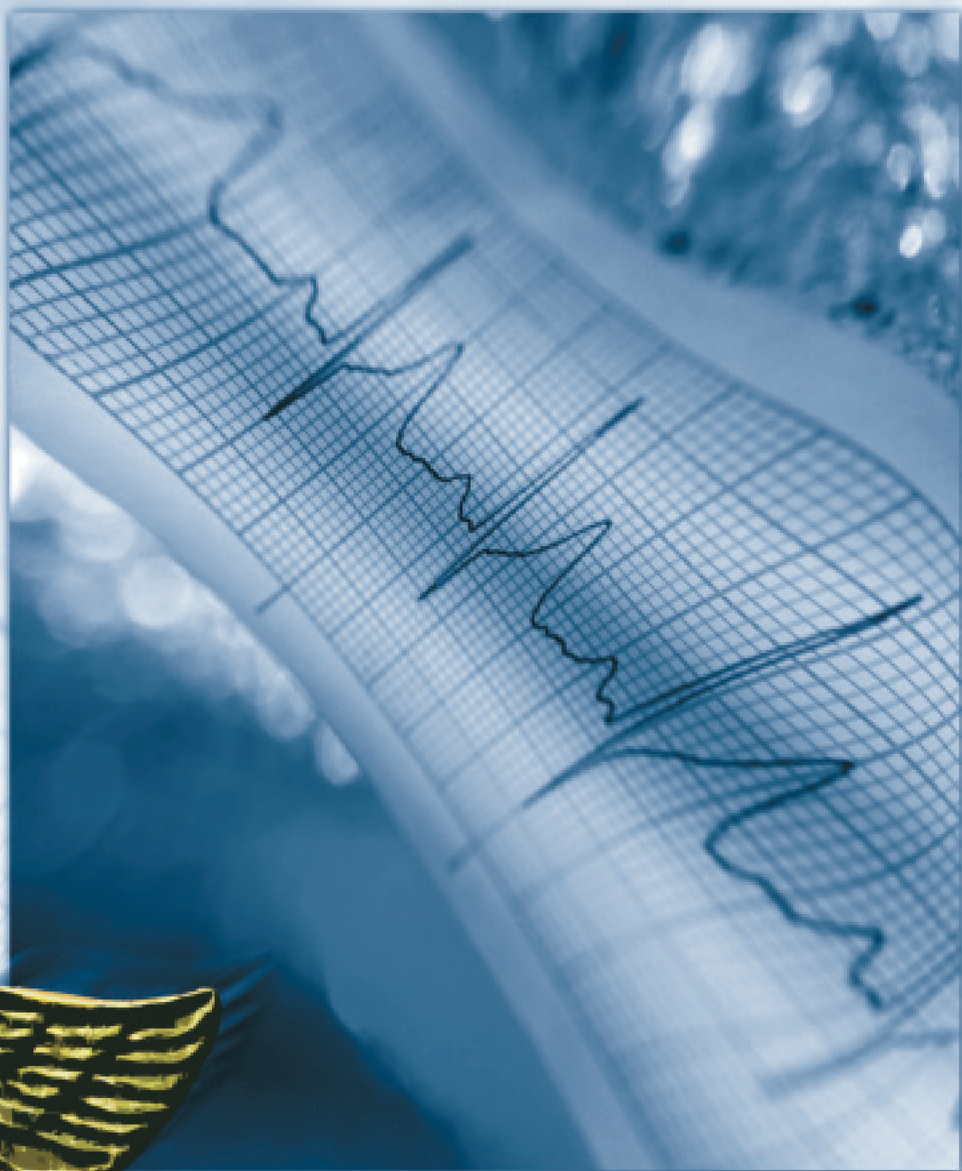
REPORT TO THE FEDERAL MINISTER OF HEALTH



Consultative Committee for English-Speaking Minority Communities

July 2002

Health Canada   Santé Canada

Canada

REPORT TO THE FEDERAL MINISTER OF HEALTH

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English-Speaking Minority
Communities

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CONSULTATIVE COMMITTEE FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

The Honourable A. Anne McLellan
Minister of Health
House of Commons
Ottawa, Ontario K1A 0K6

Madam Minister:

As co-chairs of the Consultative Committee for English-Speaking Minority Communities, we are pleased to submit the enclosed final report, which is the result of a core study commissioned by the Committee.

The report provides an overview of the situation of the English-speaking population in a minority context. According to our findings, the demographic characteristics and the vitality of the English-speaking communities in Quebec vary tremendously across regions. Also, access to health and social services in English is lacking in several areas.

The report proposes a series of measures that will enable Anglophone minority Canadians to improve access to services in English, and to address demographic and vitality issues through better coordination and cooperation between public institutional networks, community institutions and community-based organizations.

Yours sincerely,

Marcel Nouvet

Eric Maldoff

Co-chairs

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INTRODUCTION

The Consultative Committee for English-Speaking Minority Communities was created by Health Canada in October 2000. Its mandate is to provide advice to the federal Minister of Health on ways to enhance the vitality of English-speaking communities in Quebec and to support their development, as stated in section 41 of the *Official Languages Act*. A majority of its members are representatives of various groups involved in the health and social services system (see Appendix).

Few issues unite the English-speaking communities of Quebec as does the question of access to health and social services in English. According to a survey conducted for the Missisquoi Institute in 2000, this is the number one concern of Quebec's English-speaking communities. The Committee supports their concern and seeks to contribute to government actions in response.

The current social, legal and political context is highly favourable for examining the issue of access to health and social services for official language minority communities. As noted in *Time for a Change in Culture*—the 2001 national report of the Commissioner of Official Languages on service to the public in English and French—the January 2001 Throne Speech emphasized the growing importance of using our country's two official languages, and the federal government has formally repeated its commitment to Canada's linguistic duality, which lies at the heart of our Canadian identity.

Of course, delivery of health and social services is a provincial responsibility. At the same time, the *Official Languages Act* mandates the federal government to act on behalf of official language minority communities.

In its work, the Committee has drawn on the report entitled *Building on our Strengths* (Saber-Freedman 2001). According to this document, access to health and social services in English is lacking in several regions in Quebec, and improvements are needed requiring coordination and cooperation between public institutional networks, community institutions and community-based organizations. The report has served as a core reference for the Committee's deliberations.

In fulfilment of its mandate, the Committee is proposing a five-year Global Intervention Plan. This identifies five levers framing a series of measures to promote the demographic vitality of English-speaking communities and improved access to health and social services in English. The Plan is discussed in this report.

THE FEDERAL GOVERNMENT'S COMMITMENT TO OFFICIAL LANGUAGE MINORITY COMMUNITIES

In August 1994, the Government of Canada approved an accountability framework for implementing sections 41 and 42 of the *Official Languages Act*. Section 41 commits the federal government to enhancing the vitality of official language minority communities, as well as fostering the full recognition and use of both English and French in Canadian society. Section 42 of the Act mandates the Minister of Canadian Heritage to promote a coordinated approach to meeting the commitments enunciated in section 41.

By making those commitments, the federal government was seeking to ensure the participation of key federal departments and agencies in efforts on behalf of official language minority communities. For this purpose, in October 2000 Health Canada created the Consultative Committee for English-Speaking Minority Communities.

HEALTH CANADA'S ROLE IN HEALTH ISSUES

Health and social services are fundamental to maintaining the vitality of English-speaking minority communities. Each provincial government is primarily responsible for delivering health and social services within its jurisdiction. Health Canada's responsibilities for maintaining and improving the health of Canadians are carried out through leadership, funding and regulation. The Department conducts its work under four business lines: health care policy; health promotion and protection; First Nations and Inuit health; and information and knowledge management.

IMPORTANCE OF LANGUAGE

Language is a key factor in successful delivery of health and social services. Health services involve much more than technical procedures; professionals must help, advise, guide and educate their patients. Language is a leading health determinant; for this reason, when combined with other factors, health risks are higher for those lacking access to services in their own language. As a Health Canada report states, "There is compelling evidence that language barriers have an adverse effect on access to health services" (Bowen 2001).

Access to health and social services in English is a key priority of Quebec's English-speaking communities. A survey by the Centre de recherche sur l'opinion publique (CROP) for the Missisquoi Institute confirms that access to services in English is a top concern of Quebec Anglophones (Saber-Freedman 2001). The Committee has accepted this concern, understanding that access to services is an essential element of a community's vitality and well-being.

HISTORICAL BACKGROUND AND POLITICAL CONTEXT

Over the past 200 years, English-speaking communities in Quebec created a wide range of educational and health and social service institutions. These ensured access to services for the English-speaking communities in which they were rooted. At the same time, the institutions provided a community focus. Aside from being key service providers, they were and still are a primary source of community leadership development and employment.

During the 1960s and the 1970s, health and social service institutions came under government control in conformance with the view that the services they provided should be operated in the public domain.

In 1977, the Government of Quebec adopted the *Charter of the French Language*, establishing French as the normal language of work and public services in Quebec. Subsequent amendments to the Charter provided for a special category of "minority" institutions, defined as those with clients or constituents a simple majority (i.e. 50 percent plus one) of whom are speakers of a language other than French. Such institutions are exempted from the obligation to function exclusively in French, and can continue to offer their services in both French and another language.[1]

In 1986, Quebec amended its health and social services legislation to state that English-speaking persons are entitled to receive health and social services in English in keeping with the resources of the system, and to the extent provided by an access program approved by the Quebec Cabinet. The amendments were also intended to protect the network of institutions historically serving English-speaking communities. These institutions benefit from an exemption from certain provisions of the *Charter of the French Language*, and have been designated by the provincial government to provide their services in English.

As a result of legislative guarantees and federal-provincial agreements supporting them, English-speaking communities have increased their participation in the health and social services system. For example, they have worked with Quebec's Regional Health and Social Services Boards to identify needs and develop access programs; with institutions of the majority community serving English-speakers; and with community organizations that complement their region's health and social services system.

Nevertheless, for English-speaking communities in Quebec, access to health and social services in their own language continues to vary depending on such factors as demographic strength, economic constraints and shifting government priorities. One notable factor has been the expiry in 1999 of the Canada–Quebec agreement supporting Quebec's initiatives in the area of linguistic accessibility.

[1] Section 29.1 of the *Charter of the French Language* (chapter C-11).

AN ISSUE FOR MOBILIZATION

English-speaking communities have traditionally mobilized in support of access to health and social services in their language; this is recognized as one of the most critical challenges for community survival and well-being. The Quebec Community Groups Network, linking 20 organizations from across the province, has placed health and social services high on its list of priorities for collective action.

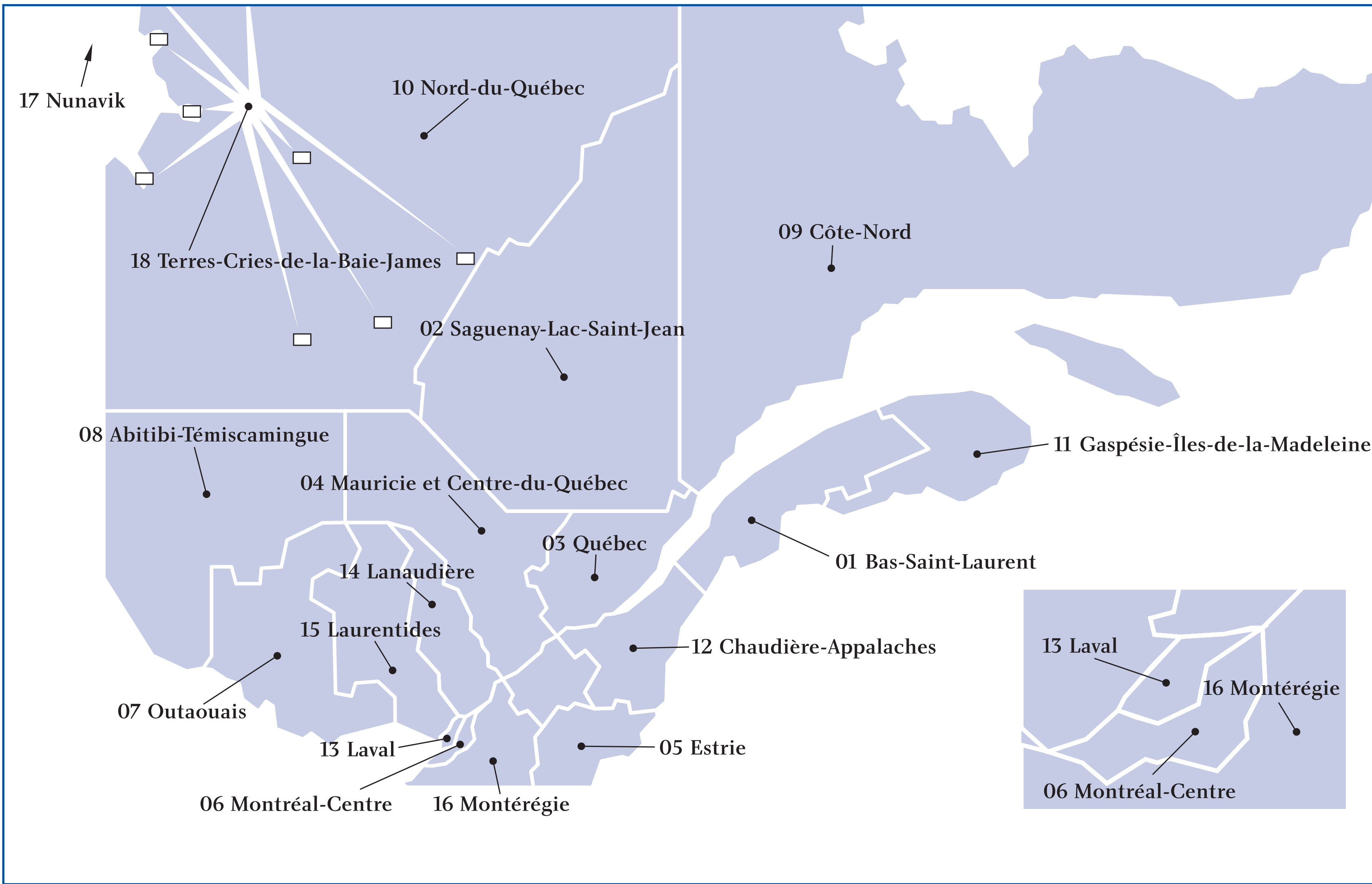
In many regions, English-speaking communities participate on advisory bodies to Regional Health and Social Services Boards. The boards and the communities concerned have identified important gaps in accessibility of services in English.

Given the federal government's responsibility under the *Official Languages Act*, English-speaking communities in Quebec have also made representations to federal departments such as Canadian Heritage and Health Canada, as well as to the Commissioner of Official Languages. Their goal has been to ensure that the federal government fully exercises its mandate to enhance their vitality and development.

These community actions respond to diverse demographic realities and differing degrees of access to English-language health and social services across the province of Quebec.

MAP

Quebec provincial administrative regions for health and social services



Source: Ministère de la Santé et des Services sociaux du Québec, Service du développement de l'information, January 2000.

TABLE 1

Selected demographic characteristics of Quebec's English-speaking communities by administrative region, 1996

	Rate of ageing (%)	Unemployment rate (%)	Caregiver-to-senior ratio	Level of bilingualism (%)	Regional proportion (%)	Community size	Aggregate rank	Demographic vitality
Quebec (province)	12.8	13.2	2.3:1	61.2	13.3	925 830	n/a	n/a
01 Bas-Saint-Laurent	7.7	17.7	4.5:1	89.6	0.5	905	15	very low
02 Saguenay-Lac-Saint-Jean	10.9	15.7	3.3:1	92.1	0.6	1 795	13	very low
03 Québec	15.6	11.9	2.1:1	89.5	2.0	12 745	6	average
04 Mauricie	18.4	13.1	1.6:1	92.0	1.3	3 383	16	very low
05 Estrie	19.8	11.9	1.4:1	63.0	9.1	24 770	8	low
06 Montréal	13.3	13.4	2.1:1	60.0	33.0	560 813	4	very high
07 Outaouais	9.8	11.8	3.2:1	50.3	17.7	53 863	2	very high
08 Abitibi-Témiscamingue	14.4	15.3	2.0:1	63.1	4.2	6 363	12	very low
09 Côte-Nord	8.9	42.2	3.1:1	35.9	6.0	6 100	11	low
10 Nord-du-Québec	1.2	17.3	20.4:1	19.8	36.1	12 080	5	very high
11 Gaspésie-Îles-de-la-Madeleine	16.0	35.8	1.8:1	43.5	10.2	10 580	14	very low
12 Chaudière-Appalaches	10.9	14.5	3.4:1	86.5	0.9	3 340	10	low
13 Laval	9.2	11.6	3.2:1	69.3	15.7	50 713	1	very high
14 Lanaudière	15.9	14.1	2.2:1	82.7	2.4	8 850	9	low
15 Laurentides	16.0	13.0	2.0:1	68.0	7.3	31 213	7	average
16 Montérégie	11.7	10.8	2.7:1	64.5	11.0	135 653	3	very high

Notes:

1. Figures are for 1996 Census of Canada respondents indicating English as their first official language spoken; multiple responses have been distributed proportionately. Not included here are statistics for Centre-du-Québec. For that reason, the sum of the regional populations does not equal 925 830. The gap corresponds to 0.3%; as a result, there is no significant impact on the total data. Note that the division of territory varies from one table to another in this report.
2. The rate of ageing is the proportion of the community aged 65 and over.
3. The unemployment rate is the proportion of unemployed individuals aged 15 and over in the work force.
4. The caregiver-to-senior ratio is the proportion of individuals aged 35 to 64, compared with those aged 65 and over.
5. Bilingualism is self-assessed according to the Census question.
6. The regional proportion is the percentage of the total population of the region represented by a particular community.
7. The community size is the population count.
8. The aggregate rank is calculated by taking the average ranking for each characteristic (with double weighting for proportion and size). The ranking for a characteristic is either ascending or descending, depending on whether or not the phenomenon is desirable. For example, a high level of bilingualism is desirable, whereas a high level of unemployment is not.
9. The overall demographic situation (or demographic vitality) is based on the aggregate ranking in relation to the provincial norm.
10. The "very high" rating of demographic vitality in Region 10 is due to particular factors affecting the Cree and Inuit communities of northern Quebec, such as the low rate of ageing (the result of a high birth rate) and the high caregiver-to-senior ratio.

Source: William Floch, Department of Canadian Heritage, compilation based on first official language spoken, 1996 Census of Canada.

DEMOGRAPHIC SNAPSHOTS OF QUEBEC'S ENGLISH-SPEAKING COMMUNITIES

The demographic characteristics and vitality of Quebec's English-speaking communities vary tremendously across regions. Referring to the administrative regions used by the Government of Quebec for the planning and delivery of services, we find that the ageing rate (i.e. the proportion of the population aged 65 and over) varies from a low of 7.7% in Bas-Saint-Laurent and 1.2% in Nord-du-Québec to a high of 19.8% in Estrie and 18.4% in Mauricie. The caregiver-to-senior ratio also varies from 4.5:1 in Bas-Saint-Laurent and 3.4:1 in Chaudière-Appalaches to 1.4:1 in Estrie (caregivers are defined as people aged 35 to 64). The unemployment rate is higher and median income lower for Anglophones than for Francophones. Unemployment is particularly high in Côte-Nord (42.2%) and Gaspésie-Îles-de-la-Madeleine (35.8%), but relatively low in Centre-du-Québec (8.8%) and Montérégie (10.8%).

In community size and regional weight (proportion of the total population), the variations are similarly great. Some regional communities have fewer than 5000 persons (e.g. Bas-Saint-Laurent, Saguenay-Lac-Saint-Jean, Mauricie, Chaudière-Appalaches). At the other end of the spectrum are the Montréal region, with more than 500 000 people, and Laval and Outaouais, each having more than 50 000.

These characteristics can be combined to present a demographic typology of regions. The data suggest that there are regions where English-speaking communities have what may be called "very low" demographic vitality (Bas-Saint-Laurent, Saguenay-Lac-Saint-Jean, Mauricie, Abitibi-Temiscamingue and Gaspésie-Îles-de-la-Madeleine). Although the particular mix of demographic indicators may vary, Anglophones in these regions are low in both numbers and proportion of the total population; as a result, they cannot command high consideration in the planning of service programs and policies. The lack of demographic weight is exacerbated in some regions by high unemployment, a high ageing rate, a low rate of bilingualism and a low caregiver-to-senior ratio among Anglophones.

In a stronger position are regions where English-speaking communities have "low" demographic vitality (Estrie, Côte-Nord, Chaudière-Appalaches, Lanaudière). In these regions, ageing rates or unemployment may be high among Anglophones.

In Laurentides, English-speaking communities stand in the middle range of demographic vitality: Anglophones are relatively numerous and constitute a significant proportion of the regional population. They also have average levels of employment and bilingualism. These factors combine to balance the challenges inherent in the high rate of ageing and low caregiver-to-senior ratio among Anglophones.

In the regions of Montréal, Montéregie, Laval and Outaouais, the English-speaking communities undoubtedly have high demographic vitality: by the

measure of both numbers and proportion of the regional population, they are strong and highly visible. These communities have relatively low unemployment and low ageing rates, with higher proportions of younger and middle-aged people. An anomaly is a slightly lower level of bilingualism in Montréal and Outaouais compared with other regions.

Any approach to social planning must take account of these variations in the circumstances of Quebec's English-speaking communities.

These demographic snapshots reveal English-speaking communities that are vulnerable because of ageing populations and, in some cases, the out-migration of youth. Compounding the situation is the loss of caregivers—the age group that acts as a critical support and a link to the public health and social services system for the older generation.

Income and employment are important determinants of the health of individuals and communities. Table 1 shows that in nine regions unemployment rates are above the provincial average among Anglophones; in four regions the rate is 17% or higher.

Table 1 also reveals an important factor of vulnerability for certain regions (Côte-Nord and Gaspésie-Îles-de-la-Madeleine): a relatively low rate of bilingualism. These are also regions that experience the highest levels of unemployment.

When the health determinants and demographic indicators are combined to give a relative measure of demographic vitality, it may be seen that ten regions have a low or very low measure of vitality compared with the average for all regional English-speaking communities.

ACCESSIBILITY OF SERVICES IN ENGLISH

Determining the level of accessibility of services in English in each region is critical to defining the specific measures and the resources required to support them. The accessibility of health and social services in English may be evaluated in two respects:

- the direct experience of English-speaking communities in seeking services; and
- the outcomes of government-approved plans identifying services accessible in English.

COMMUNITY EXPERIENCE

In spring 2000, the Missisquoi Institute commissioned an omnibus survey from the Centre de recherche sur l'opinion publique, on the attitudes and experiences of English-speaking Quebecers. The survey provides a wide range of information about the real experience of English-speaking residents of each region as regards the ease with which they are able to access health and social services in their own language.

Among the key findings are the following:

- There is a dramatic variation between regions in the reported levels of access to services in English.
- Services in English are more readily available from physicians, private nursing agencies and community-based resources than from public institutions such as Centres locaux de services communautaires (CLSCs, i.e. local community service centres) and long-term care centres, or telephone help-lines such as Info-Santé.
- English-speakers are much more likely than French-speakers to say that they would turn to family first in case of illness; French-speakers would turn to public services first.
- English-speakers are far less likely than French-speakers to have a family member living nearby.
- English-speakers consider long-term care centres and telephone help-line services (Info-Santé) as being particularly important in terms of ensuring linguistic access.

The survey findings support the Committee's view that the vitality of many communities is compromised by their tendency to use the public system less often than the majority, and also to rely more heavily on family first in the case of illness even though they are less likely than their Francophone neighbours to have a family member close by. This portrait of vulnerability is reinforced by the demographic reality of ageing communities and loss of caregivers in several regions.

Analysis also reveals that the six regions scoring very low with respect to ability to obtain a range of health and social services in English are regions where the English-speaking community forms 2.4% or less of the regional population: Bas-Saint-Laurent (0.5%); Saguenay-Lac-Saint-Jean (0.6%); Québec (2.0%); Mauricie (1.3%); Chaudière-Appalaches (0.9%); and Lanaudière (2.4%). These communities appear to lack the demographic weight to influence regional priorities and obtain expanded access to services in English. This finding suggests that such vulnerable communities should be the focus of strategies to develop community capacity and increase the level of access to services in English.

TABLE 2

Use of English in various health and social service (H&SS) situations

Region	Doctor	CLSC	Info-Santé	Emergency room	Hospital overnight	Public long-term care	Private residence	Private nursing services	Community-based group	Aggregate service in English	Total service situations	% of services delivered in English	Index relative to provincial average	Regional rank	Use of English in H&SS situations, relative to provincial average
	English-speakers receiving service in English (%)														
Quebec (province)	86	66	61	73	80	70	72	75	78	5 072	6 727	75.4	1.00	n/a	n/a
01 Bas-Saint-Laurent	26	6	31	28	n/a	n/a	n/a	n/a	n/a	13	72	17.9	0.24	15	very low
02 Saguenay-Lac-Saint-Jean	42	n/a	n/a	8	12	n/a	n/a	n/a	n/a	19	114	16.3	0.22	16	very low
03 Québec	52	21	21	20	27	43	18	n/a	21	59	187	31.7	0.42	13	very low
04 Mauricie-Centre-du-Québec	31	26	13	4	39	19	n/a	62	15	26	116	22.8	0.30	14	very low
05 Estrie	79	72	56	40	63	61	56	89	75	407	630	64.6	0.86	7	low
06 Montréal	93	74	69	83	83	75	73	82	80	1 861	2 255	82.5	1.09	2	high
07 Outaouais	92	68	42	69	74	67	70	69	45	347	473	73.4	0.97	4	average
08 Abitibi-Témiscamingue	54	43	27	59	63	50	82	100	100	119	215	55.6	0.74	10	very low
09 Côte-Nord	76	71	83	65	92	100	86	95	95	237	301	78.8	1.05	3	high
10 Nord-du-Québec	86	84	100	73	87	89	100	89	71	139	167	83.5	1.11	1	high
11 Gaspésie-Îles-de-la-Madeleine	83	70	60	58	60	66	65	82	74	279	402	69.5	0.92	6	low
12 Chaudière-Appalaches	49	46	70	14	44	67	100	n/a	56	34	78	43.3	0.57	11	very low
13 Laval	73	44	55	47	72	89	83	30	64	191	322	59.4	0.79	8	very low
14 Lanaudière	56	16	48	41	38	40	81	72	100	52	126	41.1	0.54	12	very low
15 Laurentides	64	43	43	49	56	52	65	97	67	186	334	55.7	0.74	9	very low
16 Montérégie	75	59	48	78	94	59	82	63	94	674	935	72.1	0.96	5	average

Notes:

1. Findings are based on 3 126 survey respondents.
2. The index is calculated by comparing the regional result with the provincial average.
3. The "high" use of English in health and social services situations in Region 10 is due to the particular organization of services in Cree and Inuit communities of northern Quebec.

Source: CROP and Missisquoi Institute survey on attitudes, experiences and issues for Quebec's Anglophone communities, June 2000.

Provincially, about 6 out of 10 English-speaking people who used Info-Santé during the period surveyed obtained service in English. The finding suggests that remedial measures are required to ensure that this major program is more accessible in English. There were nine regions where less than half of respondents obtained Info-Santé service in English.

The survey reveals weaknesses in the area of primary care (CLSCs). Provincially, about two thirds of the Anglophones surveyed received their primary care services in English. There were nine regions where less than half of the respondents received primary care services in English.[2]

Similarly, there were nine regions where less than half the Anglophones who used hospital emergency services or outpatient clinics obtained their services in English.

The survey results point out significant regional variations in levels of access to various health and social services in English. This finding supports the need for strategies to build community capacity to forge networks and mobilize resources. It also justifies increasing resources in targeted services and identified regions to support models of service adapted to regional and community circumstances. Also indicated are directed measures to provide language training and development of personnel.

The CROP-Missisquoi survey shows how the health and social services system is responding to the linguistic and socio-cultural needs of English-speaking communities. Another view of the system measures the results of government-approved programs for access to health and social services in English. This assessment supports a strategic approach that targets the categories of services and the regions where concerted action is called for to address access gaps.

[2] In the Québec region, many Anglophones also receive primary care services from Holland Centre, a community resource. This circumstance may not be reflected in the CLSC survey results for that region.

TABLE 3

Determinants of Anglophone communities' demographic vitality and access to health and social services—summary of regional rankings

Region	Demographic characteristics	Services delivered in English	Access to entitled services	Summary rank	Community situation with respect to access to H&SS
01 Bas-Saint-Laurent	15	15	15	15	very weak
02 Saguenay-Lac-Saint-Jean	13	16	14	14	very weak
03 Québec	6	13	6	9	average
04 Mauricie	16	14	16	16	very weak
05 Estrie	8	7	4	6	very strong
06 Montréal	4	2	2	1	very strong
07 Outaouais	2	4	5	3	very strong
08 Abitibi-Témiscamingue	12	10	11	13	very weak
09 Côte-Nord	11	3	10	8	strong
10 Nord-du-Québec	5	1	12	5	very strong
11 Gaspésie-Îles-de-la-Madeleine	14	6	13	12	very weak
12 Chaudière-Appalaches	10	11	7	10	weak
13 Laval	1	8	3	4	very strong
14 Lanaudière	9	12	9	11	weak
15 Laurentides	7	9	8	7	strong
16 Montérégie	3	5	1	2	very strong

Notes:

1. The ranking of demographic characteristics is taken from Table 1, p. 8.
2. The ranking of services delivered in English is taken from Table 2, p. 12.
3. The ranking of access to entitled services is taken from an evaluation prepared by James Carter, October 2001 (unpublished).
4. The "very strong" rating of Region 10 is due to the particular demographic circumstances of Cree and Inuit communities of northern Quebec. It also reflects the particular organization of health and social services in these communities (column 2). The ranking for access to entitled services (column 3) is very high because the regional access programs defining entitled services for Anglophones exclude the Cree and Inuit communities.

TABLE 4

Access to entitled services by region and category of service

Region	Primary care (CLSCs)	General and specialized medical services	Long-term care	Youth protection	Rehabilitation	Inter-regional agreements	Designated institutions	Sum of indicators of level of access	Regional ranking
01 Bas-Saint-Laurent	4	2	4	4	4	4	4	26	15
02 Saguenay-Lac-Saint-Jean	4	4	4	1	4	4	4	25	14
03 Québec	1	2	1	1	4	4	1	14	6
04 Mauricie-Centre-du-Québec	4	4	4	4	4	4	4	28	16
05 Estrie	1	1	2	1	1	4	1	11	4
06 Montréal	2	1	1	1	1	1	1	8	2
07 Outaouais	1	1	1	1	2	4	1	11	5
08 Abitibi-Témiscamingue	2	1	4	1	3	4	4	19	11
09 Côte-Nord	2	3	3	1	3	4	1	17	10
10 Nord-du-Québec	2	3	4	3	3	2	4	21	12
11 Gaspésie-Îles-de-la-Madeleine	2	3	3	2	4	4	4	22	13
12 Chaudière-Appalaches	1	2	1	1	4	1	4	14	7
13 Laval	1	2	1	1	1	1	1	8	3
14 Lanaudière	3	3	2	3	3	1	1	16	9
15 Laurentides	1	3	3	1	3	4	1	16	8
16 Montérégie	1	1	1	1	1	1	1	7	1

Notes:

1. Entitled services are those defined in regional access programs approved by the Quebec government for health and social services in English. Access programs are intended to implement section 15 of the *Act respecting health services and social services* (chapter S-4.2), which states that English-speaking persons are entitled to receive health services and social services in the English language, in keeping with the resources of the system.
2. Definition of the level of access to a service: 1 = substantial; 2 = moderate; 3 = limited; 4 = extremely limited.
3. The sum of indicators represents the total of the values assigned to the level of access in each of the seven categories of entitled services.

Source: James Carter, "Evaluation of levels of access to entitled services identified in access programs of health and social services in the English language," October 2001 (unpublished).

RESULTS OF GOVERNMENT ACCESS PROGRAMS

An advisory body appointed by the Quebec government has produced evaluations of regional access programs for health and social services in English. The committee measured progress in the application of legislative guarantees of services in English since the Quebec government approved the first plans in 1989. For each administrative region, the evaluations identify gaps in services and priorities for improvement. The opinions constitute a systematic evaluation of results of government decrees identifying the services that English-speakers are entitled to receive in their language under section 348 of Quebec's *Act respecting health services and social services.*[3]

These evaluations have been consolidated and analysed to permit a rating of access to entitled services by service category and by region (Carter 2001). The results have been added to the demographic data, health determinant indicators and the CROP-Missisquoi survey findings in order to provide a composite portrait of the overall situation of regional English-speaking communities with respect to access to services in English (see Table 3).

At least seven dimensions of the entitlement to services in English can be identified (see Table 4):

- primary care (CLSCs);
- general and specialized medical services;
- long-term care;
- youth protection;
- rehabilitation;
- agreements on inter-regional services; and
- designated institutions.

1) Primary care (CLSCs)

According to Carter (2001), four regions have limited, extremely limited or non-existent access to entitled services provided by the range of primary care programs delivered by CLSCs: Bas-Saint-Laurent; Saguenay-Lac-Saint-Jean; Mauricie-Centre-du-Québec; and Lanaudière.

[3] Provincial Committee on the Dispensing of Health and Social Services in the English Language, *Opinions and recommendations with respect to approval by the Government of the programs of access to health and social services in the English language for English-speaking persons of each administrative region of Quebec*, January 1997; and *Report on the decrees adopted by the Government of Quebec concerning programs of access to health and social services in the English language*, November 1999.

2) General and specialized medical services

Seven regions are considered to have limited, extremely limited or non-existent access to entitled services provided by the range of general and specialized medical services delivered by hospitals: Saguenay-Lac-Saint-Jean; Mauricie-Centre-du-Québec; Côte-Nord; Nord-du-Québec; Gaspésie-Îles-de-la-Madeleine; Lanaudière; and Laurentides.

3) Long-term care

Eight regions are considered to be in deficit with respect to having moderate to substantial access to entitled services provided by long-term care centres: Bas-Saint-Laurent; Saguenay-Lac-Saint-Jean; Mauricie-Centre-du-Québec; Abitibi-Témiscamingue; Côte-Nord; Nord-du-Québec; Gaspésie-Îles-de-la-Madeleine; and Laurentides.

In Estrie, English-speaking people appear to underuse the public long-term care system, preferring private resources more adapted to their linguistic and cultural needs; they thus incur considerable costs to themselves and their families.

4) Youth protection

Four regions are assessed as having limited, extremely limited or non-existent access to entitled services provided by youth protection centres: Bas-Saint-Laurent; Mauricie-Centre-du-Québec; Nord-du-Québec; and Lanaudière.

These are often statutory services that youth in difficulty are required to use under provincial and federal legislation.

5) Rehabilitation programs for all categories of clientele

Access to entitled rehabilitation programs is generally weak for all categories of clientele (persons with physical or intellectual disabilities, youth in difficulty, persons with drug and alcohol addictions).

Eleven regions (over two thirds) are considered to have limited, extremely limited or non-existent access to entitled services provided by rehabilitation centres: Bas-Saint-Laurent; Saguenay-Lac-Saint-Jean; Québec; Mauricie-Centre-du-Québec; Gaspésie-Îles-de-la-Madeleine; Chaudière-Appalaches; Abitibi-Témiscamingue; Côte-Nord; Nord-du-Québec; Lanaudière; and Laurentides. Of these, the first six are judged to have extremely limited or non-existent access to entitled services.

Persons with disabilities constitute a minority within a minority. For example, hearing-impaired persons face major obstacles communicating with health care providers. Although the Supreme Court of Canada has ruled that sign language interpretation is covered by Medicare and must be provided to all

such persons, the service delivery system has not adequately adjusted to meet this need.[4]

6) Agreements on inter-regional services

Access programs allow for agreements on inter-regional services permitting English-speaking people in one region to have access to entitled services elsewhere, subject to confirmation by government decree.

Inter-regional agreements are critical as Quebec continues to consolidate its model of regionalization for specialized and ultra-specialized medical care. Further, entitled residential treatment programs for English-speaking youth in difficulty exist in only one centre in Montréal. Administrative arrangements for inter-regional access must be formally recognized in access programs.

Ten regions have no inter-regional agreements in their access programs approved by the Quebec government in 1999: Bas-Saint-Laurent; Saguenay-Lac-Saint-Jean; Québec; Mauricie-Centre-du-Québec; Estrie; Outaouais; Abitibi-Témiscamingue; Côte-Nord; Gaspésie-Îles-de-la-Madeleine; and Laurentides. Five of the regions have no designated English-language institutions, while nine regions scored low or very low in terms of the level of accessibility of a range of services in English, compared with the other regions (see Table 4).

While communities in many regions may turn primarily to Francophone institutions in their own regions to obtain specialized medical services (for reasons of geography, mobility or cost), Quebec government data show a consistent pattern of use of designated English-language hospitals in Montréal by patients coming from other regions.[5]

Technology now permits the extension of certain services to distant or rural regions.

7) Designated institutions

Designated institutions are authorized by Quebec government decree to offer all their services in English. They are principally the institutions historically developed and supported by English-speaking communities Their presence in a region is important for the range of services offered, as well as for their contribution to the community's vital infrastructure.[6]

[4] In *Eldridge v. British Columbia* (1997), the Supreme Court of Canada unanimously held that sign language (ASL/LSQ) interpretation must be provided to all hearing-impaired persons as a service insured by Medicare.

[5] Provincial Committee on the Dispensing of Health and Social Services in the English Language 1997.

[6] From among the institutions recognized under section 29.1 of the *Charter of the French Language* (chapter C-11), the Quebec government designates those authorized to make their services accessible in English for English-speaking persons.

Reforms have dropped the overall number of Quebec public health institutions from approximately 1000 to 500 in the last decade. As a consequence, institutions serving English-speaking communities have closed (e.g. Queen Elizabeth Hospital, Reddy Memorial Hospital and Lachine General Hospital). Mandates of others have changed (e.g. Sherbrooke Hospital and Jeffrey Hale Hospital).

Almost half the administrative regions have no designated English-language institutions: Bas-Saint-Laurent, Saguenay-Lac-Saint-Jean, Chaudière-Appalaches, Mauricie-Centre-du-Québec, Abitibi-Témiscamingue, Gaspésie-Îles-de-la-Madeleine and Nord-du-Québec. The first four of these regions ranked very low with respect to their relative degree of access to the range of services cited in the CROP-Missisquoi survey, while Abitibi-Témiscamingue and Gaspésie-Îles-de-la-Madeleine ranked low.[7] This signals a weakness in the level of accessibility of services compared with other regions having designated institutions.

[7] Nord-du-Québec is a special case because of the significant presence of Cree and Inuit populations, which are more likely to have access to culturally adapted services within their territories.

To deal with the problems identified, the Committee is proposing a five-year Global Intervention Plan. This would promote the demographic vitality of English-speaking communities through concerted government and community action to improve access to the range of health and social services in English.

For this purpose communities must have the capacity to mobilize resources, and the system must respond with sufficient resources and with service delivery approaches adapted to regional and community realities.

The Global Intervention Plan identifies **five levers** to orient measures that directly support efforts by both communities and the health and social services system to improve access to English-language services:

- **networking and cooperation** within English-speaking communities to mobilize institutional and community capacity in order to meet needs;
- **strategic information** to build a knowledge-based approach mobilizing resources and identifying needs;
- **technology** to extend provision of services to distant, dispersed or rural English-speaking communities;
- **service delivery models** to develop new services adapted to regional and community realities; and
- **training and human resources development** to promote language training and professional development, recruitment of English-language personnel, and their retention in all regions.

The Global Intervention Plan calls for the following measures.

1) Networking and cooperation

Establish 16 regional networks, 4 sub-regional networks and 1 provincial network to:

- provide information on English-speaking communities and their needs;
- draft strategies to meet the needs identified;
- support and carry out initiatives leading to the implementation of service delivery models that take into account regional and community circumstances;
- develop networks that will link health and social services institutions with communities;
- develop the volunteer sector;
- facilitate exchanges between regional and sub-regional networks;
- represent local and regional interests at the provincial level; and
- assist in the development of partnerships with other networks (e.g. educational institutions, including universities).

2) Strategic information

- Develop academic and institutional research around key community concerns.
- Build community research capacity.
- With other departments and other levels of government, encourage government research.

3) Technology

- Expand use of tele-health and tele-medicine.
- Support the development of multi-disciplinary intake centres for distance services (e.g. health, education, community services).
- Develop connectivity and technology infrastructure.

4) Service delivery models

- Establish and support the implementation of the best service delivery models for primary care, general and specialized medical services, long-term care, youth protection services, and rehabilitation programs.
- Develop service delivery models taking into account regional and community circumstances, including demographic and geographic factors, as well as the level of access to English-language services in each region.
- Draft strategies to build community capacity by promoting community participation in the planning and delivery of services.
- Determine human, material and information resources required to improve the level of accessibility of services in English within Quebec's health and social services system.
- Promote integration of the needs of English-speaking communities into the planning of local and regional services.

5) Training and human resources development

- Promote professional and language training (French/English as a second language) in partnership with CEGEPs, universities and others.
- Develop incentives for recruitment and retention in Quebec and its regions, including bursaries, daycare, and incentives to return to the regions after graduation or professional training.

The Global Intervention Plan proposed by the Committee would promote the demographic vitality of English-speaking communities in every region of Quebec by means of levers that improve access to health and social services in English. The Plan provides a solid basis for the contribution of federal institutions and the provincial government to the development and vitality of Quebec's English-speaking communities.

The Committee recognizes that certain conditions will enhance the chances for success of the Plan:

- The Quebec government is responsible for delivery of health and social services, and so its cooperation and collaboration will be important in order to ensure successful implementation of service delivery models.
- At the same time, within its mandate the federal government has a role to play in carrying out its commitment to actively support the development and vitality of Quebec's English-speaking communities.
- The availability of services in English within Quebec's health and social services system should evolve in response to evolving needs.
- Measures must be implemented in a way that takes into account regional and sub-regional circumstances.
- To ensure that solutions are lasting, government and institutional or community stakeholders should commit to making concerted and sustained efforts with the aim of improving access to services and thereby supporting the vitality and development of English-speaking communities.
- English-speaking communities must be consulted and must participate actively in developing and implementing the Global Intervention Plan's measures.

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APPENDIX: HEALTH CANADA'S CONSULTATIVE COMMITTEE FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

MANDATE

The Consultative Committee's mandate is as follows:

1. To provide advice to the Minister of Health on ways of enhancing the vitality of English-speaking minority communities in Quebec and to support their development.

2. To provide its perspective on initiatives which are in the development phase with a view to ensuring an optimal impact on English-speaking minority communities in Quebec.

3. To provide a forum to help update the Multi-Year Action Plan in order to assist the Department in meeting its obligations under section 41 of the *Official Languages Act*.

4. To liaise with English-speaking minority communities in Quebec so as to facilitate information sharing.

5. To liaise with French-speaking minority communities outside Quebec so as to facilitate information sharing.

STRUCTURE

The Consultative Committee will comprise:

- two co-chairs (one representing the community party and one representing the federal party);

- eight representatives of the English-speaking minority communities in Quebec;

- a representative of the Province of Quebec (to be confirmed);

- senior officials of Health Canada with specific responsibilities in priority program and policy sectors;

- the National Coordinator, Section 41, Part VII, and the Quebec Regional Coordinator, as needed;

- a secretary general for the community party and a secretary general for the federal party; and

- a representative of Canadian Heritage, acting as an observer, with a view to maximizing partnership opportunities.

MEMBERSHIP

CO-CHAIRS

Eric Maldoff	Partner, Heenan Blaikie
Marcel Nouvet	Assistant Deputy Minister, Information Analysis and Connectivity Branch, Health Canada

CO-SECRETARIES

Deborah Hook	Executive Director, Quebec Community Groups Network
Muguette Lemaire	Program Analyst, Health Canada

COMMUNITIES REPRESENTATIVES

James Carter	Coordinator, Community Health and Social Services Network
Christina Davidson Richards	Translator, South Stukely, Quebec
Patti Arnold	Communication Specialist, Îles-de-la-Madeleine, Quebec
Louis Hanrahan	President, Voice of English-Speaking Quebec
JoAnn Jones	Clinical Nurse Specialist, Sutton, Quebec
Dr. James MacDougall	President and CEO, Canadian Deafness Research and Training Institute, and Associate Professor, Department of Psychology, McGill University
Dr. William Rowe	Director, Centre for Applied Family Studies, and Director, School of Social Work, McGill University
Marion Standish	Nursing Consultant, Courville Geriatric Centre
James Warbanks	Founding member, Advisory Committee to Regional Health Board of Laurentides

CANADIAN HERITAGE REPRESENTATIVES

Beverley Caplan	Senior Advisor, Official Languages Programs, Quebec Regional Office
William Floch	Manager, Research and Policy Development, Official Languages Programs Branch
Sheila MacDonald	Manager, Interdepartmental Coordination Directorate

HEALTH CANADA REPRESENTATIVES

Jean-Louis Caya	Director, Population and Public Health Branch, Quebec Region
Susan Hicks	Senior Nursing Consultant, Health Policy and Communications Branch
Jacques Cloutier	Director, Official Language Community Development Bureau
Michel Léger	Director, Information, Analysis and Connectivity Branch
Lucie Myre	Regional Director General, Quebec