner in the establishment of the CFMNB. The CNFS is a national organization that groups together 11 universities and colleges across the country (including the Université de Moncton) that offer French-language programs in various health disciplines. It is intended to increase the presence and contribution of francophone health professionals and researchers in responding, in French, to the needs of minority francophone communities so as to contribute significantly to the communities' well-being and full development. The CNFS – Université de Moncton component supports both training and research in French. The Université de Moncton offers around 20 health and wellness programs, including some in partnership with the

Collège communautaire du Nouveau-Brunswick. All of this training meets important needs within Acadian and francophone communities. In short, it is thanks to the mobilization of numerous players that a French-language health and wellness infrastructure has developed in New Brunswick since the 1990s.

Despite some progress in French-language health services since the 1960s, New Brunswick's Acadian and francophone community must continue to urge the provincial government to meet its linguistic and cultural obligations vis-à-vis the French-language minority and to fill the gaps in health services between francophone and anglophone regions. In 2006, the SANB presented a plan for the reorganization of French-language health services that was based on real influence by francophones over their health and wellness services and a francophone structure within the Department of Health.⁸ The proposed structure was composed of representatives of francophone RHAs, francophone community health centres in regions served by anglophone RHAs, and the francophone community. This francophone health council would report to a francophone associate deputy minister. The 2008 reform took certain elements proposed in the SANB plan into account, but not all. We hope that the recommendations that follow will help the government to respond to the concerns expressed by New Brunswick's Acadian and francophone community.

Findings and Recommendations

In the light of the feedback we gathered at our sessions and following a survey of the literature and an analysis of the models with the potential to

⁸ The SANB plan was presented at a national conference and published in a collective work. See Marie-Pierre Simard, « La santé en français au Nouveau-Brunswick : vivre en santé en français », in Sylvain Vézina (ed.), *Gouvernance, santé et minorités francophones: stratégies et nouvelles pratiques de gestion au Canada*, Moncton, Éditions de la Francophonie, 2007, pp. 165-186.

enhance and build on the 2008 reform, we will now present our findings and our recommendations to the Government of New Brunswick. We have endeavoured to articulate these recommendations in the form of substantive measures that can be adopted and implemented through new public policies or through amendments to the Act by the Legislative Assembly of New Brunswick.

I. Is the new Regional Health Authority A francophone?

Much has been said in recent months about the linguistic status of the new Regional Health Authority A. At each of my sessions, the participants asked relevant questions and sought clarification of the linguistic status of the new Regional Health Authority A. The assertion that the linguistic rights of Acadians and francophones have suffered with the creation of Regional Health Authority A was widespread. Many expressed concern, fearing that it was a step backwards, not forwards. However, confusion continues to prevail among the public, and few stakeholders have dared thus far to correct the misinformation that is being bandied about in the public arena. Some say that the new Regional Health Authority A is bilingual, but they do not expound on the nature of this bilingualism. It is misleading not to clarify the obligation of the two health authorities to serve the public in the official language of its choice and to not indicate that French is the working language of the new Regional Health Authority A. Is it important to elucidate certain rather clumsily worded provisions in the reform bill? It most certainly is. Before we make our recommendations on how to improve the current situation, we must make a crucial distinction regarding the linguistic situation within the new Regional Health Authority A. To determine whether Regional Health Authority A is a francophone institution that reflects the priorities of the

Acadian and francophone community, we must first answer two separate questions:

(a) What is the working language of the new Regional Health Authority A, that is, the headquarters' language of work and operations?

(b) Do the governance mechanisms (board of directors) of the new Regional Health Authority A actually represent New Brunswick's Acadian and francophone community?

To be very clear, the legislation creating the two new regional health authorities and the administrative by-laws adopted by Regional Health Authority A are fairly explicit: the working language of the new Regional Health Authority A is French. While we do not claim to have all the expertise of legal scholars, we were told that the wording used in the bill is clumsy and could be much more explicit. In our view, this is a very pertinent remark, and we are making a recommendation below in that regard. However, concerning the second question above on the issue of governance, we believe, as did almost all of the people we met with, that significant changes have to be made to the governance mechanisms before it can be said that the board of directors of Regional Health Authority A legitimately and democratically represents the collective interests of the province's Acadian and francophone community. Recommendations are needed.

(a) Regional Health Authority A – working in French

The working language of Regional Health Authority A must absolutely be French. Further, a number of executives and managers currently employed with Regional Health Authority A indicated that in actuality, the day-to-day activities of the Health Authority take place in French. Several of them even went further and said that this new francophone health space, i.e., Regional

Health Authority A, affords them the unique opportunity to pursue their careers as senior executives managing health services in French, which is rather exceptional, including at the Department of Health in Fredericton. What is more, the executives were adamant that their vision was to make Regional Health Authority A a francophone health space and to have it become a leader in the field of health care in French in Atlantic Canada.

Indeed, New Brunswick's *Official Languages Act* (and not the 2008 health reform as such) requires the new Regional Health Authority A to serve the public in the official language of its choice. However, the working language of its board of directors and the language of work of its employees at headquarters is French. Does the new Regional Health Authority A have to serve the public in both French and English? Yes, although even the health authorities in existence prior to the reform, including the Beauséjour Regional Health Authority and the Acadie-Bathurst Health Authority, had to provide services in both official languages, pursuant to the province's *Official Languages Act*.

The administrative by-laws adopted by Regional Health Authority A are somewhat more explicit and state clearly that

- the language of work of the board of directors will be French,
- the language of work at headquarters will be French, and
- the institutions will continue to operate in their habitual language.

This means that for most of the institutions, including the Dr. Georges-L. Dumont Regional Hospital, the Edmundston Regional Hospital, and the Enfant-Jésus Hospital in Caraquet, French will continue to be the working language. The 2008 reform will not change that situation at all.

In actuality, French is the working language (language of work and operations) of the administration of Regional Health Authority A. However, as it is currently written, the *Regional Health Authorities Act* affirms that

Regional Health Authority A operates in French by taking a demolinguistic approach, instead of affirming it explicitly. Sections 19(1)(a) and 19(9), for example, read as follows:

19(1) The business and affairs of a regional health authority shall be controlled and managed by a board of directors as follows:

(a) seventeen voting members appointed by the Lieutenant-Governor in Council, which appointments shall be reflective of the linguistic community served and shall have regard to gender, representation from urban and rural areas and predetermined competencies determined by the Minister as being necessary to ensure the appropriate skills for the positions;

19(9) Subject to subsection (8), the board of directors shall conduct its affairs in the majority language of the linguistic community which it serves, namely the board of directors of Regional Health Authority A/Régie régionale de la santé A shall conduct its affairs in French and the board of directors of Regional Health Authority B/Régie régionale de la santé B shall conduct its affairs in English.

The linguistic designation of the health authorities is therefore based on the linguistic composition of the population in the communities they serve. The situation quickly becomes muddled when we consider that the areas covered by Regional Health Authority A and Regional Health Authority B overlap in the South East, which could suggest that Regional Health Authority A is only 55% francophone (and not 85%) if we did not subtract the anglophone population, which would normally come under Regional Health Authority B. This ambiguity would not exist if it were simply affirmed that Regional Health Authority A, both in terms of its administration and the working language of its board of directors, is a health authority that functions in French, without referring to the linguistic majority in the area it serves. Further, let us quickly say that the decision to assign regions to the health authorities instead of affirming the existence of a health care system with two networks belonging to each of the two linguistic communities is

questionable. Even though very few people mentioned it during our discussions, it is clear to us that the provincial system as it currently stands is more a historic extension originating from the merger of the former health authorities. Some workers at the francophone community health centres in Fredericton and Saint John feel that these centres could come under Regional Health Authority A, at least where frontline health services are concerned. Discussions on the issue must continue in these communities.

Recommendation 1

We recommend that to clarify the intent of the Government of New Brunswick, the Premier affirm that Regional Health Authority A is a francophone institution. The intent of the Legislative Assembly must be clarified: Regional Health Authority A operates in French, respects the working language of the institutions that report to it, and communicates with the public in the official language of its choice.

Recommendation 2

That the *Regional Health Authorities Act*, S.N.B. 2002, c. R-5.05 be amended to explicitly state that the working language of the administration of Regional Health Authority A and the board of directors is French. It would be a good idea to remove all references to the language of the majority of the people living in the regions assigned to the health authorities and in their place affirm that Regional Health Authority A is francophone and that Regional Health Authority B is anglophone.

(b) Representation of the Acadian and francophone community on the board of directors of Regional Health Authority A

The people we met with all said that representation of the Acadian and French community within the management entity of Regional Health Authority A must absolutely be improved. The current formula whereby the

Minister appoints the 17 members is fundamentally flawed in terms of representativity and in terms of management by and for the community. Everyone agreed on the introduction of an elective dimension and on the participation, in one form or another, of the Acadian and francophone community, and particularly its organizations in the health sector, in the make-up of the management entity of the new Regional Health Authority A. That said, many were in favour of the development of competency profiles that imposed a minimum level of knowledge and experience on the members of the board of directors, who have to manage the largest envelope in the provincial budget. It is necessary, however, to strike a balance between a board of directors which is accountable to voters in the Acadian and francophone community so as to legitimately represent the latter and one which has the abilities and expertise deemed necessary for the sound and efficient management of Regional Health Authority A. Clearly, significant changes must be made to the existing governance mechanisms before it can be said that the board of directors of Regional Health Authority A legitimately and democratically represents the collective interests of the Acadian and francophone community. It must be ensured that a certain number of the members of the board of directors of Regional Health Authority A are elected by universal suffrage and that others are appointed on the basis of individual abilities. The desirable competencies for such appointments, in certain cases at least, should include active participation in francophone organizations in such areas as health and wellness, economic and community development, and French cultural life, to name but a few.

We do not understand why some people said that having members whose mother tongue is English (or who come from non-Acadian or non-francophone ethnic backgrounds) disqualifies the board of directors as an entity representative of the Acadian and francophone community. Such remarks take us down a slippery slope, and it is of course inadmissible and

unacceptable to devise profiles based on ethnic origin or to exclude individuals whose mother tongue is not French. Obviously, the ability to speak French and to function in an organization whose working language is French is essential and compulsory. Further, it would be desirable for linguistic ability to be included in the profile of competencies determined by the Minister, in accordance with subsection 19(1) above. In other words, the ability of all of the members of the board of directors to function in the official language of each health authority must be an essential requirement. It would place the emphasis on “linguistic” competency criteria only, and not on ethnic or national provenance.

New Brunswick’s Acadia is intent on reaching out more and more to the world and celebrating its cultural diversity. In our view, a French-language competency criterion is definitely needed for the members of the board of directors of Regional Health Authority A. Any other criterion with respect to mother tongue or ethnic origin is totally unacceptable in a pluralistic, democratic, and egalitarian society. That said, the terms and conditions currently governing the membership of the board of directors emphasize the importance of certain characteristics (e.g., male-female, urban-rural balance). However, competency in French should be mentioned as well.⁹

Recommendation 3

That the majority of the board of directors of Regional Health Authority A consist of representatives of the Acadian and francophone community who are elected by universal suffrage every four years.

⁹ See section 19(1) cited earlier in the text.

Recommendation 4

That, to properly represent all of the regions served by Regional Health Authority A, all of the elected positions on the board of directors of Regional Health Authority A be representative of the health areas corresponding to the former health authorities.

Recommendation 5

That a minority of representatives on the board of directors of Regional Health Authority A be appointed by the Minister of Health in consultation with the Acadian and francophone community, and particularly with organizations active in the areas of health and wellness in French in New Brunswick. These appointments should be made based on profiles of desirable competencies determined by the administration of Regional Health Authority A.

Recommendation 6

That, when determining representation criteria and competency profiles for future members of the board of directors, it be explicitly affirmed that these persons must have the linguistic competencies needed to function in French in order to manage the affairs of Regional Health Authority A.

Recommendation 7

Names and symbols have a role to play in the construction of the social and cultural fabric of society. We see that Regional Health Authority A has launched a contest to come up with a new name. We applaud this initiative. Clearly, Regional Health Authority A needs a name with considerable symbolic value evocative of its francophone character, and we recommend that it choose a name reflective of this linguistic and cultural status.

II. Greater equity between the health authorities in order to shrink the gaps and enhance service in French in Health Authority B

At most of our sessions, the participants underscored the historic inequities in the allocation of certain health services (secondary and tertiary levels) and

the attribution of resources between the English- and French-speaking regions of the province, between the north and the south and, thus, between the new Regional Health Authorities A and B. We also note the historical gaps reported in the outstanding studies by Jean-Bernard Robichaud (1985–1987) and, more recently, by Léandre Desjardins (2003). Several people we met with said that the grouping of the eight former health authorities under the new model of two health authorities makes the inequities between north and south even more apparent. However, care must be taken not to create the impression that Regional Health Authority A must absolutely duplicate that which exists in Regional Health Authority B, or vice-versa. Everyone agrees that our province cannot afford to have two health care systems. The people that I spoke with all agreed that there should be a single health care system with two management entities (Regional Health Authorities A and B), on the condition that it serve everyone in the official language of his or her choice, regardless which entity the health institution comes under.

Several people talked about the language barriers that are still present within Regional Health Authority B. Indeed, Regional Health Authority B has expressed its desire to enhance access to services in French, and it has made this goal one of its strategic objectives. It has committed to setting up a francophone liaison committee, and intends to develop and implement a strategic plan on official languages. These initiatives are commendable, but an even firmer commitment is required on the part of the health care system in general and the provincial Department of Health in particular.

We met with official languages coordinators from Regional Health Authority B. Their role is significant, despite the limited resources at their disposal. Regional Health Authority B has to address major challenges regarding the ability of its health care institutions to provide services in French to francophones in its catchment area and to provide tertiary services to all

francophones in the province when those services are not available within Regional Health Authority A. This illustrates the importance of having a plan that establishes protocols to ensure that the francophone community is served in its language when services are provided by Regional Health Authority B. The active offer of services in French is not a wish by the Acadian and francophone community, but rather a right conferred upon it by New Brunswick's *Official Languages Act*. We are still waiting to see significant progress in this area. The Department of Health and the two regional health authorities must devise an action plan to ensure that the province's health care system as a whole complies with the *Official Languages Act*.

Recommendation 8

That the provincial health care plan include specific and measurable targets with regard to official languages.

Recommendation 9

That a joint provincial action plan involving Regional Health Authority A and Regional Health Authority B with regard to health services in both official languages be developed within the next 12 months. A balanced entity chaired by the Deputy Minister of Health would be responsible for implementing a provincial action plan on official languages. The plan would contain performance evaluation and accountability mechanisms in order to measure progress. Regional Health Authorities A and B must include the language aspect in their respective plans. An annual report on progress made in health services in both official languages in New Brunswick must be submitted to the Legislative Assembly.

A comparative list of services offered by the two health authorities can serve to illustrate certain inequities, but it cannot be the foundation for the future development of new services for Regional Health Authority A. The principle of linguistic equality means that we must consult the Acadian and francophone community and plan its growth together on the basis of its capacities, its clinical volumes, its human resources, and on what it would like to see in terms of secondary and tertiary services in its health care network. We have to build on the basis of the principles of need and complementarity, not duplication. Compiling lists and denouncing inequities are useful strategies in the world of communications, but duplicating services is not a proper strategy for building health in French in New Brunswick. Regardless of the expression used, e.g., catching up, narrowing the gap, or building equity between the two health authorities, it is essential that we do not dilly-dally and especially that we do not delay in establishing a mechanism to assess Regional Health Authority A's priorities and in adopting a preliminary action plan. The distribution of specialized services between the two health authorities is indeed uneven, and no one would dispute that fact. In announcing the 2008 reform, the Minister of Health acknowledged that this imbalance predated the overhaul of the system, and he confirmed the need to allocate specialized services more effectively and to restore equity.

Recommendation 10

That the Premier and the Minister of Health affirm the Government's commitment to paying particular attention to the current and future development of tertiary health care within Regional Health Authority A by establishing the first phase of a five-year action plan to ensure greater accountability in Regional Health Authority A's efforts to catch up. The committee responsible for developing this action plan under the direction of the Deputy Minister of Health should consist of representatives of the management team of Regional Health Authorities A and B, the Associate Deputy Minister (Francophone Services), and

representatives of the Acadian and francophone community involved in the development of health and wellness services in French.

Recommendation 11

That, to begin narrowing the gap between the two regional health authorities, the principle of “equitable distribution” be applied immediately. This principle can be explained as follows: in the case of new health services or the extension of services that are slated to be offered at more than one institution in the province, the Government undertakes to consult the health authority where the service does not exist, in order to give it the opportunity to provide it in its network on a priority basis. The principle of “equitable distribution” is part of a catch-up strategy, and its objective is to provide where possible a second point of service or extension of service in the health authority not currently offering it.

III. The New Brunswick Health Council: a stakeholder in the development of health services in French

Some of the people we met with felt that the New Brunswick Health Council has a role to play in enhancing health services in French in the province. Indeed, if we look at its mandate, which is to measure, monitor, and evaluate health care services in New Brunswick, we could surmise that the linguistic aspect is a significant factor in the Health Council’s work. The current mandate of the New Brunswick Health Council is as follows:

New Brunswickers have a right to be aware of the decisions being made, to be part of the decision-making process, and to be aware of the outcomes delivered by the health system and its cost. The New Brunswick Health Council will foster this transparency, engagement, and accountability by:

- *engaging citizens in a meaningful dialogue;*
- *measuring, monitoring, and evaluating population health and health service quality;*
- *informing citizens on health system’s performance;*
- *recommending improvements to health system partners.*

Recommendation 12

That in its studies, its engagement mechanisms and its work, the New Brunswick Health Council systematically take a separate and comparative look at the state of the health and services of each official language community in the province and that it take into account the separate and common values of the two linguistic and cultural communities. The Council should also take into consideration and measure the ability of the health authorities to meet the linguistic needs of the two official languages communities.

IV. FacilicorpNB – a new government agency created to rationalize health resources, including management of the procurement of non-clinical programs and services for the entire health care system

FacilicorpNB Inc. is a commercial corporation whose sole shareholder is the Minister of Health. Its mandate is to provide support services to the two regional health authorities in the areas of materials acquisition, information technologies and telecommunications, and laundry services.

According to what we heard at our sessions, the establishment of FacilicorpNB caused consternation in the Acadian and francophone community. The discontent stems particularly from the fact that employees who used to report to the former health authorities now come under this brand-new provincial public sector agency. Some of the employees who used to work in francophone environments, such as the Dr. Georges-L. Dumont Regional Hospital, voiced fears about the language of work. Clearly, FacilicorpNB must ensure that acquired rights are upheld and, what is more, that francophone spaces are developed in the workplace.

First, since the inception of FacilicorpNB, the place of work of each employee has changed very little or not at all. Most of the employees have remained at the health care institutions where they were prior to the 2008 reform, and are still in the same work and social areas. Further, FacilicorpNB is subject to the *Official Languages Act*, and it was confirmed to us that this agency has

promised Regional Health Authority A that it will respect the language of work at the institutions, such as the Dr. Georges-L. Dumont Regional Hospital, in its communications with the employees who are still there. Last, but not least, it is our understanding that prior to the establishment of FacilicorpNB, non-clinical product and service procurement groups had been set up by certain health authorities and that most, if not all, communications concerning these groups took place in English. However, at present the agency is formally committed, besides being legally obligated, to meeting the linguistic obligations in effect in New Brunswick.

Nonetheless, FacilicorpNB continues to be a sensitive issue in the eyes of many, and it would be in the government's interest to rethink the structure of this new agency. A fundamental structural problem with FacilicorpNB has to do with the fact that the real consumers and users of services provided by the public agency are not true members. FacilicorpNB's actual shareholders are the two regional health authorities, not just the Minister. As the actual agent of the two health authorities, FacilicorpNB should have at the table the real users of its goods and services to ensure proper alignment of procurement in order to meet the needs of the two health authorities more effectively. The presence of Regional Health Authority A within the governance structure would lessen a good many fears regarding language issues and the influence it wields over the agency's decisions. FacilicorpNB's shareholders should therefore include the two regional health authorities and the Minister on the basis of a representation formula of one-third each.

Recommendation 13

That FacilicorpNB's shareholders consist of the Minister, Regional Health Authority A and Regional Health Authority B (Horizon) and that the members of the board of directors of this agency also be chosen by

the new shareholders in accordance with the customary rules of corporate law.

V. Training in French for health and wellness professionals in New Brunswick: formally recognize the right to a francophone network and to separate education, training, and research institutions.

The development of training programs in French for health care professionals in New Brunswick has been, quite frankly, astounding. The Université de Moncton has made health a strategic focus, and it currently offers more than 20 programs and nearly 300 health science courses. The contribution of the Centre de formation médicale du Nouveau-Brunswick to the development of the health care system is remarkable, and it offers the only medical training program in French in the Atlantic Provinces. The Centre is the result of a partnership between the Université de Moncton, the faculty of medicine and health sciences of the Université de Sherbrooke, the Government of New Brunswick, and Regional Health Authority A. The Dr. Georges-L. Dumont Regional Hospital has unquestionably made a major contribution when we look at the progress that has been achieved, and conditions seem ripe for a university hospital centre to be established in the near future. Such a centre is bound to be highly treasured by New Brunswick's Acadian and francophone community, which aspires to achieve greater institutional completeness. This future university hospital centre will play a unique role and have a provincial vocation as regards teaching, training and research in French with the above-mentioned partners. It is equally important to develop the network of affiliated university hospital centres, which will make it possible to roll out programs and partnerships across the province. Further, many stakeholders said that the shortage of bilingual health care workers is causing serious problems that are affecting the institutions' ability to meet their obligations under the *Official Languages*

Act, i.e., to provide services of equal quality to all members of the public in the official language of their choice.

Health care in French is a booming field. Teaching, research, and training are components that require francophone spaces from which these activities can take place. Whether it be a student intern or a health care professional taking a training course, it is crucial to have francophone spaces where people can study and broaden their knowledge. These new venues must enjoy the same recognition as entrenched in, and guaranteed by, the *Act Recognizing the Equality of the Two Official Linguistic Communities in New Brunswick*.

The Government of New Brunswick must strengthen its commitment to francophone teaching, training, and research spaces in the area of health care in French. It would be to the government's advantage to formally and substantively recognize that these spaces are part and parcel of the province's linguistic framework and that they are consistent with the vision of the equality of the two linguistic communities in New Brunswick. In her 2009 annual report, the President formally indicated that Regional Health Authority A and its partners have taken steps to designate the Dr. Georges-L. Dumont Regional Hospital as a university hospital centre and the Bathurst, Campbellton, and Edmundston regional hospitals as affiliated university hospital centres. It would therefore be in the Government of New Brunswick's interest to clarify these new structures through legislative channels or through other formal mechanisms and thus to create this new francophone space in the areas of health education, training, and research. The explicit creation and recognition of a university health centre and an affiliated university health centre could be achieved by legislative means or by any other formal government act, i.e., by enacting legislation establishing the new structure or simply by inserting a clarification into the *Act Recognizing the Equality of the Two Official Linguistic Communities in New*

Brunswick. Such recognition of a health education, training, and research network for each official language community would mirror the steps taken by elected officials when the Act was adopted, i.e., when in 1981 they unanimously recognized and affirmed their commitment to the existence of a public school network managed by and for francophones. At the very least, the consultations over the past few weeks have shown that it would be in the Province's interest to clarify its commitment to the designation of a university hospital centre and an affiliated university hospital centre using any means it deems appropriate to ensure that this important francophone space can come into being.

Recommendation 14

That the Government of New Brunswick formally recognize and establish, by way of legislation or another type of formal government commitment, a health and wellness education, training, and research network that is established on a homogenous linguistic basis so that appropriate training can be provided to all health care professionals, thus allowing all citizens to receive their health-care services in the official language of their choice, through the provision of equal services of equal quality.

Conclusion

At the end of this health reform debate, New Brunswick's Acadian population is very much divided on the issue of the future of the French health care network in the province. The discussions highlighted certain historical rifts and showed New Brunswick's Acadia to be more divided than united at present, which I hope is only temporary. It is not in the best interest of small nations such as Acadia to be perpetually divided. While debate and questioning are signs that democracy is alive and well in the Acadian and francophone community, we must nonetheless be wise and mature enough to

recognize the importance of building common fronts. As mentioned earlier, this debate over health care governance structures is crucial, and we must take the time to think collectively about the reference points we wish to establish. The construction and advancement of a society cannot rely solely on legal avenues. However, the current situation will have allowed us to take a moment to think about acceptable solutions. I dare hope that we are on the verge of achieving a certain degree of consensus regarding the governance structures and that we can now begin putting our energy into enhancing the delivery of quality health care in French, boosting our community capacity and, especially, taking steps to create environments and living conditions that are auspicious for the health and wellness of all Acadians.

It would no doubt have been preferable had the dialogue between the government and the Acadian community, which the SANB initiated in March 2006 with its top-drawer position paper titled *Vivre en santé en français*, continued. It is surprising to see that since the release of that position paper in 2006, and particularly since the filing of legal action against the Government of New Brunswick by *Égalité santé en français* (with the support of community leaders), that no group, institution, or organization has proposed for public debate recommendations on how to improve the health care system in French. The 2008 reform was formally and loudly denounced, but very few tangible solutions or options have been put forward.

Just as surprising is the fact that the government has no formal mechanisms for analyzing the impact of public policies, not just those already in place but also those being developed, under the lens of official languages. Forty years after the adoption of the *Official Languages of New Brunswick Act*, how is it that successive governments have not developed an action plan for official languages? Do central agencies, such as the Executive Council Office and even the Department of Justice—the government's chief advisor with regard to

linguistic rights—have venues for discussion and dialogue with Acadian and francophone community leaders? Are they accountable for the attainment of anticipated outcomes as regards the development and prosperity of the Acadian and francophone community? Everything remains to be built. In my view, we have to bank on the efforts currently being made by the Office of the Premier and the Department of Intergovernmental Affairs to develop a government action plan for official languages.

The establishment of collaborative forums and the development of government action plans will not produce automatic consensus or immediate results. However, contemporary representative democracy requires that civil society be more engaged than ever in processes to develop and implement public policies. While New Brunswick's Acadia has built a most impressive community infrastructure over the last 30 years, I often have the feeling that the provincial government is not taking that fact into account enough and is making little use of it in managing public affairs. And yet, in times of crisis, the importance of working relationships and relationships of trust between government and civil society quickly becomes apparent.

New Brunswick's Acadian and francophone community has every reason to be vigilant, as must all minorities confronted with sweeping reforms and changes initiated by governments. New Brunswick's linguistic framework is built on the recognition of the equality of the two official linguistic communities. This equality of status applies to the population as a whole and manifests itself in different ways, depending on aspirations and outlooks. The needs of the two linguistic communities are similar in some cases and different in others. Contrary to what many stakeholders in the provincial government may believe, government services are not neutral, and more often than not, they tend to reflect the cultural reality of the majority. It is not enough to serve the two linguistic communities in the same manner. Truth be

told, reproducing a service designed in English and translated into French shows a profound misunderstanding of New Brunswick's language framework. Serving a minority community properly means that government services must be sensitive to both the linguistic and cultural needs of the community and meet its aspirations.

The Government of New Brunswick must incorporate into its day-to-day operations the principle of the equality of the two linguistic communities and forge with the community sector relationships of trust and cooperation. This vision of the political pact is at the centre of the social cohesiveness of our province. This political pact was hammered out and implemented based on a vision of equal opportunity for all, as espoused by the Robichaud government in the late 1960s and revived by its successor—the Hatfield government—in a vision of equality of the linguistic communities. This political pact for our province was crafted by politicians of both genders, and it is vital that our current political leaders, with the backing of the community, continue to advance all facets of life in French in New Brunswick.