Building on our strengths:

An Action Plan for Improving access to Health and Social services in English in Quebec and enhancing the vitality of its English-speaking minority communities

Prepared on behalf of Health Canada’s Consultative Committee for English-speaking Minority Communities

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Me Richard Silver’s *The Right to English-language Health and Social services in Quebec: A Legal and Political Analysis* (McGill Law Journal, Volume 45, no 3, June 2000,) stands as a superb review of the evolution of the legal right to English-language health and social services in Quebec; much of the material contained in the sections concerning the legislative context are drawn from this text.

Muguette Lemaire of Health Canada and Deborah Hook of the Quebec Community Groups Network serve as co-secretaries of Health Canada’s Consultative Committee for English-speaking Minority Communities, and, together with members of the steering committee that helped direct the drafting of this document, they provided much helpful advice as the work progressed.

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The first section of this document reports extensively on the fruit of remarkable work, done over two decades, by a vast number of community-based volunteers and staff. Their efforts have been immeasurably enhanced by the contributions of numerous administrators and professionals working within Quebec’s health-care system, both at the institutional level and within the Quebec Department of Health and Social Services. Were it not for their collective determination and good will, this would have been a very slim volume indeed. The title of this report is a tribute to their accomplishments.

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Action Plan prepared on behalf of Health Canada’s Consultative Committee for English-speaking Minority Communities

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In August 1994, the Government of Canada approved the establishment of an accountability framework for the implementation of Sections 41 and 42 of the Official Languages Act. Section 41 commits the federal government to enhancing the vitality of English-speaking minority communities, as well as fostering the full recognition and use of both English and French in Canadian society. Section 42 of the Official Languages Act mandates the Minister of Canadian Heritage to promote and encourage a coordinated approach to these commitments.

Access to health and social services in English for members of Quebec’s English-speaking minority communities is a key determinant of the quality of the service delivered. It is also an essential element to ensuring the ongoing vitality of those communities.

This document provides historical overview of the legislative and political context, a detailed review of regional demographic and polling data, information about the extent of legally mandated service availability, material about the pressures affecting the minority community’s institutional infrastructure, and a discussion of new models of service delivery as well as the evolution of government support. This material supports recommendations for strategies that will improve access to English-language health and services, and thus, contribute to the vitality of Quebec’s English-speaking minority communities.
THE LEGISLATIVE AND POLITICAL CONTEXT

The present legislative framework, both within the Quebec Act respecting Health and Social Services and the Charter of the French language, is reviewed. While the Act contains guarantees of access to English-language services for English-speaking people, the current political context has had the effect of significantly dampening the willingness of the public administration to energetically implement those guarantees. As a result, the last review of access plans mandated by section 348 of the Act resulted in a reduction of services guaranteed in a number of administrative regions, and a number of obligations flowing from the Act remain unmet.

The legal framework that favors access to English-language health and social services in Quebec is constrained by the political context in which it operates. An action plan will need to take this into account, and develop strategies that are insulated from the broader political climate. This implies that the communities themselves will need to be far more central to the development and implementation of specific activities aimed at promoting service accessibility.

Regional coordination has been a critical element in the development of access to services in English. Diminished support for coordination threatens the future development of services. It also threatens the capacity of various communities across the province to coordinate their activities at the pan-provincial level, sharing best practices and resources. An action plan should prioritize the development of a significant capacity for community coordination, both at the regional and provincial levels.
THE COMMUNITY’S INSTITUTIONAL NETWORK

At the same time that the political climate has constrained the application of the right of services through the Quebec Act respecting health and social services, the institutional network historically associated with the English-speaking community has been under a number of direct and indirect pressures that have significantly impeded its ability to provide services to English-speaking Quebecers. These pressures threaten the central role played by the institutional network and, in fact, their very survival.

Among these pressures, there are many which are experienced by all public institutions across the province and indeed, throughout Canada: budgetary constraint, concentration of specialized services in a limited number of sites, redefinition of the first line for service delivery, Regionalization of budgetary envelope, and the redefinition of administrative models to favor inter-disciplinarity and economies of scale. But similar action can often yield disproportionate consequences where minority communities and their institutions are concerned. In fact, these pressures have significantly impeded the capacity of the historical network of institutions to play their traditional dual role as service provider and leadership source for the English-speaking communities of the Quebec.

The institutional network historically associated with the English-speaking community of Quebec remains the most reliable source of English-language service. An action plan will need to specifically foresee strategies which reinforce the capacity of these institutions to deliver services across the province, and which serve also to strengthen the historical linkages between the institutions and the communities. These institutions should also be supported in developing strategic approaches that take into account their special status within the English-speaking minority community of Quebec.
The action plan should ensure that the Anglophone institutions have the collective capacity to carry out medium and long-term strategic planning, communications, and lobbying, so that their shared role as bulwark of the community is not lost to the ongoing shifts of administrative restructuring, governance reform, and resource shortage.

Services in public health and social service institutions that are majority Anglophone can be extended beyond their traditional reach through the use of remote access technologies. These technologies also provide access to specialized medical expertise not readily available in most administrative regions, consolidate the sense of community ownership and accountability, and may reduce cost by diminishing the numbers of hours spent travel. An action plan should ensure that these technologies are made available to these institutions with this purpose specifically in mind.

THE EVOLUTION OF GOVERNMENT SUPPORT

Government support for measures which favor access to English-language health and social services have likewise been declining over the period during which the institutional network and the framework of legislative guarantees have come under the greatest pressure. With the expiry of the Canada-Quebec agreement supporting Quebec’s initiatives in the area of linguistic accessibility, and the simultaneous orientation of the Ministère de la Santé et des Services Sociaux du Québec to reduce or eliminate regional coordination, the capacity of local communities to actively participate in the decision-making process surrounding access to health and social services in English has been severely compromised.
At the same time, the capacity of regional boards to encourage the development of English-language services by funding of English second-language training and translation programs has been virtually eliminated.

An action plan should ensure that local communities have the capacity to carry out community consultation and coordination, and that a provincial capacity for coordination is created and supported. In addition, resources should be set aside to assist institutions and employees in improving the collective capacity to provide English-language services, and to retain bilingual staff.

DEMographics

Statistics Canada 1996 census data on English-speaking Quebecers show significant variation between English-speaking communities in the administrative regions of the province. Often, these communities are also significantly different from their francophone neighbors along such major health indicators as age distribution and poverty. Notably, 1996 census data indicate that despite having a higher level of education, English-speaking Quebecers are more likely to be unemployed and are as likely to have low income levels as French-speaking Quebecers. Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage permit the creation of a novel indicator for community demographic vitality, and support a comparison between regions for the purposes of assessing the level of community strength in each region.

General health indicators are significantly different between English speakers and French speakers living in many regions. However, despite greater economic polarization within the English-speaking population compared to the French-speaking population, median income levels are generally the same. It is highly likely that other indicators, such as obesity and smoking, will show similar
vibrations. An action plan must ensure that regional planners have access to this material so that they can adjust their strategies accordingly.

English-speaking minority communities in certain regions are at significantly greater disadvantage than others, both in terms of health indicators and community vitality. Nevertheless, English-speaking minority communities are typically treated either as an undifferentiated part of the entire regional population or, if they are treated as a separate group, it is as part of the English-speaking population of the entire province. Neither is appropriate. An action plan must ensure that local communities have the capacity to access complete, pertinent demographic information about themselves, so that they can make sound judgments for service development. Access to this material is key to ensuring the effectiveness of the community coordination efforts that must be undertaken.

THE CROP-MISSISQUOI SURVEY

The CROP-Missisquoi survey on the attitudes and experiences of English-speaking Quebecers provides information on perceptions of the English-speaking communities of current availability of English-language health and social services. On a provincial basis, the most reliable source of English language services is the private physician; the least reliable source of English-language services is the CLSC including the telephone help-line (Info-Santé). The concentration of English speakers in the metropolitan Montreal region, where services are more readily available, masks the rather low level of access provided to English speakers in the regions.

A number of regions with low or moderate numbers of English speakers are performing at or above provincial averages in terms of the satisfaction of the need for English-language services. These regions include Gaspésie-les-Îles, Côte-Nord, and Nord-du-Québec. Only two regions, Montreal western and
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central regions, consistently exceeded provincial averages for the delivery of services in English; this difference is certainly due to the concentration of “Anglophone” institutions in those sub-regions.

Services are offered in English at significantly below the provincial average in the Bas-St-Laurent, Saguenay, Québec, Mauricie-Center du Québec, Chaudière-Appalaches, and Lanaudière regions. Moreover, there is significant variation in the level of the active offer of service between various service providers. CROP-Missisquoi indicates that English-speaking clients place a higher importance on English-language access for two types of service, in nursing homes and on the CLSC telephone help-line. Finally, the data confirms that English speakers more frequently associate their decision to travel with the desire to receive services in their language.

Physicians are the most reliable source of English-language services. Services in nursing homes and CLSCs are least reliably available. An action plan should take these strengths and weaknesses into account.

English-speaking respondents prioritize English-language services in nursing homes and on telephone help-lines. An action plan should permit specific service development in function of these priorities in each region.

English speakers are far more likely to say that they would turn to family first in case of illness, even when there is no family nearby. An action plan should specifically envisage strengthening local capacity to respond to this issue in those regions where it is significant.

While services in English are more reliably available in the metropolitan Montreal region, English-speaking communities in many regions report extremely limited access to services in English. An action plan should capitalize on the resources of the Anglophone institutions located in the Montreal area through the use of
remote technologies, while foreseeing specific strategies that would develop community-controlled resources in the regions.

NEW MODELS FOR SERVICE DELIVERY

A number of strategies and approaches show real promise in permitting the improvement of English-language service availability and the health of English-speaking Quebecers. Some of these suggested activities are specific to Health Canada, while others will entail inter-departmental collaboration. Among the most interesting models for service delivery, we find tele-health and the development of novel service sources at the community level (the Holland Center model).

Services in public health and social service institutions that are not associated with the Anglophone community can be expanded through support for human resource development and retention strategies aimed at improving staff capabilities in English and enhancing their chances of remaining in the regions. An action plan should, in particular, permit English and French-second-language training, and should enhance the capacity of institutions to recruit and retain English-speaking staff.

New community-based structures can be developed to complement the services provided by local public institutions. These new structures should be developed in direct consultation with local English-speaking communities, and should take account of the best available demographic information. An action plan should support the development and funding of these new organizations, as well as the community consultation and organization process necessary to ensure their stability and viability.
THE ACTION PLAN

The action plan identifies three major themes for contributing to the vitality of Quebec’s English-speaking community by improving access to English-language health and social services: strengthening the Anglophone institutional network, increasing the capacity of Francophone institutions to deliver services in English, and supporting community capacity-building. These themes flow directly from the demographic, service availability, administrative and political review provided in the first four sections of the report.

Within each of these themes, a number of specific levers are identified, including:

- Information technology;
- Prevention and promotion services;
- Interpretation services;
- Human resources development;
- Development of the voluntary sector;
- Creation of new service sources;
- Communications strategies, and
- Research.

It is clear that there are significant outstanding needs in the areas of research, particularly around health determinants, and community coordination and capacity building. Meeting these outstanding needs is a condition for the success of other specific measures. Measures identified in each of these areas are linked to the priorities identified by Health Canada’s Consultative Committee.

In light of these priorities, and based upon the material presented in this report, it is recommended that the Committee urge Health Canada to provide funding to support the delivery of health and social services in English to Quebec's minority community in five broad areas:
1. Networking and cooperation within English-speaking communities to mobilize institutional and community capacity to meet their needs;

2. Strategic information to build a knowledge-based approach mobilizing resources and identifying needs;

3. Technology to extend provision of services to distant, dispersed, or rural English-speaking communities;

4. Service delivery models to develop new services for English-speaking communities which are adapted to regional and community realities; and

5. Training and human resource development to promote language training and professional development, recruitment of English-language personnel and their retention in all regions.
Do what it may, the terms of (a minority’s) very existence are fixed for it by the mere weight and tendencies and habits of the surrounding majority. And this is no less true when the majority is friendly than when it is hostile.

-Ludwig Lewisohn

Foreword

In August 1994, the Government of Canada approved the establishment of an accountability framework for the implementation of Sections 41 and 42 of the Official Languages Act. Section 41 commits the federal government to enhancing the vitality of English-speaking minority communities, as well as fostering the full recognition and use of both English and French in Canadian society. Section 42 of the Official Languages Act mandates the Minister of Canadian Heritage to promote and encourage a coordinated approach to these commitments.

Access to health and social services in English for members of Quebec’s English-speaking minority communities is a determinant of the quality of the service delivered. As is increasingly well-recognized, language is a key component in the delivery of health and social services: without adequate communication, we can no more expect a nurse to adequately triage an emergency room patient than we can imagine that a cardiologist would be able to function without a stethoscope. Language must thus be considered as a fundamental and necessary tool for service delivery.
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But this is more than a question of quality of service. Access to public services, especially health and social services, forms a basic part of the infrastructure of Canadian civic identity. In the context of Canada’s linguistic duality, linguistic accessibility is a confirmation that a minority community “belongs”, that it has available to it the same fundamental supports as those offered to the majority community. Thus, access to linguistically adapted services affords a sense of belonging that is indispensable to the stability and vitality of any minority community.

Developing the capacity of public and community networks to provide services in the language of Quebec’s English-speaking minority community is therefore a critical and concrete component in the implementation of Section 41 of the Official Languages Act.

The Government of Canada’s recognition of the fundamental importance of health and social services to the vitality of minority language communities led Health Canada to set up two consultative committees to advise it on the best ways to improve access to minority language health services. One committee, concerned with improving access to health services in French, has produced recommendations on the development of services in French for francophone communities outside of Quebec. A second committee, created by Minister Alan Rock in April 2001, was to provide advice on ways to enhance access to English-language services for the English-speaking minority community of Quebec. Jointly presided by Me Eric Maldoff on behalf of Quebec’s English-speaking community, and by Mrs. Marie Fortier and subsequently by Mr. Denis Gauthier for Health Canada, the Committee’s mandate is:

- 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;
• 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;

• 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;

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

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

The Committee’s Mandate, as well as a list of its members, appears in Appendix 1.

As a first step, the Committee asked that an action plan be prepared that would support its activities. The following document has therefore been developed with a view to providing both committee members and other decision-makers with relevant material that will inform a strategic and timely approach towards Health Canada’s support of Quebec’s minority English-speaking communities’ access to English-language health and social services.

The report is structured around three central premises. First, that in order to support minority communities through the development of linguistically appropriate health and social services, it is necessary to have a thorough understanding of key demographic and service realities affecting each local community. Second, the English-speaking community of each region of Quebec needs to be separately assessed and separately planned for, while ensuring
coherence and complementarity at the provincial level. Finally, community control and management of service delivery sources is both the best guarantee that services will be linguistically an culturally adapted, and also the surest means to provide communities with the kind of internal strength which will support their long-term vitality.

The present document is divided into five sections. The first section is an administrative and political overview. It summarizes the legislative context, explaining those sections of the Act respecting health and social services that touch on access to English-language services in the sector. This section also reviews the impact of the Charter of the French language on the ability of institutions to provide English-language services, and deals with the institutional network historically associated with the English-speaking communities of Quebec, with a view to understanding the present role and situation of these institutions both within the community as a whole and in the delivery of English-language services to all English-speaking Quebecers. Recent developments are reviewed, including relevant recommendations of the Larose Commission the status and future of the French language, and the Clair Commission on Health. Section one concludes with a review of funding by both the Government of Canada and the Government of Quebec for initiatives aimed at increasing access to English-language health and social services.

Section Two is a review of Statistics Canada data concerning English-speaking Quebecers, with particular reference to basic health indicators, and is organized according to Quebec's administrative regions. Section Two also includes data that support a new measure of community vitality, which can be used to help assess the stability of the various English-speaking communities in the regions.

The third section of the document deals with the data from the CROP-Missisquoi survey on the attitudes and experiences of English-speaking Quebecers (spring, 2000), and contains specific information concerning the reported experience of
respondents in each region in their ability to access English-language health and social services.

Section Four of the report provides a brief review of models for health and social service delivery currently in use in Quebec.

Based on the material presented in the first four sections, Section Five of the report contains broad recommendations for an action plan. These recommendations are organized around themes and specific strategies, and have been linked to the priorities already identified by the Committee.
SECTION ONE

Access to English-language health and social services in Quebec: Background and current status

Highlights and Key findings of the review of the background and current status of access to English-language health and social services in Quebec

The English-speaking minority community of Quebec benefits from the presence of specific legislative guarantees that help protect access to health and social services in English across the province. These guarantees have contributed to the development of access in a number of regions.

Significant political constraints have also had an impact, as in the last few years the Government of Quebec has increasingly articulated policies that place the rights of English-speaking clients to understand and make themselves understood by their health-care providers in opposition to the objective of the Charter of the French language to make French the normal language of work and public communication in Quebec. Simultaneously, the Government of Quebec has progressively withdrawn its support for regional coordination of English-language health and social services, which had been largely responsible for the development of better levels of access in the regions.
The presence of a strong network of institutions that are controlled and managed by the English-speaking community is an essential element in the availability of a full range of health and social services in English. However, major pressures of both a financial and structural nature have also reduced the capacity of the network of institutions historically associated with the English-speaking community to provide services to English-speaking clients.

1. The legal framework that favors access to English-language health and social services in Quebec is significantly constrained by the political context in which it operates.

2. The institutional network historically associated with the English-speaking community of Quebec is under major pressure from a variety of economic and structural constraints, but remains the most reliable source of English-language service.

3. Regional coordination has been a critical element in the development of access to services in English. Diminished support for coordination threatens the future development of services.
Section One
Access to English-language health and social services in Quebec: Background and current status

Introduction
In order to determine those strategies and objectives most likely to have a positive impact on the availability of English-language health and social services in Quebec, it is obviously necessary to review the current availability of these services, and to understand the legislative and political context in which service providers currently operate in the province.

This section will provide an overview of the evolution and present scope of legislative guarantees and their level of implementation. Special attention will be given to the two major venues for institutional service delivery in English: those institutions historically identified with Quebec’s English-speaking communities, and those institutions not identified with the English-speaking communities but providing all or some of their services in English pursuant to an Access Program in virtue of section 348 of the Act respecting health and social services (L.R.Q., c-4.2).

The final part of this section will trace the evolution funding provided by the Governments of Quebec and Canada for activities related to the enhancement of English-language health and social services for English-speaking Quebecers.
The legislative and political context and the legal right to health and social services in English

While the legislated right to English-language health and social services was enshrined in 1986, English-language health and social services had in fact been available to English-speaking Quebecers for generations. It is useful, however, to provide a brief overview of the legislative context surrounding access to health and social services in English in Quebec. The two major pieces of Quebec legislation that determine this context are the Act respecting health and social services (L.R.Q., c. S-4.2) and the Charter of the French language (L.R.Q., c. 11.)

The Act respecting health and social services (L.R.Q., c. S-4.2)

Quebec’s current health and social services legislation establishes a moderately decentralized model in which orientations and budget envelopes are set by the government, but organization and budgetary allocation are carried out at the regional level. This general model has been in place since 1991, when Quebec’s National Assembly adopted the current Act respecting health and social services. Prior to 1991, the health care system was managed under a more centralized model, with most major financial and planning decisions being made by the Department, and with consultation at the regional level. Recent adjustments to the Act tend towards a re-centralization of control at the Ministerial level.

In general, it is important to note that for the past twenty years, the Quebec trend has been to consolidate an integrated first-line service delivery system (Centre local de services communautaires) by restructuring many services historically based at more specialized institutions such as hospitals, rehabilitation centres, and social service centres. The legal right of access to English-language health
and social services exists in this context of slow but steady progression towards the local, community based provision of health and social services.

The legal right to health and social services in English was created through the adoption of amendments to the Quebec Act respecting health and social services in 1986. With the adoption in 1991 of new legislation governing health and social services, additional legal requirements were inserted which were broadly aimed at ensuring the interaction between access programs to health and social services in English and the overall planning process. Finally, the 1991 Act created consultative committees (sections 509 and 510), which ensure communication between the English-speaking communities and the administrative and political structures, both at the regional and provincial levels.

The Act establishes the right of every English-speaking person to receive health and social services in English, within the confines of two major constraints: the organization and resources of the health and social services system itself, and the terms of an access plan to be drafted by the regional health boards and approved by the government. Thus, the right to service was and is not unlimited. It is constrained both by the real capacity of the system to provide English-language services at the time that the program is created and, on the other hand, by the political willingness of the government of the day to translate that capacity into a legal right.

Within this framework, the development of new English-language service capacity is dependent on the interaction between the access program and the regional plans for service organization (Plans regionaux d’organisation des services or PROS). By identifying, either explicitly or implicitly, those services that are not accessible in English in the region, the access plan acts as a trigger for the general planning process to take language accessibility into account during the general planning cycle. In principle, subsequent access plans could
then capture the newly accessible services, protecting them with a legal guarantee.

From 1991 until 2001, the general economy of the Act accorded broad authority for setting orientations to the Department, whereas the responsibility for the planning and organization of services is the purview of the regional board. Indeed, the section of the Act that mandates access plans for English-language health and social services is one of three articles that broadly describe the regional board’s functions relative to the organization of services. The development of access programs was therefore under the responsibility of the board.

Recently, amendments to the Act have had the effect of concentrating much power back in the hands of the Minister, largely by giving the Government the sole authority to name members to the regional board of directors, and especially by making the position of regional director general a Cabinet-level appointment reporting to the Deputy Minister of health rather to the board. The director general will moreover serve as president of the regional board of directors. There is therefore no longer any significant possibility for independence at the regional board level.

The principal articles of the Act respecting health and social services touching on access to services in English are found in articles 15, 248, and 508. These articles need to be read and understood together. While the legislation exists in an English version, it is relevant to cite the legislation in French, since certain nuances in the text have recently become the source of disagreement as to the meaning of the legislation.
The provisions concerning access to English-language services

Three sections of the Act encompass the backbone of the legislative right to service in English. First, the right is set forth, within certain limits. Then the limits are described, integrating the institutional network that has always provided English language services.

Section 15 of the Act reads as follows (emphasis added):

Toute personne d’expression anglaise a le droit de recevoir en langue anglaise des services de santé et des services sociaux, compte tenu de l’organisation et des ressources humaines, matérielles, et financières des établissements qui dispensent ces services et dans la mesure où le prévoit un programme d’accès visé à l’article 348.

Section 348 of the Act reads as follows (emphasis added):

Une régie régionale doit élaborer, en collaboration avec les établissements, un programme d’accès aux services de santé et aux services sociaux en langue anglaise pour les personnes d’expression anglaise de sa région dans les centres exploités par les établissements de sa région qu’elle indique ou, le cas échéant, conjointement avec d’autres régies régionales, élaborer un tel programme dans les centres exploités par les établissements d’une autre région.

Un tel programme d’accès doit tenir compte des ressources humaines, matérielles, et financières des établissements et inclure tout établissement de la région qui est désigné en vertu de l’article 508.
Ce programme doit être approuvé par le gouvernement et révisé au moins tous les trois ans.

Two aspects of this text bear specific mention. First, while the general right as set forth in section 15 refers only to a right to receive *some* health and social services (*des services*) section 348 creates an obligation for the regional board to create a program of access to *all* services (*aux services*). In practical terms, this has meant that, without obliging every institution to provide all its services in English, at the regional level, the range of services which are otherwise available in French must be provided for in English, either through the institution which would normally provide service or, if resources do not permit, through another institution within or outside the region.

The second element that it is important to note is that while the development of the access plan is an administrative responsibility of each regional board, the translation of this administrative orientation into a legal right requires the step of government approval. Inevitably, this requirement politicizes the process to the confirmation of the legal right. Indeed, on both occasions when access plans have been submitted to Cabinet (in 1999 and in 1989), the process of approval has been difficult and has led to modification of the original regional board proposals.

Finally, section 508 of the Act states that

> Le gouvernement désigne parmi les établissements reconnus en vertu de l’article 29.1 de la Charte de la langue française ceux qui sont tenus de rendre accessibles aux personnes d’expression anglaise, les services de santé et les services sociaux en langue anglaise.

Thus, the institutions which are historically linked with the English-speaking community and which have, since their inception, provided services in English,
are integrated into the administrative and regulatory process which is the creation and approval of an access program. Later in this section, we will discuss in some greater detail the historical evolution of those institutions and the pressures that they face in the current context.

**A few words about the overall orientation for service delivery in Quebec**

In order to understand the context in which the right to English-language services operates, it is important to have a basic knowledge of the overall orientation for service delivery in Quebec. As we have said before, the Department of Health and Social Services operates on a quasi-decentralized basis, with some administrative flexibility at the level of the administrative region, but with an increasingly re-centralized political control at the political level.

From the standpoint of service organization, the orientation is that first line services should be provided at the local level, through the CLSC (Local Community Health Centre). These institutions, unique to Quebec, offer integrated health and social services as well as home care and some prevention/promotion services to the population of a specific geographic territory. In urban areas, the total population served generally does not exceed about 60,000; in rural areas, the delimitation is geographic rather than populational, and is kept relatively small.

Increasingly, CLSCs operate in conjunction with chronic care facilities, with the goal of offering an integrated range of services to seniors as they move from home-based services to residential services. Thus, chronic care facilities which previously were viewed as having a more regional mandate are increasingly tied to the local level for the organization of services and, thus for admissions.
Second line services, such as general surgery and basic specialties, are to be offered in each region through the hospital system. Tertiary and quaternary services are offered through the university hospitals, which exist in Montreal, Quebec City, and Sherbrooke. Each region offers rehabilitation and specialized youth services.

This, in general terms, is the “default setting” for service organization in Quebec. The exercise of determining the organization of services in English can be understood as one of determining the extent to which English-language services will be provided according to this “default setting” or along the lines of a special model which takes into account both resource availability and critical mass of clientele.

**The impact of regionalized budgets on English-language service organization**

It is useful to note that the same dispositions that give authority for planning and organization of services to the regional board also confer on that structure the ability to allocate budgets in function of those service plans. While the total dollars available are fixed by the government and apportioned between regions by the Department of Health and Social Services, this budgetary authority creates a strong dynamic towards regional self-sufficiency. This dynamic of regional budgeting has not always fit easily with the pan-provincial mandate of “Anglophone” institutions, and has tended to have a chilling effect on the willingness of regions outside of Montreal to make use of Montreal’s Anglophone institutions to provide certain English-language services.
The constraints on the right to service

While the right to services is a broad one, the constraints are significant. First, the limitation of organization and resources appears in two of the three central sections of the Act dealing with access. This is in addition to the general limitation as to organization and resources which appears in section 13 of the Act respecting health and social services and which acts as a limit on the right to choose the institution from which one receives health and social services.

Essentially, these constraints leave planners with a fairly straightforward choice: either develop the capacity of most or all institutions to provide services in English, or adjust the overall model for service organization so that English-speaking clients have ready access to those institutions which are able to provide services in English. The orientation may vary from one region to another, consistent with the regional approach to service planning. The underlying principle, however, is consistent: without requiring that all institutions deliver all services in English as well as in French, the legislation requires that the regional board prepare a plan which will guarantee the range of services (“aux services” in section 348) so that every English-speaking person may enjoy the right to receive services (“des services” in section 15) in English. Regional boards may call upon their own resources or upon the resources of other regions in order to provide a complete range of services.

The Charter of the French language

A discussion of the constraints on the ability of institutions to provide health and social services in English is incomplete without a review of sections 45 and 46 of the Charter of the French language. These sections deal with what is commonly referred to as the “language of work”.

SECTION ONE – BACKGROUND AND CURRENT STATUS
The overall objective of the Charter of the French language is the promotion of the French language in Quebec, and in particular its status as the normal language of public communication, particularly within the civil administration. The civil administration is defined as including virtually all public services, including those provided by the health and social services network.

As part of this overall objective, the Charter seeks to ensure that an appropriate knowledge of French is the only language requirement attached to most jobs, and that knowledge of other languages is required only on an exceptional basis:

45. Il est interdit à un employeur de congédier, de mettre à pied, le rétrograder ou déplacer un membre de son personnel pour la seule raison que ce dernier ne parle que le français ou qu’il ne connaît pas suffisamment une langue donnée autre que la langue officielle

46. Il est interdit à un employeur d’exiger pour l’accès à un emploi ou à un poste, la connaissance d’une langue autre que la langue officielle, à moins que l’accomplissement de la tâche ne nécessite la connaissance de cette autre langue.

To the extent that the formal requirement of a knowledge of English figures among the levers available to health and social service institutions which wish to make their services available in English, these legislative dispositions can act as a significant constraint upon their ability to provide services.
The 1999 access plans

In the spring and summer of 1999, the Government of Quebec approved a decree for each region of Quebec, pursuant to the access program foreseen in section 348 of the Act respecting health and social services. The Provincial Committee on the Dispensing of Health and Social services in the English language, which is created in virtue of section 509 of the Act and which is mandated to advise the government on the delivery of health and social services in English and the approval, evaluation, and modification of each access program, subsequently prepared a report on the Government process of approval of the 1999 access programs.

In general, the Committee concluded that the Government’s process “produced satisfactory results in nine regions”, including

- Bas-St-Laurent
- Estrie
- Montréal-Centre
- Outaouais
- Gaspésie-Îles-de-la-Madeleine
- Chaudière-Appalaches
- Laval
- Lanaudière
- Montérégie
In four regions, the decrees “significantly reduced access to English-language services within the region”. They are:

Saguenay-Lac-Saint-Jean
Mauricie - Centre-du-Québec
Abitibi-Témiscamingue
Laurentides

In three other regions, the Provincial Committee concluded that the process resulted in “weakened” access programs.

Québec
Côte-Nord
Nord-du-Québec

The Committee review further concluded that “the failure to complete inter-regional arrangements and reflect them in the Decrees is “contrary to section 348 governing joint development of access programs between regions. This will seriously undermine the assurance that services that are not accessible in one region will be accessible in another”.

“The process of Government approval is incomplete as it currently stands. As they currently read, the decrees include restrictive wording that is inconsistent with the legislator’s intent. Notably, whereas the wording of section 348 calls for an access program to health and social services” the decrees refer to a program of access to some health services and some social services”.

Finally, the report of the Provincial Committee points out that the government “must approve a decree in virtue of section 508 which designates institutions recognized under section 29.1 of the Charter of the French language and which
are required to make the health and social services they provide accessible in English”. This decree has not been amended since it was originally adopted in 1987: there are 40% fewer designated health and social service institutions today than there were at that time, and many of their mandates are significantly changed. (Provincial Committee on the Dispensing of Health and Social services in the English language, Report on the Decrees adopted by the Government of Quebec concerning programs of access to health and social services in the English language – 1999, November 1999, unpublished draft)


In addition to the administrative constraints on the legal right to service in English created by the overall structure of the system and the availability of bilingual resources to provide service in English, and the legal and political constraints created by the Charter of the French language and the right to work in French, recent political developments bear brief discussion.

The Quebec Estates General on the Future of the French language (The Larose Commission) recently carried out a major consultation on the status and future of French in Quebec. Among its findings, we note several which relate directly to the access provisions currently in place within the health and social services system. While the Commission’s role was to consult and formulate recommendations, and the Government has yet to indicate what if any action it intends to take with regard to the many recommendations submitted, we note that the Department itself had indicated informally that it wished to await the report of the Larose Commission before moving forward with an anticipated review of access programs in the fall of 2001.
The report of the Larose Commission acknowledges that access to English-language health and social services is a major preoccupation for English-speaking Quebecers, and confirms that a large number of organizations and individuals came forward to express their concern about this area. The report also concludes that there is broad public support within Quebec for the continued delivery of services in English.

The Larose Commission recommends the extension of the Department of Health and Social Services internal language policy to public health institutions. This internal policy is significantly more restrictive than the Charter itself, and would have the impact of significantly chilling the climate of goodwill that has prevailed in many health and social service institutions. (Le français, une langue pour tout le monde, Commission des États généraux sur la situation et l’avenir de la langue française au Québec, 2001, ISBN 2-550-37925-X, page. 117).

The Larose Commission concludes that a relatively small number of complaints about access to English-language services is evidence that there is in fact no real problem with such access (ibid, page 115.) The Commission’s conclusion is that the real political problem in access stems from a 1994 administrative recommendation that bilingual posts be identified in order to ensure access. The Commission report then concludes that the access provisions as implemented have had the effect of causing a significant increase in the number of positions requiring English, while concluding that the personnel of the health and social services sector is, in any event, bilingual, and such requirements are therefore abusive and unduly inflammatory.

The Larose Commission thus recommends that the Department of Health and Social Services of Quebec reposition the right to receive services in English within the broad notion of professional competence, rather than on a specific linguistic requirement attached to a given position. (Ibid, Recommendation 103,
Thus, the right to work exclusively in French should effectively have primacy over the right of clients to receive health and social services in English.

Should this recommendation be implemented, institutions and organizations which are controlled and managed by the English-speaking community will likely return to their earlier role as the sole reliable source of English-language health and social services. In effect, repositioning the right to service within the notion of voluntary measures and broad professional competency will almost certainly have the effect of removing virtually all mandated services from regional access plans of all but a few regions.

Since, as will be discussed in Section Three, the level of access to services is already so poor in those regions with small English-speaking communities and no community-controlled resources, there is strong support for a strategic approach that places those institutions and organizations which are controlled and managed by the English-speaking communities of Quebec at the front and center of efforts to improve access to services. Simply put, it is by improving access to these service sources for residents of the entire province that we are most likely to improve access to services in English.

The “Anglophone” Institutional network

*The evolution of control and management of minority health and social service institutions in Quebec*

Like a large number of health and social service institutions in Canada, Quebec’s “Anglophone” institutions have their origins in the period preceding the inception of the Medicare system as we now know it. In particular, many institutions have their origins in the 19th and early 20th centuries, and have since undergone repeated changes in their physical location and mandate.
The Montreal Extended-Care Centre is located in Montreal’s East Island, where it was established by the Molson family; the Mount Saint-Patrick’s home for Children cared for Irish orphans, the Julius Richardson Hospital began as a riverfront convalescent centre for World War I veterans who were recovering from gas poisoning, and later was a pediatric tuberculosis treatment centre. The Protestant Ladies’ Home and the Jeffrey Hale Hospitals were built in Quebec City as a nursing home and an acute care hospital providing services to the local English-speaking communities.

Today, the Montreal Extended Care is merged with another nursing home, and is known as the Grace Dart Extended Care Centre. Mount Saint-Patrick’s was merged with three other institutions in 1993, and is part of the Batshaw Youth and Family Centres. Julius Richardson is known as the Richardson Hospital, and operates both convalescent and rehabilitation beds as well as a separate chronic care facility called Henri-Bradet. The Board of Directors of the Protestant Ladies Asylum sold the property in 1990, and part of the proceeds were used to start the Holland Centre in Quebec City. The Jeffrey Hale Hospital was closed as an acute care facility in 1995, and now operates chronic care beds and an outpatient medical department. The Holland Centre is located in its former nurse’s residence.

There are but a few illustrations of the dynamic situation of the health and social service institutions serving Quebec’s English-speaking communities. The institutions of the majority community have experienced similar changes, to be sure, but the impact of the institutions on the minority community itself is qualitatively and quantitatively different.

As an illustration of this fact, we have only to compare the list of Health and social services institutions recognized under the dispositions of the Charter of the French Language in 1989 with the register of public health and social service institutions for 2000-2001. The reductions are striking. In 1898, there were 86
recognized Anglophone health and social service institutions, the vast majority of them public. A mere ten years later, less than half of those institutions were still open and operating with their previous mandate and scope; 20% of the institutions had closed outright, and 29% of them had undergone administrative mergers with other Anglophone institutions. Four had merged with Francophone institutions.

This contraction and reorganization took place, it should be noted, in a context of dramatic budget cuts and consequential rationalization. Increasingly, as is the trend in all societies seeking ways to contain spiraling health care costs, ultra-specialized services were concentrated in unique regional centres. In Montreal, where the McGill and Université de Montréal medical faculties support two distinct networks of teaching hospitals, administrative decisions frequently resulted in the Francophone institution being named the mandatory for service provision. «Thus, when called upon to designate a single treatment centre for spinal cord injuries for Western Quebec, Sacré-Cœur Hospital was chosen over the Montreal General Hospital. When the Commission de Santé et de Sécurité au travail (CSST), (the provincial workers compensation board), developed a multimillion dollar contract for a pilot site to test a new approach to lower back injury rehabilitation, the contract was given to the Francophone rehabilitation centre. When resources are limited, it is normal and correct to concentrate specialized services in order to increase efficiency. But when there are two equivalent institutions, one of which is associated with the majority community, the weight of the system naturally favors the majority community institution.

In part in the face of this reality, Anglophone institutions increasingly distanced themselves, at least in their public discourse, from their linguistic identity. For the purposes of their presentation to the system at large, at the very least, they came to think of themselves as Quebec institutions serving the English-speaking community among others, rather than as solely serving the minority linguistic communities.

SECTION ONE – BACKGROUND AND CURRENT STATUS
Simultaneously, the demographic changes following the so-called “Anglophone exodus” of the early 80’s began to make itself felt at the level of the institutional staff. Whereas the staff of these institutions had previously been made up almost entirely of English-speaking workers, the institutional staff, both at the line and administrative levels, increasingly included bilingual Francophones.

**Historical evolution and Charter status**

During the 1960’s and 70’s, educational and health and social service institutions in particular were increasingly taken under the control of the state in keeping with the increasing view of these services as “public”. The adoption of the Canada Health Act ensured that these institutions would be freely accessible to all Canadians. With public funding, however, came public control.

In 1977, The Government of Quebec adopted the Charter of the French language. The primary goal of the Charter was to create a framework in which French would become the normative language of communication and business within the public administration of Quebec. Subsequently, the Government created an exemption that gives practical expression to the preamble of the Charter, which indicates the National Assembly’s intention to respect the institutions of Quebec’s English-speaking and minority communities.

Thus, the Charter creates a special category of “minority” institution. It defines minority institutions as being those whose clients or constituents are, in simple majority of 50% plus one, members of a minority community. In this way, the reality that predated the Charter, namely that a number of institutions existed that had been founded by the English-speaking communities and which continued to operate largely, if not exclusively in English, was in theory translated into a list of institutions recognized as being “minority” institutions.
This special status, or recognition, is conferred under section 29.1 of the Charter of the French language. It is only in recognized institutions that public-sector employees have the legal right to work, to post signs, and to produce official correspondence in a language other than French. All employees working in contact with clients in recognized institutions must be able to provide services in French. All recognized institutions provide periodic detailed reports to the Office de la Langue Française, which is mandated to ensure their compliance with francisation requirements. With three exceptions, all recognized institutions are majority English: these exceptions are the Chinese Hospital, The Polish Welfare Institute, and Santa Cabrini Hospital.

In practical terms, it is only in such institutions that clients will hear staff conversing with one another in English; it is only in such institutions that the notice of the users’ committee meeting or the clinic hours may be posted in English; it is only in these institutions that the board meeting will take place in English. These recognized institutions are the only bilingual health and social service institutions in Quebec.

**The key role of Anglophone institutions in the delivery of English-language services**

Silver correctly notes in his discussion of the origins of legislative guarantees for English-language health and social services that the majority of English-speaking Quebecers, living in the Montreal area, already had access to English language health and social services via the community institutional network. Outside of Montreal, access to English-language services had always been significantly more problematic.
However, the community only began to contemplate the need for legislative guarantees when faced with the likelihood that services previously offered through the “Anglophone” institutional network would subsequently be provided via institutions such as CLSCs where there was limited availability of English-language services. Legislative guarantees thus had the potential to significantly improve access to English-language health and social services outside the metropolitan Montreal area while simultaneously preserving a stable level of access to these services in Montreal as the locus of service delivery shifted from “Anglophone” to “Francophone” institutions.

Moreover, we observe a recurrent leitmotif of system transformation as catalyst for the evolution of minority-language service guarantees. The same phenomenon occurred in 1991 when Quebec’s Act respecting health and social services was entirely replaced, and again in 1992 when additional enabling legislation was adopted. It occurred most recently in 2001, as the Government adopted amendments aimed at ensuring tighter administrative control over institutions and regional planning in a context of severe and ongoing financial constraint.

This leitmotif underscores the underlying reality faced by Quebec’s minority language communities: the institutional network which is both the most reliable source of service and the bulwark of the community itself is under constant and increasing pressure from a variety of external forces.

The legal right to service in English as it is currently constructed in Quebec’s health care legislation is predicated upon the presence of a robust and otherwise accessible institutional network that provides a broad range of basic and specialized services in English. Absent the institutional network, the dual constraints of resource availability and political will would render the other guarantees of English-language service provided by the Act respecting health and social services entirely inadequate to ensure access to the range of services.
It follows that if, as suggested by the Larose Commission, there are significant changes to the application of the right of access to services in English through Francophone institutions, then it will be necessary to re-appraise the role, mandate, and protections which will be necessary to ensure the capacity of the Anglophone institutional network to provide services.

**Institutions are central to minority community vitality: The Montfort decision**

It is of some interest to review the recent history of services delivered by the Montfort Hospital, as related in of the Ontario Superior Court of Justice. Founded in 1953, the hospital had an original capacity of 252 beds. When the Commission began its work in 1995-96, the hospital was one of 6 acute care hospitals in the Ottawa-Carleton area that maintained emergency services. However, the judgment also notes that by the time the Commission began its work, 56 of the hospital beds had been taken out of service, for a reduction of 22% over 40 years. In addition, the judgment points out that the hospital had lost its pediatric services in 1974 with the creation of the Children’s Hospital of Eastern Ontario.

This “natural history” of the Montfort Hospital is of interest precisely because it so closely evokes the situation of the health and social services institutions of the English-speaking communities of Quebec. In effect, the erosion of Montfort’s services and scope began well before the Ontario Health Services Restructuring Commission tabled its recommendations. While Quebec’s English-speaking communities obviously benefit from a significantly larger and more comprehensive range of institutions than do the Francophone minorities of the other provinces, these institutions are subjected to identical pressures of transformation and rationalization.
That institutions are necessary to the existence of a community is so critical a concept that a recent Divisional Court judgment of the Ontario Superior Court of Justice held that the decision of the Ontario Health Services Restructuring Commission to significantly transform the mandate of the Hôpital Montfort should be quashed because it did not take into account the social role of minority community institutions. Referring to evidence given by Dr. Raymond Breton and Dr. Roger Bernard, experts in the social trends affecting the existence and viability of minority communities, the judgment states that

“. . . institutions are vital to the survival of cultural communities. They are much more than providers of services. They are linguistic and cultural milieus which provide individuals with the means of affirming and expressing their cultural identity, and which by extension permit them to reaffirm their cultural adherence to a community. The individual and the family alone are incapable of maintaining the linguistic and cultural identity of a community. Thus, these institutions must exist in as wide a range of spheres of social activities as possible in order to permit the minority community to develop and maintain its vitality”.

When the institutions that serve and which are the backbone of a minority community are supported by public funds within a policy framework that is dominated by the needs of majority community, it is inevitable that those institutions should experience differential impacts of the broader public policy cycle. No deliberate or overt malice is required for that process to be destructive; the simple dynamics of policy change render such transitions disproportionately perilous for minority institutions.

As Quebec’s English-speaking minority is uniquely well-served by a network of public institutions, so it is uniquely threatened by the systemic changes affecting those institutions.
The Clair Commission and current dynamics

This was precisely the issue which gave rise to Quebec’s recent Commission d’étude sur les services de santé et les services sociaux, which, under the leadership of former Deputy Minister of Finance Michel Clair, published its report in January of 2001. The Clair Commission, in its report and recommendations, identifies its major recommendations as being the creation of “family medicine practice groups, networks of integrated services, especially for those with reduced autonomy, homogeneous services in all CLSCs, especially for the young, local, regional, and supra-regional hospitals with clear mandates and linked by service corridors and graduated medical services.

In order to achieve these objectives, the Clair Commission recommends a number of concrete measures, including the radical restructuring of regional and institutional boards of directors, the creation of a clear and unequivocal chain of command between the Department of Health and Social Services and each institution via the regional board, the continued integration of first and second-line institutions to create territorially based service delivery units providing both first line health and social services and residential services for seniors as well as local hospital services under the management of a single board of directors, and the creation of practice groups in family medicine which would receive a fixed per-client annual budget through rostering.

These recommendations scarcely take place in a vacuum. Indeed, they can be best understood within the context of the report of the Rochon Commission, flowing from a more comprehensive public consultation exercise in the mid 1980’s. Certainly, the suggestion that a single board or directors should manage, for any given CLSC territory, the CLSC, nursing home(s) and hospitals can be found in the White paper tabled by Thérèse Lavoie-Roux, Quebec Minister of
Health and Social services from 1986 to 1991. And the vast array of institutional mergers occasioned by the 1992 Act respecting health and social services, still in force, follows precisely this logic of reducing the number of institutional structures in order to improve efficiency, complementarity, and coordination.

It is worth noting that this model of single boards managing multiple service sites is found in a number of other jurisdictions: for example, in Alberta, 100% of health and social service institutions are under the control of a single, regional board. If this same model were to be implemented in Quebec, the English-speaking community would in one single stroke lose its capacity to control and manage each and every health and social service institution that it founded.

The Clair recommendations, if implemented in their current form, are equally certain to have a dramatic effect on the level of access that English-speaking Quebeckers currently enjoy to services in their language. And while this impact will be fairly subtle in the short run, they are likely to be dramatic in the medium and long term. The proposed changes will significantly reduce the numbers of “Anglophone” institutions, both by merging Anglophone institutions together and by merging Anglophone institutions with Francophone institutions. Institutions merged in this latter fashion will lose their recognized status and therefore the capacity to function as a “bilingual” institution.

Beyond service delivery, the ongoing reduction of the institutional network can only diminish the viability of the English-speaking community itself. And while the English language Quebec clearly does not exist under the same level of threat as does the French language outside of Quebec, it would be grave error to equate the future of the language with the future of the community.

The suggested changes will also drastically diminish institutional links with the English-speaking communities, by placing control over the membership of the boards of directors and of the executive director outside the community’s hands.
The proposals would further restrain the ability of English-speaking clients to gain access to specialized services offered in Anglophone institutions, and would likely reduce the scope of the specialized services they offer. In addition, the proposed changes to medical practice, particularly around rostering, may diminish client choice and thus threaten access to the single most reliable source of English-language services, the physician.

The evolution of Government support

The Canada-Quebec Agreements and the funding of regional coordination

In 1989, the Government of Canada and the Government of Quebec entered into the first of two five-year shared financing programs aimed at supporting Quebec’s initiatives to promote access to health and social services in English for English-speaking Quebecers. In the first five-year agreement, a total of 1,11 million dollars per year on a 50%/50% basis for a total investment of 2.775 million dollars from each partner over the term of the five-year agreement.

As it was originally agreed upon, the Canada-Quebec agreement included funding for three priority areas: regional coordination for English-language health and social services, the creation and maintenance of a documentation centre and the translation of documents which could be made available to all English-speaking clients, and the support for volunteer activities. In the third year of the agreement, three new administrative regions were created, with the consequence that the level of regional funding was reduced in order to accommodate the new regions.

In practical terms, the agreement financed a network of staff positions based at the level of each regional council (later regional board). As public employees working directly for the planning structure responsible for the planning and
coordination of health and social services, these strategic positions had the effect of providing a specific locus for the development of expertise on the adaptation of services to the needs of the English-speaking population of each region. In addition, the regional coordinator in each region was responsible for ensuring community participation through the means of the regional advisory committee on English language health and social services. This committee ensured that the regional board was in regular direct contact with English-speaking citizens, and that those citizens had the means to participate in the regional decision-making process.

This is how the Provincial Committee on the Dispensing of Health and Social services in the English Language summarized the role of the regional coordinator:

“Apart from the core activity of communication and liaison with the community and institutions, here are some other aspects of the coordination function that have developed in the last decade:

- Liaison with the regional councils or regional boards to inform the different directorates of the needs of English-speaking people;
- Involvement in the development of regional plans for the organization of services
- Involvement in studies of needs, surveys, and the development of inventories of resources accessible in English;
- Support of other measures such as translation, information, joint projects; and grants to volunteer organizations;
- Application of measures to support the 1989 access program;
- Distribution of information pertinent to the 1991 Reform and amendments to the Act;
- Promotion of the participation of English-speaking people on the boards of institutions;
Support for the regional access committees;
Preparation of the new access programs.

The Department’s assessment of the role of the coordinator at the end of the first agreement is best summed up as follows:

“In summary, the Department considers that the coordinators have made and indispensable contribution to the improvement of accessibility of services in English at the regional level.” (Assessment of the Canada-Quebec agreement, Secretary of State for Canada and the Department of Health and Social Services (Quebec), July, 1993, p. 15, as cited in Opinion concerning the Canada-Quebec agreement of Canada’s contribution to Quebec's initiatives promoting access to health and social services for English-speaking persons in their own language, The Provincial committee of the dispensing of health and social services in the English language, May 1999, page 13).

Beyond funding the coordinator positions, the entente provided basic funding to the regions for a variety of specific measures aimed at improving access to health and social services in English. These measures included the translation of documents, the creation and maintenance of a documentation centre housed at the provincial association of CLSCs, the provision of English-second-language training for employees in targeted institutions, publicity concerning the legal right to service in English, and the financing of activities in community organizations working with the English-speaking population. In 1992-1993, for example roughly half of the total budget of 1.11 million dollars was spent on activities other than coordination. Thus regional coordinators were provided with specific tools which allowed them to invest in the development of English language services according to the needs of each region, and province-wide programs like the documentation bank and volunteer training were also funded.
In the second phase of the Federal-Provincial agreement, the Government of Canada began to decrease its contribution to the agreement, leading Quebec to do likewise. The Annual appendices of the Canada-Quebec Agreement show that between 1990-91 and 1998-99, total funding was cut by more than a third, from an original annual amount of 1.11 million to a total annual amount of 718,000 dollars.

It is notable that, as the Government of Canada began, in the context of overall budget constraints of that period, to reduce its contribution to the agreement, the Government of Quebec made up the difference until 1997-98, when it, too reduced funding.

The following data is drawn from the Annual appendices of the Canada-Quebec Agreement:

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<tr>
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<td>98-99</td>
<td>718,000</td>
<td>359,000</td>
<td>359,000</td>
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</tbody>
</table>

Figure 1.1
In practice, what this reduction meant was that there was a virtual elimination of all activities other than coordination. While the coordination element is clearly among the most critical of the measures financed, the virtual termination of any discretionary budget left the regional coordinators with few means at their disposal other than moral suasion and political leadership on the part of the regional boards when it came to the development of English language accessibility.

Following the termination of the Federal-Provincial agreement in 1999, Government of Canada offered to re-negotiate the Federal-Provincial agreement. That offer remains an active one on the part of the Department of Canadian
Heritage. However, the Government of Quebec declined to re-negotiate the agreement. Since that time, annual allocations to the regional boards has steadily decreased, and coordination expenses exceeding 50% of the total allocation are specifically excluded. A number of regional boards have supplemented this budget from within their recurrent global funding and have made the regional coordinator positions permanent.

Other funding

The Department of Canadian Heritage funded a major translation project through the English-speaking Catholic Council, the Omnibus survey of the attitudes and experiences of English-speaking Quebecers through the Missisquoi Institute, and a number of other, smaller projects.

In another initiative, the Department of Canadian Heritage, with the participation of the Quebec Community Groups Network, has provided funding to the Community Health and Social Services Network (CHSSN). (Core funding in 200-2002 of $60,000.00. The CHSSN is a network of organizations that are collectively concerned with the provision of English-language health and social services. The CHSSN is currently finalizing a portal project that will permit access to a wide range of web-based information concerning health and social services in Quebec.

Conclusion

The legislative guarantees which were integrated into the Act respecting health and social services in the 1980’s are predicated upon the presence of a robust and accessible network of Anglophone Institutions. For these guarantees to operate as they were intended, moreover, a number of factors need to be in place. These factors include political willingness on the part of the Government
of Quebec, participation and support by the administrative structures involved at the regional level, an ongoing commitment on the part of institutions and their staff, and a capacity for community participation at the regional and provincial levels.

It is clear that the Anglophone institutional network has faced unprecedented pressures since the inception of legislative guarantees for English-language health and social services. Despite substantial efforts to adapt the legislative framework in order to maintain the necessary equilibrium between the protection of Anglophone institutions and the development of accessible services in Francophone institutions, the additional weight of an increasingly difficult political context and the reduction in funding to regional coordination has stymied the ongoing application of the right of access to services as set forth in section 15 of Quebec’s Act respecting health and social services. As the community’s institutional infrastructure continues to lose critical mass, it is increasingly likely that the range of services now provided in English will shrink.
SECTION ONE: IMPLICATIONS FOR AN ACTION PLAN

1. The legal framework that favors access to English-language health and social services in Quebec is significantly constrained by the political context in which it operates. An action plan will need to take this factor into account, and develop strategies that are insulated from the broader political climate. This implies that the communities themselves will need to be far more central to the development and implementation of specific activities aimed at promoting service accessibility.

2. The institutional network historically associated with the English-speaking community of Quebec is under major pressure from a variety of economic and structural causes, but remains the most reliable source of English-language service. An action plan will need to specifically foresee strategies which reinforce the capacity of these institutions to deliver services, and which serve also to strengthen the historical linkages between the institutions and the communities. These institutions should also be supported in developing strategic approaches that take into account their special status within the English-speaking minority community of Quebec.

3. Regional coordination has been a critical element in the development of access to services in English. Diminished support for coordination threatens the future development of services. It also threatens the capacity of various communities across the province to coordinate their activities at the pan-provincial level, sharing best practices and resources. An action plan should prioritize the development of a significant capacity for community coordination, both at the regional and provincial levels.
SECTION TWO

A Demographic Portrait of Quebec’s English-speaking communities

Highlights and key findings of the Demographic portrait

The demographic situations of Quebec’s English-speaking minority communities vary dramatically from one administrative region to another. A sound understanding of regional demographic issues is critical to the development of service delivery models which are adapted to local realities and which serve to enhance community vitality. In addition, these demographic factors are among known health determinants that may affect the health of a population.

Income and employment data from 1996 confirm that English speakers are on average no better off than their Francophone neighbors, despite the fact that they are on the whole better educated. In many regions, there is a substantially higher rate of unemployment among workforce aged English speakers than among French speakers, as well as higher proportions of elderly. The English-speaking community as a whole appears to be somewhat polarized along economic lines, with higher concentrations members at both ends of the economic spectrum.

As a result of out-migration, many regions have English-speaking populations whose ratio of caregivers to elderly is significantly lower
than average. This factor has direct implications for planning of certain services, particularly services to the elderly.

Selected demographic characteristics compiled by Mr. William Floch of the Department of Canadian Heritage permit the creation of a novel indicator for community demographic vitality, and support a comparison between regions for the purposes of assessing the level of community strength in each region and thus, the relative need for intervention and current capacity to support that intervention.

1. English-speaking minority communities in certain regions are at significantly greater disadvantage than others, both in terms of health indicators and community vitality.

2. General health indicators are significantly different between English speakers and French speakers living in many regions. However, despite greater economic polarization within the English-speaking population compared to the French-speaking population, median income levels are generally the same. An action plan must ensure that regional variations are specifically considered when regional strategies are developed.

3. The data presented strongly supports the need to carry out further research into the realities of Quebec’s English-speaking minority communities.
Section Two
A Demographic Portrait of Quebec’s English-speaking communities

The purpose of this section is to provide a basic demographic portrait of the English-speaking minority communities, both provincially and in each administrative region of Quebec. Regional data for some major health indicators is provided, including age, income, and level of education. For the purposes of comparison, similar data for the French-speaking majority of each region will be furnished. In conjunction with the information provided in section two, this material serves as a foundation for regional planning for activities aimed at improving access to English-language health and social services.

Income and health

The relationship between income and health is well established. “Despite the global reduction of mortality, despite medical progress, despite policies of universal access and free health and social services in many industrialized countries, the poor are less healthy and die younger than the rich”. (Social Inequalities in Health, Direction de la Santé Publique, Régie régionale de Montréal-Centre, 1998, p. 13)

But low income is not the single determinant of poverty. As the Montreal Department of Public Health points out, it is a “complex, multifaceted phenomenon, a set of cumulatively interactive material and social shortfalls: low schooling, poor housing, poor working conditions, economic inactivity, exclusion from the decision-making process – which, pushed to the extreme, lead to social exclusion” (ibid, p. 15.)
As we will see in both the provincial and regional data, English-speaking Quebecers have lower average income, higher unemployment rates, and higher proportions of those with extremely limited revenue than do French speakers, and this despite the fact that English speakers have significantly higher levels of education than do their French-speaking neighbors. A multivariate analysis would help to clarify this relationship.

The data, drawn from the most recent available census (1996), is based on the First Official Language Spoken definition of English-speaker. This fundamental choice bears explanation.

The choice of demographic indicator: First Official Language Spoken

The basic rationale for ensuring that services are delivered in the language of the client rests upon the principle that communication is a critical component in health and social service delivery. Sara Bowen, in a recent monograph published by Health Canada, states: “there is compelling evidence that language barriers have an adverse effect on access to health services. These barriers are not limited to encounters with physician and hospital care. Patients face significant barriers to health prevention/promotion programs: there is also evidence that they face significant barriers to first contact with a variety of providers.” Moreover, Bowen continues, “a review of the literature reveals consistent and significant differences in patients’ understanding of their conditions and compliance with treatment when a language barrier is present.” (Language Barriers in Access to Health Care, Health Canada, Health Systems Division, Health Policy and Communications Branch, Sarah Bowen and Joseph Kaufert, 2001, pVI).

As language is so central to the delivery of service, Quebec’s minority language community must, for the purposes of this exercise, include all those who are
likely to choose to express themselves in English when they interact with a health or social service provider. Clearly, and particularly in certain regions, this group will include a certain number of persons whose first language or language spoken at home is not English.

Moreover, the criteria of First Official Language Spoken was the one used to include respondents in the CROP-Missisquoi survey discussed in Section two.

Since Health Canada’s primary mandate is to promote Canadians’ health, first official language spoken best fits the service objectives of this exercise. But we must not neglect the context in which this exercise is taking place: one of a commitment to enhance the vitality of minority language communities. Demographic growth is an essential element to the vitality of any community, and the integration of new members is a primary source of demographic growth for all segments of Canada’s increasingly diverse and multi-cultural society. Indeed, Quebec’s English-speaking community is already among the most diverse of any group in Canada.

The inclusion of those whose first language is neither English nor French in the broad group of citizens who will choose to receive their health and social services in English in Quebec is therefore both an acknowledgement of a reality that has existed for several generations and a validation of in-migration as a legitimate and appropriate contributor to the vitality of Quebec’s minority language community.

It should therefore be noted that all data cited in this section refers to FOLS (first official language spoken) unless specified otherwise. It should also be noted that the income figures are for individuals, rather than for households; a more detailed analysis of regional poverty among English and French speakers would need to examine household income and take into account local cost of living as a measure of the poverty line in each region.
Finally, unless otherwise noted we have, used proportionately distributed multiple responses for the purpose of establishing the First Official Language Spoken figures.

**Provincial data**

Before examining the distribution and features of Quebec’s English-speaking minority communities, it is useful to place their total size in the context of all Canadian minority linguistic communities. As a percentage of the total provincial population, only the Francophone population of New Brunswick represents a larger percentage of the total provincial population.

![Diagram of Official Language Minorities Across Canada](image)

**Relative Share of Province/Territory’s Population**

Source: Department of Canadian Heritage, Quebec Regional Office. Based on 1996 Census of Canada.

**figure 2.1**
Distribution of the English-speaking communities: Quebec’s Administrative Regions

The 1996 census shows that in a total Quebec population (FOLS with proportionate distribution of multiple responses) of 6,975,531, 6,049,701, or 86.7%, identified French as their first official language spoken. 925,830, or 13.3%, identified English as the official language in which they were most comfortable.

Quebec’s minority linguistic community is heavily concentrated in the metropolitan Montreal region, but is present in each administrative region. In contrast, Quebec's majority communities are much more evenly distributed across each administrative region of Quebec.
The consequences of this uneven distribution of English-speaking population are evident: a concentration of Anglophone community resources in the regions where the community is more numerous, masking the limited services available to English speakers living in regions where the population is relatively small.

The particular problems faced by very small minority communities clearly affect a large number of Quebec's minority linguistic communities. In fact, Quebec’s minority communities represent a large number of Canadian minority communities with fewer than 20,000 persons.
**OL Communities Across Canada (less than 20,000)**

Community size (First official language spoken)

![Bar chart showing community size](image)

Source: Department of Canadian Heritage, Quebec Regional Office. Based on 1996 Census of Canada.

**Gender and Age distribution: Provincial**

There is no difference between English speakers and French speakers in terms of gender distribution: in both communities, women make up 51% of the population, while 49% of the population is male.

Overall, the English-speaking population is slightly older than the French-speaking population; 80% of French speakers are aged 54 or younger, compared to 78% of English speakers, whereas 22% or the English-speaking population of the Province as a whole is aged 55 or over compared to 18% of their French-speaking counterparts.
Education and Employment - Provincial

English speakers are, on the whole, better educated than French speakers. Among those aged 15 or over, 12% of the English-speaking population, compared to 18% of the French-speaking population, left school before grade 9. Conversely, 18% of English speakers had completed a bachelor degree or higher, compared to only 11% of French speakers.
figure 2.6

However, this higher educational level clearly does not translate into greater economic success for English speakers in Quebec.

Despite their significantly higher levels of education, adult English speakers had somewhat lower median income and a 12% higher rate of unemployment than did French speakers.

Across the province, 12.9% of English speakers were unemployed, compared to 11.5% of French speakers.

It is interesting to see how Quebec Anglophones compare to francophones on a region-by-region basis in terms of unemployment.
Quebec’s Anglophone and Francophone Communities
Unemployment Rates, 1996, by Region, by First Official Language Spoken

Source: Department of Canadian Heritage, Quebec Regional Office. Based on 1996 Census of Canada.

figure 2.7
Income - Provincial

Normally, a higher level of education increases your chances of finding a stable, well-paid job; it “improves your ability to run your life and deal with change; it reinforces the feeling that you have some control over your destiny. All these factors have a positive bearing on health” (Social Inequalities in Health, p.34). In the case of English speakers in Quebec, the equation between education and income does not seem to function consistently.

At $17,487 a year, French speakers have a slightly higher median employment income than English speakers at $17,416. We note a higher degree of economic polarization within the English-speaking population than among French speakers; 20% of English speakers, compared to 18% of French speakers, have incomes

SECTION TWO – DEMOGRAPHIC PORTRAIT
below $15,000 a year; 4% of English speakers compared to 2% of French speakers have annual incomes of more than $75,000.

However, while English speakers make up 12% of the total Quebec population, they represent 13.2% of those with less than $2000 a year in income. As we will see in the discussion of regional data, this latter indicator shows some very pronounced regional variations.

In effect, the higher educational levels of English speakers should translate into a higher concentration of the population in the higher income brackets: as shown in figures 2.5 and 2.6, English speakers and French speakers have nearly identical percentages of population in the lower income brackets.

SECTION TWO – DEMOGRAPHIC PORTRAIT
Building on Our Strengths
Health and social services in English in Quebec

Figure 2.10
Income Among English-speaking Quebecers

- 36%
- 34%
- 8%
- 4%

Figure 2.11
Income Among French-speaking Quebecers

- 36%
- 35%
- 20%
- 7%
- 2%

SECTION TWO – DEMOGRAPHIC PORTRAIT


Towards a standard demographic indicator for community vitality

The notion of community vitality is central to this exercise; as has already been mentioned more than once, the objective of improving access to English-language health and social services for Quebec's minority communities is inscribed in an legislative mandate which has community development as its central focus.

Section 42 of the Official Languages Act mandates the Minister of Canadian Heritage to promote and encourage a coordinated approach to the Government's commitments to enhancing the vitality of English-speaking minority communities as described in Section 41. In that context, Committee-member William Floch, Manager, Research and Policy Development, Official Languages Programs Branch of the Department of Canadian Heritage, has recently undertaken work on the development of a standard set of indicators that can be used to help assess local minority community vitality. While this work is not yet complete, its results to date provide material that is significantly more pertinent than anything else currently available. It is therefore included in this report with Mr. Floch's permission.

A variety of factors may be said to reflect and impact minority community vitality. In general, community vitality is a function of the interaction between a local community's strengths and the challenges that it faces. Indicators of community strength include overall size and relative size within the regional majority, bilingualism, internal age structure, income and employment, access to community-controlled institutions and service providers including health and social service providers, schools, churches, and the like. For the purposes of this report, we have chosen to present a limited number of these factors in the data presented on each region, and we have further classified the relative level of community vitality (very low, low, average, high, or very high) yielded by the

SECTION TWO – DEMOGRAPHIC PORTRAIT
aggregate rankings for each region. We note that no weighting has been assigned to the importance of the various factors included for the purposes of calculating the rankings.

Among the more interesting elements that are included in the community vitality measure, we find the notion of caregiver ratio. This ratio places the number of elderly in a community in a ration with the number of those in the care-giving age cohort (35-54), and allows a relative rank to be created. This same measure can be used to compare the presence of caregivers in the English-speaking community to the presence of caregivers in the French-speaking population of the same region. It thus becomes possible to identify those regions that are locally different from their neighbors in this crucial regard. The following map illustrates this particular use of the data.
Regional data

Region 01 Bas-St-Laurent

The English-speaking population of Bas St-Laurent is very small, with only 890 persons in a total regional FOLS population of 202 095, for a proportion of less than half of one percent.

The majority and minority communities compare as follows for age distribution:

Among those aged 15 and over, 23% of French-speaking residents of the Bas-St-Laurent had less than a grade 9 education. In the same group of English speakers, only 5% had less than a grade 9 education. This disparity is likely due to the fact that a large number English speakers in this region are relatively well-educated employees of a research institute located in Rimouski. This likely also
accounts for the fact that this is one of the few regions in which the percentage of English speakers in the 20-54 age cohort is larger than the corresponding percentage in the French-speaking population.

Income distribution for English speakers and French speakers for Region 01 is as follows:

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 7.7% of the Bas-St-Laurent ‘s English-speaking community is over the age of 65, there is an unemployment rate of 17.7%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 4.5:1, and an 89.6% level of bilingualism. Together with the size of the local community and its proportion within the population of the region, this data yields a very low vitality rating (1) on a five-point scale.
Region 02  Saguenay-Lac St-Jean

Out of 283 360 residents of the Saguenay region, 1630 have English as their first official language spoken. This represents about .6% of the regional population.

The majority and minority communities compare as follows for age distribution:

![Region 02 Age distribution](image)

113 440 French-speaking residents of the Saguenay are aged 15 or over, and 18% of them did not complete Grade 9. Among English speakers, 13% had not completed grade 9.

Income distribution for English speakers and French speakers for Region 02 is as follows:
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 10.9% of the Saguenay's English-speaking community is over the age of 65, there is an unemployment rate of 15.7%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 3:3:1 and an 92.1% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very low vitality rating (1) on a five-point scale.

Region 03 Quebec

The region of Quebec has a total FOLS population of 624 785, of whom 11 585, or 1.8%, speak English as their first official language.

The majority and minority communities compare as follows for age distribution:
It is worth noting that 25% of Quebec region's English-speaking population is aged 55 or over, compared to 21% of the region's French-speaking population.

Among Quebec region residents aged 15 and over, 16% of French speakers, compared to 8% of English speakers, had not completed grade 9. Despite the fact that the proportion of French speakers with limited education was twice as large as the proportion of English speakers, the percentage of those with less than $12,000 a year in income or less was virtually identical for the two language communities.

While twice as many French speakers as English–speakers in this region did not complete grade 9, similar proportions of the two communities had income of $12,000 or less. A somewhat larger proportion of the English speakers than French speakers of this region falls into the higher income brackets. Income
distribution for English speakers and French speakers for Region 03 is as follows:

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 15.6% of the Quebec region’s English-speaking community is over the age of 65, there is an unemployment rate of 11.9%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 2.1:1 and an 89.5% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields an average vitality rating (3) on a five-point scale.

Region 04  Mauricie – Centre du Quebec

The region of Mauricie – Centre du Quebec has a total FOLS single response population of 466,995, of whom 5,705, or 1.2%, speak English as their first official language.
The majority and minority communities of the Mauricie-Bois Francs compare as follows for age distribution:

![Region 04 Age distribution](image)

27% of English speakers, compared to 22% of French speakers, are aged 55 and over.

Among French-speaking residents of Region 04, 22% of those aged 15 and over had not completed grade 9. Among English-speaking residents of this region, the proportion not having completed grade 9 is 11%. In this region, 8.8% of Francophones compared to 7.6% of Anglophones had less than $2,000 a year in income. We are unable to provide detailed income distribution figures for this region at this time.

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 18.4% of the Mauricie’s English-speaking community is over the age of 65, there is an unemployment rate of

**SECTION TWO – DEMOGRAPHIC PORTRAIT**
13.1%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 1.6:1 and an 92% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very low vitality rating (1) on a five-point scale.

Region 05 Estrie

The region of Estrie has a total FOLS population of 273,325, of which 23,895, or 8.7% speak English as their first official language.

The majority and minority communities of Region 05 compare as follows for age distribution:
Some 19% of the 15-and-over French-speaking population of the Estrie had not completed grade 9. Among English speakers, this figure is 15%. Despite having a higher educational level, English speakers tended to be much poorer overall, with a higher proportion than Francophones in the lower income brackets and a similar concentration in the higher income brackets.

Income distribution for English speakers and French speakers for Region 05 is as follows:

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 19.8% of the Estrie’s English-speaking community is over the age of 65, there is an unemployment rate of 11.9%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 1.4:1 and an 63% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a low vitality rating (2) on a five-point scale.
Region 06 Montreal-Centre

The region of Montreal-Centre has a total FOLS population of 1,749,515, of whom 502,425, or 29%, speak English as their first official language.

The majority and minority communities compare as follows for age distribution:

In a Regional population of 768,790 French-speaking persons aged 15 and over, almost 20% had not completed grade 9. Among the 15-and-over English-speaking population, this figure is a little less than 12%. However, 8.76% of English speakers, compared to 7.73% of French speakers, had very low income (<$2000), and similar proportions were in the $12,000 and less income group. We note that while the proportion of those in the lower income brackets is similar for both communities, the percentage of English speakers with high income (over $75,000) is twice that of French speakers.

SECTION TWO – DEMOGRAPHIC PORTRAIT
Income distribution for English speakers and French speakers for Region 06 is as follows:

![Region 06- Comparison of Income Distribution](image)

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 13.3% of the Montreal region’s English-speaking community is over the age of 65, there is an unemployment rate of 13.4%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 2.1:1 and an 60% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very high vitality rating (5) on a five-point scale.

**Region 07 Outaouais**

The region of Outaouais has a total FOLS population of 305 365, of whom 51 765, or 17% speak English as their first official language.
The majority and minority communities of the Outaouais compare as follows for age distribution:

Among Outaouais French speakers aged 15 and over, 22% had less than a grade 9 education, whereas among English-speaking residents of the Outaouais aged 15 and over, this proportion is about 13%. There was nonetheless a higher proportion of Anglophones than Francophones in the lower income brackets.

Income distribution for English speakers and French speakers for Region 07 is as follows:
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 9.8% of the Outaouais region’s English-speaking community is over the age of 65, there is an unemployment rate of 11.8%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 3.2:1 and an 50.3% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very high vitality rating (5) on a five-point scale.

**Region 08 Abitibi-Témiscamingue**

The Abitibi has a total FOLS population of 152 550, of whom 6055 speak English as their first official language. This represents 4% of the regional population.
The majority and minority communities compare as follows for age distribution:

![Region 08 Age distribution](image)

Among French speakers aged 15 and over in the Abitibi-Témiscamingue region, 22% had less than a grade 9 education. Among English speakers, this proportion is 24%. This is one of only a few regions where the English-speaking population includes a larger cohort than the French-speaking population with low education.
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 14.4% of the Abitibi’s English-speaking community is over the age of 65, there is an unemployment rate of 15.3%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 2.0:1 and an 63.1% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very low vitality rating (1) on a five-point scale.

**Region 09  Cote-Nord**

The FOLS population of the Cote-Nord is 102 420, of which 5875, or 6% speak English as their first official language.

The majority and minority communities compare as follows for age distribution:
Among French speakers aged 15 and over in the Cote-Nord region, 22% had less than a grade 9 education. Among English speakers, this proportion is 50% higher at 33%. 8.87% of English speakers had less than $2000 in income, compared to 8.23% of French speakers. English speakers in this region show lower incomes overall, with three out of four (76%) reporting less than $30,000 in annual income, compared to two out of every three (67%) of French speakers.
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 8.9% of the Côte-Nord’s English-speaking community is over the age of 65, there is an unemployment rate of 42.2%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 3.1:1 and an 35.9% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a low vitality rating (2) on a five-point scale.

**Region 10 Nord-du-Quebec**

Region 10 has a large aboriginal population, and a significant percentage speak English as their first official language. Of a total population of 38 350, some 10 735 or 28% are English-speaking. We note that members of First Nations make up a significant portion of the English-speaking population of this region.

The majority and minority communities compare as follows for age distribution:
Among French speakers aged 15 and over in Region 10, 25% had less than a grade 9 education. Among English speakers, this proportion is 31%. 11.39% of English-speaking residents of region 10 had income of less than $2000, compared to 9.16% of French speakers. Overall, English-speaking residents are substantially poorer than French-speaking residents.
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 1.2% of the Nord-du-Quebec’s English-speaking community is over the age of 65, there is an unemployment rate of 17.3%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 20.4:1 and an 19.8% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very high vitality rating (5) on a five-point scale.

**Region 11  Gaspésie-les Îles de la Madeleine**

Region 11 has a total FOLS population of 104 170, and an English-speaking population of 10 405, or about 10%.

The majority and minority communities compare as follows for age distribution:
Among French speakers aged 15 and over Region 11, 26% had less than a grade 9 education. Among English speakers, this proportion is 24%. Despite similar educational levels, a much higher proportion of English speakers than French speakers had extremely low income (<$12 000).
Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 16% of the Gaspésie-les Îles English-speaking community is over the age of 65, there is an unemployment rate of 35.8%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 1.8:1 and an 43.5% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very low vitality rating (1) on a five-point scale.

**Region 12  Chaudière-Appalaches**

Region 12, which was formerly combined with the Quebec region, has a regional FOLS population of 374 805, and an English-speaking population of 3145, representing .8% of the regional population.

The majority and minority communities compare as follows for age distribution:
Among French speakers aged 15 and over in the Chaudière-Appalaches region, 22% had less than a grade 9 education. Among English speakers, this proportion is half as much as it for French speakers, at 10%. Nevertheless, 9.66%, or almost one in ten English speakers had income of less than $2000; this figure is 7.85% for French speakers.

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 10.9% of Chaudière-Appalaches’ English-speaking community is over the age of 65, there is an unemployment rate of 14.5%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 3.4:1 and an 86.5% level of bilingualism. Together with the size of the local community and its proportion within the regional
population as a whole, this data yields a low vitality rating (2) on a five-point scale.

**Region 13 Laval**

Region 13, Laval, has a total regional FOLS population of 326,610, of which 430,025 speak English as their first official language. English speakers comprise about 13% of the regional population.

The majority and minority communities compare as follows for age distribution:

![Region 13 Age distribution](image)

Among French speakers aged 15 and over in the Laval region, 16% had less than a grade 9 education. Among English speakers, this proportion is slightly higher at 17%. 26% more English speakers than French speakers had income of less than $2,000. Laval’s percentage of French-speaking residents with extremely low income (6.31%) is lower than that of any other region, whereas the
percentage of English speakers with extremely low income (7.94%) is the fourth-lowest in the province. Overall, a somewhat higher proportion of English speakers than French speakers fall into the lower income brackets.

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 9.2% of Laval’s English-speaking community is over the age of 65, there is an unemployment rate of 11.6%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 3.2:1 and an 69.3% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very high vitality rating (5) on a five-point scale.

Region 14 Lanaudière

Lanaudière, located to the north east of Montreal, has a regional FOLS population of 371 050, and an English-speaking population of 8205, or 2%.

The majority and minority communities compare as follows for age distribution:
Among French speakers aged 15 and over in Region 14, 19% had less than a grade 9 education. Among English speakers, this proportion is 16%. The two linguistic communities have similar rates of extremely low income (7.6% for Francophones and 7.68% for Anglophones).

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 15.9% of Lanaudière English-speaking community is over the age of 65, there is an unemployment rate of 14.1%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.3:1) of 2.2:1 and an 82.7% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a low vitality rating (2) on a five-point scale.
Region 15  Laurentides

The total FOLS population of the region is 426 300, and the English-speaking population is 29 865, or 7%.

The majority and minority communities compare as follows for age distribution:

![Age distribution chart](image)

Among French speakers aged 15 and over in the Laurentides region, 18% had less than a grade 9 education. Among English speakers, this proportion is 12%. There are proportionately slightly more English speakers than French speakers with extremely low income.

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 16% of the Laurentides' English-speaking community is over the age of 65, there is an unemployment rate of 13%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English
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speakers is 2.3:1) of 2:1 and an 68% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields an average vitality rating (3) on a five-point scale.

**Region 16 Montérégie**

This large and geographically diverse region, which is bounded on the north by the St Lawrence river and on the south by the U.S. border, has a total population of 1,243,375, making it second in total population only to Montreal. 126,855 residents of the Montérégie speak English as their first official language, for a proportion of about 10%.

The majority and minority communities compare as follows for age distribution:

![Region 16 Age distribution](image)

*Figure 2.38 Region 16 Age distribution*
Among French speakers aged 15 and over in the Montérégie region, 17% had less than a grade 9 education. Among English speakers, this proportion is 11%. Nevertheless, 8.65% of English speakers, compared with 7.28% of French speakers have extremely low incomes. Similar proportions of French and English speakers have incomes of below $12,000, while a higher proportion of English speakers have incomes of more than $30,000.

Selected demographic characteristics compiled by William Floch of the Department of Canadian Heritage indicate that 11.6% of the Montérégie English-speaking community is over the age of 65, there is an unemployment rate of 10.6%, a care-giver ratio (the proportion of those in the 35-54 year age cohort compared to those aged 65 and over, where the provincial average for English speakers is 2.7:1) of 2.2:1 and an 62.4% level of bilingualism. Together with the size of the local community and its proportion within the regional population as a whole, this data yields a very high vitality rating (5) on a five-point scale.
Conclusion

While there are some regions that fall outside the broader general portrait, a regional comparison confirms the data at the provincial level: the English-speaking population of Quebec differs somewhat from the French-speaking population according to certain basic health indicators. Better-educated on the whole, English speakers in general are no more likely than French speakers to be better off. English speakers are also slightly older, more likely to be unemployed and more likely to have an extremely low income.

We note that English speakers often appear not to fare as well economically as their education would predict. While education is one major health determinant, other factors such as income and employment status are also highly influential. In order to complete this portrait, it would be useful to carry out an analysis of such health indicators as obesity, smoking, and high blood pressure among English and French-speaking Quebecers.

The demographic overview provided here is far from being a complete analysis. Rather, it is hoped that this material will raise a number of questions for further investigation. At a minimum, the traditional image of the affluent Anglophone should be categorically dispensed with as myth. While it is true that the English-speaking minority community of Quebec has a somewhat higher proportion of well-off people than does the Francophone majority, it is clear that on the whole, these communities often resemble the majority community with regard to as income, gender, and age. In many regions, however, English speakers are notably disadvantaged compared to the majority population: poorer, more frequently unemployed, and often older, it should be expected that their health will be affected.
Finally, the indicators provided for community vitality allow us to go beyond the specific question of health indicators to look at the context in which the Health Canada Consultative Committee operates: one in which promoting the vitality of English-speaking communities is the primary goal, and the improvement of access to English-language health and social services is both an end in itself and the chosen means to achieve that goal.
SECTION TWO: IMPLICATIONS FOR AN ACTION PLAN

1. English-speaking minority communities in certain regions are at significantly greater disadvantage than others, both in terms of health indicators and community vitality. An Action plan must ensure that local communities have the capacity to access complete, pertinent demographic information about themselves, so that they can make sound judgments for service development.

2. General health indicators are significantly different between English speakers and French speakers living in many regions. However, despite greater economic polarization within the English-speaking population compared to the French-speaking population, median income levels are generally the same. It is highly likely that other indicators, such as obesity and smoking, will show similar variations. An action plan must ensure that regional planners have access to this material so that they can adjust their strategies as needs be.
SECTION THREE
The CROP- Missisquoi Survey

Highlights and key findings of the CROP-Missisquoi survey

The CROP-Missisquoi survey on the attitudes and experiences of English-speaking Quebecers, carried out in the spring of 2000, gives a portrait of the real levels of accessibility reported by English speakers in each administrative region. This information allows an assessment of the extent to which the access plans are in fact ensuring that services are available. The results show that levels of access vary dramatically from one region to another, and that significantly higher levels of access in the metropolitan Montreal area tend to distort the rather poor levels of access which continue to be experienced in many regions.

In addition, the survey provides information about the active offer of service in English, the identification of service gaps in each region, the types of services which are prioritized by English speakers, and the tendency to rely on family versus public service providers.

1. While services in English are more reliably available in the metropolitan Montreal region, English-speaking communities in many regions report extremely limited access to services in English.
2. **Physicians are the most reliable source of English-language services.** Services in nursing homes and CLSCs are least reliably available.

3. **English-speaking respondents prioritize English-language services in nursing homes and on telephone help-lines.**

4. **English speakers are far more likely to say that they would turn to family first in case of illness, even when there is no family nearby.**
Section three
The CROP- Missisquoi Survey

The Missisquoi Institute

The Missisquoi Institute, which became active in 1999, was founded in 1991 in order to create a social research capacity within Quebec’s English-speaking community. While a large amount of data is regularly generated concerning the Quebec population as a whole, there was no organization that had a mandate to collate and assess that data for the purposes of understanding the specific needs and concerns of English-speaking Quebecers. As a result, a key input was missing for effective social planning on behalf of the English-speaking community, particularly at the regional level.

This section of the action plan has been prepared with the permission of the Missisquoi Institute.

The survey among English-speaking Quebecers

In the spring of 2000, the Department of Canadian Heritage responded favorably to a funding request by Missisquoi to carry out an omnibus survey on the attitudes and experiences of English-speaking Quebecers. This survey provides a comprehensive overview of the experiences of the community across the province. Particular attention is paid to the differences in attitudes and experiences of English speakers across the regions of Quebec, since there was concern that a centralization of media and community advocacy in the metropolitan Montreal region may have resulted in a failure to appreciate and attend to those regional differences.

For this reason, the Missisquoi survey was carried out in such a way as to permit comparisons between the English-speaking populations of the various...
administrative regions. Moreover, in order to provide the basis for comparison with French-speaking Quebecers, control groups of French-speaking respondents were surveyed in each administrative region.

Yet another concern that the survey attempted to address was the ethnic and linguistic diversity within the English-speaking population, particularly on the Island of Montreal. In effect, a significant proportion of those whose first official language is English has another language as their mother tongue or as the language that they speak at home. An even greater number have one or both parents who had a third language as their mother tongue. It seemed timely to assess the possible differences between these segments of the English-speaking population in regard to issues cited as being of concern to the entire community.

The survey questions themselves were developed in consultation with a cross-section of partners within government and the community’s institutional and community leadership, including organizations, health and social service providers, and the educational milieu. These individuals were asked to suggest topics for investigation within the areas of education, health and social services, employability and manpower development, media and internet consumption, community leadership, geographic stability and mobility, and French language literacy. While some of the information gathered can be compared and validated by referring to data from the recent census, the findings relate primarily to specific experiences and attitudes. The survey thus provides a unique opportunity to verify a number of common assumptions about the English-speaking communities of Quebec as well as to provide, for the first time, a sound and reliable basis for future community planning.

CROP Inc., a Montreal-based marketing research and consulting firm, was commissioned by the Missisquoi Institute to conduct the survey.
Methodology and Administrative results

Two separate studies were conducted, the first among English-speaking Quebecers aged 18 and over, and the second among French-speaking Quebecers aged 18 and over. In both cases, the samples were randomly drawn according to a non-proportionate stratified sampling model, in order to allow for adequate representation of residents of the 17 administrative regions of Quebec. The data were then weighted according to the region, sex and age in order to ensure the representativity of the sample. In total, 3,126 interviews were carried out among English speakers between May 16 and June 28, 2000. In addition, 1,264 interviews were carried out among Francophones. The Francophone interviews were carried out in two groups, the first 1,000 between May 24 and June 11, 2000, and an additional 274 between September 22 and 30, 2000.

The results are subject to the following maximum margins of error, in 19 cases out of 20:

- Total Anglophones (n=3126) ±1.8%
- Total Francophones (n=1264) ±2.8%

Administrative results – Anglophones

Out of an initial sample of 63,612 telephone numbers, there were 8848 invalid numbers (no service, non-residential, fax, etc.), 36,123 out of sample numbers (sickness, Francophone, etc.) and 14,292 numbers whose eligibility could not be established (no answer, answering machine, refusal of the household). In the final sample of 4,349 questionnaires, 1,223 were incomplete, and a total of 3,126 completed interviews for a 53.4% response rate

Administrative results – Francophones

For the first wave of the Francophone survey, out of an initial sample of 2,743 telephone numbers, 433 were invalid, 376 were out of sample, and 622 were for numbers where eligibility could not be established. There was a total of 1,312
numbers, 312 incomplete questionnaires, and a 55.8% response rate for the completed interviews. For the second wave, the response rate was 54.6%.

**Survey results- Access to English language services**

In light of Quebec’s legal guarantee of health and social services in English, The Missisquoi Institute wanted to examine the real experience of English-speaking clients of the system in gaining access to these services. The following charts indicate the percentage of those respondents who had received a given service in English in the preceding 12 months as a function of those respondents who had had occasion to use that service.

Before reviewing the regional data, it is useful to review the Provincial availability of specific services in English according to service provider.
Quebec’s Anglophone Communities
Percentage who used English, with doctors, by Region, June 2000

Source: CROP/Missisquoi survey, June 2000. Based on 3,126 interviews.

Quebec’s Anglophone Communities
Percentage who used English, at CLSCs, by Region, June 2000

Source: CROP/Missisquoi survey, June 2000. Based on 3,126 interviews.
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Quebec’s Anglophone Communities
Percentage who used English, in contact with Info-santé, by region, June 2000

Quebec’s Anglophone Communities
Percentage who used English, in emergency rooms, by Region, June 2000

Source: CROP/Missisquoi survey, June 2000. Based on 3,126 interviews.

SECTION THREE – THE CROP-MISSISQUIO SURVEY
While a primary goal of the CROP-Missisquoi survey was to gather of statistically reliable samples in each administrative region of Quebec, certain regions with small English-speaking communities proved more challenging in this regard. Since not all respondents had used a given service, the regional breakdowns do not always provide adequate numbers of respondents to permit accurate reporting of response rates. We have shown the regional data here; where there is no value shown for a given service category, it is because there were not enough respondents to support a conclusion.

![Service Availability: Region 01- Bas-StLaurent](n=32)

Figure 3.6
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Health and social services in English in Quebec

Service availability: Region 02 - Saguenay
(n=50)
Figure 3.7

Service availability: Region 03 - Quebec
(n=98)
Figure 3.8
SECTION THREE – THE CROP-MISSISQUIO SURVEY
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Service availability - Region 06e - Montreal eastern sector
(n=189)  
Figure 3.13

Service availability - Region 07 - Outaouais
(n=248)  
Figure 3.14
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Health and social services in English in Quebec

Service availability - Region 08 - Abitibi
(n=100)
Figure 3.15

Service availability - Region 09 - Cote-Nord
(n=175)
Figure 3.16

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**Service availability - Region 10 - Nord du Quebec**
(n=98)
Figure 3.17

**Service availability - Region 11 - Gaspesie-les-iles**
(n=175)
Figure 3.18

SECTION THREE – THE CROP-MISSISQUOI SURVEY
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Service availability Region 12 - Chaudiere-Appalaches
(n=36)
Figure 3.19

Service Availability - Region 13 - Laval
(n=173)
Figure 3.20

SECTION THREE – THE CROP-MISSISQUIOI SURVEY
SECTION THREE – THE CROP-MISSISSOUI SURVEY
Beyond the question of whether or not a service was received in English, Missisquoi sought to clarify a number of specific questions concerning the interaction between English-speaking client and the service provider. Among the questions Missisquoi asked was whether, for those who had in fact received a service in English, that service in English was provided spontaneously or at the explicit request of the client.

This information is critically important, because it allows us to assess the extent to which health care workers and professionals actively view language as a service tool and as an essential element of client satisfaction. For a definition of the term “active offer” we refer the reader to the Definitions section (Appendix 2) of the present report.
Clearly, both from a standpoint of overall accessibility and also with regard to the active offer of service, private physicians are the most reliable source of English-language health and social services available to English-speaking Quebecers. Conversely, Info-Santé health line is both the least accessible in English overall, and more frequently requires a specific request on the part of the client in order to obtain those services that are provided.

The following table shows, among those who had used a given service and had received that service in English, the percentage of respondents that received an active offer of service. We note that 90% of those who had been served in English by a physician in private practice received an active offer; only 68% of callers to Info-Santé were given English-language service spontaneously.

Another way to examine this question is by simply comparing the percentages of those who asked for service when it was not spontaneously offered.
Another question that can help clarify how English-speaking users of the health and social service system view the question of linguistic accessibility had to do with the level of importance accorded to services in English in various types of institutions. The CROP-Missisquoi survey asked this question of all respondents who had used a given service, whether or not the service had been obtained in English.
What we can see from this chart is that while service in English is consistently evaluated as being very important (about 85%) when service is received, the evaluation is more variable when service is NOT received in English. In essence, services in nursing homes and for Info-santé are seen as being of a higher importance when they are not received. This data offers some guidance to those who wish to determine how to prioritize the development of English-language health and social services across the Province.

One of the questions which Missisquoi wanted to address was whether Anglophones are more likely than Francophones to travel outside their region for health and social services, and if so, whether they were doing so in order to access services in English which were available in French in their region.

The comparative data for Anglophones and Francophones reveal few differences between the groups in terms of the likelihood that they had used services in another region. The single exception to this is in the use of private physicians: Anglophone respondents were three times more likely to have traveled outside their region for a doctor’s visit than were Francophone respondents.

![Using services in another region](image)
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Health and social services in English in Quebec

The region of residence has a major impact on the likelihood that respondents would have traveled to another region for service. Anglophone residents of the Outaouais are more than three times more likely that average to have traveled outside the region to see a doctor, and it is clear that they are traveling to Ontario. Anglophone residents of Laval are four times more likely that the average to have traveled to another region for emergency room services.

However, the reasons cited by the two respondent groups are different. Anglophone respondents are dramatically more likely to cite reasons associated with service availability, personal preference, and medical referral than are Francophone respondents. Francophone respondents are far more likely to say that they used services in another region either because a caregiver lives there or because they happened to be in that region when they became ill.

What emerges is a portrait that strongly suggests that when Anglophones travel in order to receive health and social services, they do so for reasons directly associated with personal choice and comfort. This choice may or may not be consciously associated with the issue of linguistic access. However, 69% of those who used the services in another region reported that the service was provided in English, a figure which is virtually identical to the 70% average for services in English for all services and all regions.
Among the areas examined by the CROP-Missisquoi survey, a question was asked concerning the tendency to turn to public services for support. This question yielded a marked difference in the responses of English and French-speaking respondents.

In the diagram above, the reasons for using services outside one's region are shown. The chart indicates that a significant number of participants used services outside their region because they existed elsewhere (32% for English, 8% for French), or because a family doctor was there (32% for English, 8% for French). Other reasons included personal preference, medical referral, and the quality of service.

The chart illustrates that English-speaking respondents are more likely to use services outside their region due to the availability of services in English and because someone helped them in another location.

The Missisquoi Institute

SECTION THREE – THE CROP-MISSISQUOI SURVEY
In addition to the rather pronounced differences between Anglophone and Francophone respondents with regard to whom they would first turn for support in case of illness, there are significant differences between various regions as to the reaction of local communities to this question. In fact, English-speaking residents of the Chaudière-Appalaches region were substantially less likely than the provincial average among Anglophones to say that they would turn first to family if they needed support. Conversely, English-speaking residents of the Laurentides and Abitibi regions are far more likely than the average to say that they would turn to family first.

While these data are interesting, they are most useful when used in conjunction with information about the proximity of family members. Among the questions asked by the survey was whether respondents had a member of their family living within an hour’s driving distance from them. As expected, there are significant regional variations in the level of isolation from family. When these results are placed together with the regional responses for tendency to turn to
family in case of illness, we can see that in some regions, expectations significantly exceed likely available resources.

It is possible to see from this comparison of proximity of family members and the stated tendency to turn to family that, in some regions, there is an imbalance between local capacity, in the form of presence of family members, and expectations of support from family in case of illness. This information can be correlated with that provided in the demographics section, in which the “caregiver ratio” is provided for each region. Notably, in a number of regions, shown to the negative side of the chart and in red, the expectations of family support exceed the presence of family members. These regions are Saguenay, Quebec, Northern Quebec, Gaspé, Lower St-Lawrence, Lanaudière, Montreal Eastern sector, and Montreal Central sector.

While a more complete analysis of this data would be required in order to be certain of their significance, it is important to retain that any proposed strategies
for improving access to English-language health and social services need to be targeted to the particular needs and habits of local residents.

We have already established that Francophones are significantly less likely to say that they would turn to family first, despite the fact that they are substantially more likely to have family members living within an hour’s drive. Clearly, the mere presence of family is not in and of itself, a reason to say that one would turn to them first in case of illness.

**Conclusion**

The preceding material is intended to be used in conjunction with other data provided in this report concerning demographics and access plans. It can also stand alone as a portrait of the perception of English speakers of a variety of questions related to their level of access to services which were linguistically adapted, the priorities they ascribed to service in English and the obstacles they faced in gaining access to them.

It is clear that the level of access to different services varies quite widely from one region to another, but that overall, physicians are the most reliable source of English-language services, CLSCs and nursing homes are the least reliable sources of those services, and that these latter two are also highly prioritized by English speakers across the Province.

This material has clear implications for the development of service delivery systems that are responsive to local priorities and service gaps.

This Missisquoi Institute will make this material available to the general public in the form of a forthcoming monograph in its ongoing series.
SECTION THREE: IMPLICATIONS FOR AN ACTION

PLAN

1. While services in English are more reliably available in the metropolitan Montreal region, English-speaking communities in many regions report extremely limited access to services in English. An action plan should capitalize on the resources of the Anglophone institutions located in the Montreal area through the use of remote technologies, while foreseeing specific strategies that would develop community-controlled resources in the regions.

2. Physicians are the most reliable source of English-language services. Services in nursing homes and CLSCs are least reliably available. An action plan should take these strengths and weaknesses into account, and should target use of English-second language training funding in prioritized areas.

3. English-speaking respondents prioritize English-language services in nursing homes and on telephone help-lines. An action plan should permit specific service development in function of these priorities in each region.

4. English speakers are far more likely to say that they would turn to family first in case of illness, even when there is no family nearby. An action plan should specifically envisage strengthening local capacity to respond to this issue in those regions where it is significant.
SECTION FOUR

Models of service delivery

Highlights and key findings of the review of models of service delivery

New technologies and an increased interest in the development of specially adapted community-based partnerships that are controlled and managed within the English-speaking communities of Quebec offer exciting new ways to capitalize upon the traditionally strong sources for English-language health and social service delivery. These service models serve to simultaneously enhance access to services and to serve community structures that are vital to the long-term vitality of the community.

1. Services in public health and social service institutions that are majority Anglophone can be extended beyond the traditional reach through the use of remote access technologies. These technologies also provide access to specialized medical expertise not readily available in most administrative regions, consolidate the sense of community ownership and accountability, and may reduce cost by diminishing the numbers of hours spent travel.

2. Services in public health and social service institutions that are not associated with the Anglophone community can be expanded through support for human resource development and
retention strategies aimed at improving staff capabilities in English and enhancing their chances of remaining in the regions.

3. New community-based structures can be developed to complement the services provided by local public institutions. These new structures should be developed in direct consultation with local English-speaking communities, and should take account of the best available demographic information.
SECTION FOUR
Models of service delivery

Three main venues of service delivery in English currently exist in Quebec:

- Service in recognized (Anglophone) institutions
- Service in other (Francophone) institutions capable of providing service based on the language skills of their personnel
- Service provided by community organizations, either alone or in partnership with public institutions.

In addition, new technologies make remote access an increasingly viable method for supporting communications between clients who do not live nearby a particular service provider.

MODEL 1  Service in recognized (Anglophone) institutions

This model, already in wide use in Quebec, consists of providing services in those institutions where the English-speaking community represents the majority of the clientele and where, therefore, the institution already benefits from exemptions which permit it to function internally in both French and English.

As has been discussed in Section 3.3, Quebec’s English-speaking community relies heavily on the network of recognized institutions to provide health and social services in English. Moreover, since a sizable majority of Quebec’s English-speaking population is concentrated in the Montreal metropolitan area and therefore within relatively close proximity to those institutions, access to
English-language services is comparatively easy for a large number of English-speaking Quebecers.

Currently, recognized institutions exist within all sectors of the institutional network. In the greater Montreal area, we find one pediatric acute care hospital (now part of the McGill University Health Centre) one psychiatric hospital, a number of acute care hospitals and chronic care facilities, four rehabilitation hospitals, a child and youth centre (specialized youth services, including residential care and young offenders), a range of rehabilitation centres for persons with intellectual, motor, visual, and speech/hearing handicaps, as well as a centre specialized in alcoholism and drug abuse. A number of Local Community Health Centres, known as CLSCs, exist on territories where the critical mass of English speakers exceeds the 50% mark, permitting them to gain recognized status and thus offer services in both English and French.

**Administrative barriers**

*Regionalization and territoriality*

Despite the presence of this comprehensive range of institutions, a variety of administrative barriers impede access to these institutions for an increasing proportion of the English-speaking population.

First, Quebec’s health care system increasingly operates on a principle of territoriality. This administrative structure, which is intended to equalize access to services for all residents of the province, sometimes has the paradoxical effect of diminishing access to those services that are linguistically accessible. Sectors especially affected by these artificial barriers include psychiatric services, specialized youth services, rehabilitation services for the intellectually handicapped, and first line services. While the Quebec Act concerning Health and Social services acknowledges the right of users, including English speakers, to choose the institution from which they wish to receive services, institutions...
regularly invoke the territory of the client’s residence as a motive for referring the client to an alternative service provider.

The decision in 1992 to move to a regionally based system for budget allocation has further complicated access for English speakers who do not reside on the island to institutions in Montreal. In effect, institutions are given a budget that is, in part or in whole, fixed in relation to the population of a geographic territory. Thus, institutions may find themselves financially penalized by a decision to serve out-of-region clients. Moreover, as waiting lists have grown, institutions have found it more and more reasonable to prioritize service to one category (in-region) of clients than another. Few mechanisms facilitate budgetary adjustments in function of inter-regional transfers, including those which are language-based. While the official position of the Montreal Regional Health Board is that Montreal’s specialized institutions provide services to all, in practice, these institutions will likely come under increasing structural pressure to prioritize residents of their catchments area or region.

As an illustration, the model for service to the intellectually handicapped in Montreal is a case in point. Following the mergers of institutions in 1992-93, Montreal was left with five institutional groups providing services to the intellectually handicapped: four institutions which had a strict sub-regional mandate, and a fifth which had a double mandate for the population a sub-region plus a religious/cultural mandate for all Jewish clients on the island of Montreal. The Jewish institution and one of the four other institutions are recognized under the Charter of the French language to provide all their services in English, and do in fact serve a majority English-speaking clientele.

Despite the relative ease with which these institutions provided English-language services and an English milieu de vie for residential clients, all rehabilitation centers for the intellectually handicapped insisted on their desire to provide services to their own local English-speaking clientele; the other three institutions
have been resistant to negotiating inter-institutional agreements with regard to the provision of English-language services. Thus, English-speaking clients in Montreal’s East end are for all practical purposes unable to receive services from the Anglophone institutions in the region. At the same time, the true capacity of the other three institutions to provide English-language services has developed gradually, but is unlikely, for reasons exclusively related to critical mass, to ever succeed in providing a linguistic environment which is on a par with that provided at the recognized institutions.

If this has been a problem within a single administrative region, one can imagine the difficulties associated with reaching agreements between regions for the provision of a given service. To date, only one type of service, namely second-line youth services, has been the object of a serious evaluation leading to the conclusion of inter-regional agreements which will ensure that the Anglophone youth centre (Batshaw) has a clear and unequivocal mandate to provide residential services for English-speaking youth from other regions: these agreements will have to be negotiated individually between Batshaw, the Montreal Regional Board, and the respective Board and youth centre of every other region.

**The shift towards first-line services**

In a complementary administrative trend, the continual evolution in the distinctions between first and second-line services have tended to favor increasing development of services in institutions not historically linked with the English-speaking community. In effect, the range of services offered in second-line institutions has decreased, favoring the expansion of local, first line services. For English-language services, this has tended to favor the development of the capacity of local institutions to provide services in English.
Indeed, this was part of the rationale argued by the government when it moved to close three acute care hospitals with Charter recognition (The Queen Elizabeth, Reddy Memorial, and Lachine General Hospitals). The government argued before the court that the presence of legislative guarantees protecting access to English-language health and social services in CLSCs would ensure that the apprehended erosion of access to English services would not occur as a result of these hospital closures.

In addition to administrative obstacles, Anglophone institutions are penalized by the obligation to produce nearly all documents in both languages. Many maintain in-house translation personnel, a cost which they bear without additional government financing. In addition, these institutions’ requirement that all client-contact personnel be functionally bilingual in English and in French increases the complexity of their staff recruitment task. This has become especially clear in a context of manpower shortages, especially affecting the nursing profession. As a result, many of these institutions have self-financed English second-language training programs for new employees who lack sufficient fluency in English.

Despite these obstacles, Anglophone institutions remain the most reliable source of English-language health and social services.

*Information technologies: a critical tool for the future*

If the network of institutions associated with Quebec’s English-speaking community suffers from a certain number of structural obstacles, it has at its increasing disposal a resource that has the potential to make its services available to a dramatically widened range of Quebec Anglophones. This resource is popularly referred to as “tele-health” or “tele-medicine”.
In essence, new technologies permit those at great distance from a service provider to use many of the services it offers. This model is already in use in at least two sites in Quebec, in a pilot project at the Ste Justine pediatric hospital (Réseau mere-enfant) and in a project on Quebec’s lower north shore which links residents of remote communities to professionals at the regional health centre.

This technology offers the most promising means for increasing the reach of those institutions which are able to provide English-language services, thus providing services in English to those who would not otherwise be able to obtain them and at the same time consolidating the presence and role of these institutions as focal points for the English-speaking community of Quebec as a whole.

MODEL 2 Service in other Quebec (Francophone) institutions

This model, foreseen primarily in the access programs drafted as a result of legislative guarantees, consists of legally mandating specific services in those institutions where the English-speaking community represents a minority of the clientele.

At the current time, more than 150 Quebec health and social service institutions are named in a government decree (access plan) for some or all of their services.

Provision of English-language services in Francophone institutions has for some 15 years been acknowledged as an entitlement for English-speaking Quebecers, and this entitlement is generally favorably viewed by French-speaking Quebecers as a whole. Indeed, the CROP-Missisquoi survey asked francophone respondents whether they supported the statement that English-speaking
Quebecers should have access to English-language health and social services wherever they lived: 75% of those surveyed were totally or largely in agreement.

Regrettably, the provision of English-language services in non-recognized institutions has become the object of increasing criticism from those who equate the right to service in English with the bilingualisation of the health care network. In effect, the Government of Quebec has increasingly taken the position that the right of an employee to speak French supersedes the right of a client to receive services in English.

As a consequence, a number of strategies are now at play whose goals are to decrease the scope of the entitlement to English-language health and social services by essentially treating such services as voluntary, rather than obligatory. Clear evidence of this trend is found in the report and recommendations of the Larose Commission on the future of the French language, which recommends among other things, that a recent highly restrictive ministerial language policy be applied to all public health and social service institutions, and that institutions provide English services on a voluntary basis. Since this report recommends that the guidelines for preparing access plans be amended to reflect these recommendations, and since the Commission consulted with the Department of Health and Social Services prior to formulating its recommendations, it is likely that the next access plan review cycle will result in a significant reduction of the number of institutions which have a legal obligation to provide English-language services.

In this context, appears unlikely that most institutions will be willing to expand their capacity to provide English-language services, and many of those which have made efforts to increase the availability will be discouraged from pursuing and consolidating those services. If the model of English-language service provision in non-recognized institutions is to continue to be a useful one in the short term, a strong and well organized effort will have to be made to reach the
administrations of each institution and to encourage their ongoing voluntary participation in the provision of English-language services.

Model 3  The Community-based service provider

This model ensures minority community control and management of services by the creation of a community-based organization providing health and social services complementary to those provided by the public health and social services system. Such services may be offered either in partnership with public services or in parallel to them.

English-speaking Quebec has a strong and rich history of community development and community based organizations. Indeed, such organizations as the Catholic Community Services and Jewish Family Services in Montreal have for half a century played key complementary roles to services provided by the public sector.

Community-based service models operate along a continuum of close or distant relationship with public service providers. That relationship is a function of the extent to which the organization takes on an advocacy versus a direct service provision role, as well as the willingness of the local public structures to work in a collaborative manner. An excellent and extensive review of similar available models in the rest of Canada has been prepared for the Federation des communautés Francophones et acadienne (FCFA) du Canada (Community Health Services in French: An analysis of Four existing Models in Francophone and Acadian Communities, June 2000).

A relatively recent and highly promising Quebec model is provided by the Quebec City Holland Center. The Holland Center is a community-based organization that was originally founded with a view to providing day services for
the English-speaking elderly population of the Quebec City area. Its’ mandate has subsequently expanded to include, on a partnership basis with local CLSCs and other centers, the provision of a range of first line health and social services in English.

It is interesting to note that the Holland Center has its genesis in the disappearance of two English-language health and social service institutions in the Quebec City region. First, the Ladies Protestant Home, a nursing home for English-speaking elderly, closed its doors in the early 1990s. In an effort to mitigate the negative effects that this closure would have on its clients and on the community, the foundation of the Ladies Protestant home chose to allocate a significant part of its assets to the support of the Holland Center for seniors.

In the mid 1990’s transformation of the health and social services system in region 03 led to the closure of the Jeffery Hale hospital as an acute care hospital. While the Jeff, as it is known in the region, did not have official status under the Charter of the French language, it nevertheless was known, by Francophones and Anglophones alike, as « the English hospital ». Its staff was largely bilingual, and the English-speaking population of the region regularly used its services.

As a result of transformation, The Jeffery Hale’s mandate was modified to providing emergency room services and chronic care services; however, it lost its acute care beds. This decision led to a great deal of reflection on the part of the community and the regional board, with the result that a partnership was developed between a variety of public institutions and the Holland Center. The basic rationale of their eventual decision was that a critical mass of both English-speaking clients and English-speaking personnel was required to provide an environment which would be linguistically adapted to the needs of English-speaking clients. A variety of local institutions essentially loaned their English-speaking staff to the Holland Center, and English-speaking clients from a group of CLSC territories are now referred to the Holland Center for service. This
arrangement touches, among others, school social work, Info-Santé health line services. These services are now offered directly by the Holland Center in an atmosphere that is unmistakably “English”.

The leadership of the Holland Center notes that in their view, the success of their project is grounded in a strong community consultation process, which identified local needs and garnered support of the community’s leadership. They point out that the English-speaking populations of other regions seeking to create a similar resource should not assume that the eventual range of services offered will be the same: what is critical, they believe, is that a strong community consultation process be the first step, and that the type and organization of a local model be the result of the specific needs and interests of local community. Those involved with the Holland Center have also stressed the importance of a solid demographic analysis of the local community. This demographic work will allow planners to ensure that any eventual structure responds to the needs of the population, and not simply the interests of those directly involved in organizing the new structure.

A major private foundation has taken a direct interest in the work of the Holland Center, and the center will shortly produce a detailed analysis of the evolution of the project and the key points that those seeking to generalize the model should retain. While this report is unfortunately not available at this time, it is recommended that it be appended to this document as a primary resource as soon as it becomes available.

**Conclusion**

Development of access to English-language health and social services in Quebec is less a matter of developing novel structures for service delivery than it is one of adapting existing models, capitalizing on technological advances,
diminishing administrative barriers, and developing partnerships which facilitate the critical mass necessary to ensure linguistically comfortable environments in those regions with small English-speaking populations. Local projects that aim to improve access can and should make use of a variety of tools at their disposal. Thus, the Holland Center might become a resource by which English-speaking residents of eastern Quebec gain access to primary care services in English through remote-access technology; a community-based organization in Eastern Montreal might enter into a partnership with local CLSCs and hospitals to provide accessible English-language services in Montreal’s east end; the McGill University Health Center might undertake a major development of its capacity to interface via the internet with clients and service providers in the regions; or a local CEGEP might offer subsidized English-second-language training for local health-care professionals. Finally, in a region where there is limited capacity and willingness of public institutions to provide English-language health and social services, a structure that provides a range of primary health and social services that is parallel to the publicly funded system might be appropriate.
SECTION FOUR: IMPLICATIONS FOR AN ACTION PLAN

1. Services in public health and social service institutions that are majority Anglophone can be extended beyond the traditional reach through the use of remote access technologies. These technologies also provide access to specialized medical expertise not readily available in most administrative regions, consolidate the sense of community ownership and accountability, and may reduce cost by diminishing the numbers of hours spent travel. An action plan should ensure that these technologies are made available to these institutions with this purpose specifically in mind.

2. Services in public health and social service institutions that are not associated with the Anglophone community can be expanded through support for human resource development and retention strategies aimed at improving staff capabilities in English and enhancing their chances of remaining in the regions. An action plan should, in particular, permit English and French second language training, and should enhance the capacity of institutions to recruit and retain English-speaking staff.

3. New community-based structures can be developed to complement the services provided by local public institutions. These new structures should be developed in direct consultation with local English-speaking communities, and should take account of the best available demographic information. An action plan should support the development and funding of these new organizations, as well as the community consultation and organization process necessary to ensure their stability and viability.
SECTION FIVE
Elements of an Action plan

Review of key findings and implications of the report

An introduction to the action plan

1. The legal framework that favors access to English-language health and social services in Quebec is significantly constrained by the political context in which it operates. An action plan will need to take this factor into account, and develop strategies that are insulated from the broader political climate. This implies that the communities themselves will need to be far more central to the development and implementation of specific activities aimed at promoting service accessibility.

2. The institutional network historically associated with the English-speaking community of Quebec is under major pressure from a variety of economic and structural pressures, but remains the most reliable source of English-language service. An action plan will need to specifically foresee strategies which reinforce the capacity of these institutions to deliver services, and which serve also to strengthen the historical linkages between the institutions and the communities. These institutions should also be supported in developing strategic approaches that take into account their special status within the English-speaking minority community of Quebec.
3. Regional coordination has been a critical element in the development of access to services in English. Diminished support for coordination threatens the future development of services. It also threatens the capacity of various communities across the province to coordinate their activities at the pan-provincial level, sharing best practices and resources. An action plan should prioritize the development of a significant capacity for community coordination, both at the regional and provincial levels.

4. English-speaking minority communities in certain regions are at significantly greater disadvantage than others, both in terms of health indicators and community vitality. An Action plan must ensure that local communities have the capacity to access complete, pertinent demographic information about themselves, so that they can make sound judgments for service development.

5. General health indicators are significantly different between English speakers and French speakers living in many regions. However, despite greater economic polarization within the English-speaking population compared to the French-speaking population, median income levels are generally the same. It is highly likely that other indicators, such as obesity and smoking, will show similar variations. An action plan must ensure that regional planners have access to this material so that they can adjust their strategies as needs be.

6. While services in English are more reliably available in the metropolitan Montreal region, English-speaking communities in many regions report extremely limited access to services in English. An action plan should capitalize on the resources of the Anglophone institutions located in the Montreal area through the use of remote technologies, while foreseeing
specific strategies that would develop community-controlled resources in the regions.

7. Physicians are the most reliable source of English-language services. Services in nursing homes and CLSCs are least reliably available. An action plan should take these strengths and weaknesses into account.

8. English-speaking respondents prioritize English-language services in nursing homes and on telephone help-lines. An action plan should permit specific service development in function of these priorities in each region.

9. English speakers are far more likely to say that they would turn to family first in case of illness, even when there is no family nearby. An action plan should specifically envisage strengthening local capacity to respond to this issue in those regions where it is significant.

10. Services in public health and social service institutions that are majority Anglophone can be extended beyond the traditional reach through the use of remote access technologies. These technologies also provide access to specialized medical expertise not readily available in most administrative regions, consolidate the sense of community ownership and accountability, and may reduce cost by diminishing the numbers of hours spent travel. An action plan should ensure that these technologies are made available to these institutions with this purpose specifically in mind.

11. Services in public health and social service institutions that are not associated with the Anglophone community can be expanded through support for human resource development and retention strategies aimed at improving staff capabilities in English and enhancing their chances of remaining in the regions. An action plan should, in particular, permit
English and French second language training, and should enhance the capacity of institutions to recruit and retain English-speaking staff.

12. New community-based structures can be developed to complement the services provided by local public institutions. These new structures should be developed in direct consultation with local English-speaking communities, and should take account of the best available demographic information. An action plan should support the development and funding of these new organizations, as well as the community consultation and organization process necessary to ensure their stability and viability.
Section 5  
Elements of an Action plan

Quebec's English-speaking minority community is both uniquely advantaged and uniquely threatened in the area of access to health and social services in English. Stewards of a remarkably complete network of institutions which were developed during the 19th and 20th centuries, the community, particularly where it exists in high concentration, continues to be the beneficiary of both of the services provided by those institutions and of the community infrastructure which they provide. It is clear that, until the mid-1980's English speakers at least in Montreal had little difficulty obtaining health and social services in English.

As reviewed in Section One of this report, the 1980s saw an attempt to generalize access to minority-language services outside of the metropolitan Montreal area, through the inclusion of specific legislative guarantees protecting and promoting access to English-language services in Quebec's health care legislation. These legislative guarantees reflect a widely held belief among Quebecers that health and social services should be available in both French and English, according to the needs and wishes of the client. They have formed the basis of a unique partnership between the communities, institutions, and the administrators of Quebec's health and social services system, and constitute in many ways one of the great success stories on Quebec’s minority linguistic communities.

But despite the unquestioned importance and relevance of the legislative guarantees, despite the presence of a still-significant network of publicly financed, community-controlled health and social service institutions, this report clearly demonstrates that English-speaking communities in many regions are significantly under-serviced, that many are at genuine risk, that the organizational
health of the institutions is increasingly tenuous, and that the political climate has become increasingly tendentious.

Since the 1980's a number of intense pressures have been brought to bear upon the system, and these pressures have had a direct impact on the prospects for maintaining adequate levels of access to English-language health and social services in Quebec. These factors are both political and administrative. At the political level, it will be necessary to resolve the argument that dispositions of the Charter of the French Language are incompatible with the legally assured capacity of the system to offer services in the language of its minority linguistic community. At the administrative level, challenges included Regionalization, system transformation and the trend towards developing multidisciplinary front-line services. Finally, in many regions, limited bilingualism among French-speaking employees leads to genuine precariousness of the offer of service in English in majority community institutions. To these factors, we must add the enormous pressures to which all health care systems across Canada are subjected: those of rapidly increasing costs and limited prospects for new funding, a frantic search for new administrative and governance models which will facilitate cost-effective management of public resources, ongoing uncertainty as to future the scope of services to be financed, and the realities of a political cycle which is far shorter than the normal timeframe required to effect policy change within the sector.

These pressures are not unique to the beginning of the new millennium. In the mid-1980's, equivalent and often similar pressures led the community to work together to secure legislative guarantees for English-language health and social services. The presence of these guarantees provided an important bulwark against the early changes to the system, particularly in terms of transfers of services away from the traditional institutions of the community and towards the first line service system (CLSCs). However, the pace of change within the system has accelerated dramatically in the past five years. Despite the presence
of both and institutional infrastructure and the fact that a network of regional coordinators, now largely dispersed, was in place at the regional level, the various external pressures have nearly overwhelmed the capacity to preserve the current levels of access. Those same pressures have to all practical purposes blocked any possibility for further development of service accessibility within the public sector.

If the goal is to preserve and promote access to English language health and social services, both within and in conjunction with the public health and social service system of Quebec, a new paradigm will have to be found. It is clear that the foundation of this new paradigm must be the development and consolidation of structures that are within the control of the English-speaking communities themselves.

The priorities established by the Committee

Health Canada's consultative committee, in its meeting of February 15th 2001, identified a number of specific priorities.

1. Improving access to services especially in Info-Santé and CHSLDs;
2. Improving access to services in outlying regions with small critical mass, especially for long-term interventions and specialized services
3. Support communities' capacity to provide complementary services
4. Support capacity of communities to carry out our community coordination function
5. Build on existing ONG networks
6. Develop remote access technology to facilitate access to services in outlying regions
7. Develop innovative applications of Health Canada programs to address the needs of the English-speaking minority in Quebec, including development of partnerships with other Federal departments.
The material presented in the body of the report provides, for the first time, a comprehensive and systematic review of the extent to which members of Quebec’s English-speaking minority communities are able to obtain health and social services in English. As we said at the outset, this is a matter of critical importance for the health of members of the community, for their sense of belonging in the broader communities in which they live, and thus for the vitality of the minority communities themselves.

The question of community vitality is therefore central to the action plan, both as a goal and as a means to the end of promoting access to services. As an illustration of how this dynamic operates, we need only look at the report’s review of regional community vitality, along with a variety of specific demographic indicators for health. What we can see from this material is that in certain communities, the proportion of older English-speaking citizens is larger than the proportion of French speakers; moreover, the size of the care-giving age cohort is proportionally smaller with the English-speaking communities of many regions. We also know from the CROP-Missisquoi data the English speakers are significantly more likely than French speakers to indicate that they would turn first to family in case of illness.

The problem of youth out-migration is hardly unique to English-speaking minority communities in the Quebec regions. Indeed, youth out-migration is a generalized problem in the regions, and, indeed, for minority communities across Canada. What is perhaps different in Quebec is the extent of the linguistic attraction of Montreal and of other Canadian and North American cities, and the long-standing nature of this problem. In effect, the demographic material suggests that at least some of Quebec’s minority communities are on the point of losing the kind of critical mass that is necessary to ensure their survival.
How might an action plan address this issue, in the context of promoting access to English-language health and social services? By ensuring that each of the strategies proposed has a direct and positive effect both on community and on access. Thus, human resource development strategies should have a component that encourages youth retention in the regions; new technologies can be deployed in a way that helps ensure that English-language group and psychosocial services can be offered to local families as needed; new community-based service providers can be created in areas where the local community has lost or never had a community-controlled service source, providing both employment and a focal point for local community leadership development. All activities increase access to services, and all help to strengthen the community itself.

*In light of the priorities set forth by the Committee, and based upon the material presented in the preceding sections of this report, we suggest that the Committee recommend that Health Canada provide funding to support the delivery of health and social services in English to Quebec’s minority communities by setting aside resources over an initial five-year period to support activities in the following areas:*

1. **Networking and cooperation within English-speaking communities to mobilize institutional and community capacity to meet their needs.**

2. **Strategic information to build a knowledge-based approach mobilizing resources and identifying needs.**

3. **Technology to extend provision of services to distant, dispersed, or rural English-speaking communities.**
4. Service delivery models to develop new services for English-speaking communities which are adapted to regional and community realities, and

5. Training and human resource development to promote language training and professional development, recruitment of English-language personnel and their retention in all regions.
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MANDATE OF THE CONSULTATIVE COMMITTEE
FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

OFFICIAL LANGUAGES ACT,
SECTION 41, PART VII
Mandate

The Consultative Committee’s mandate is as follows.

3. 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;

4. 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 of the Committee

The Consultative Committee will comprise:

8. two co-chairs (one representing the community party and one representing the federal party);
9. eight representatives of the English-speaking minority communities in Quebec;

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

11. seniors officials of Health Canada with specific responsibilities in priority program and policy sectors;

12. the National Coordinator, Section 41, Part VII and the Quebec regional Coordinator, as needed;

13. a secretary general for the community party and a secretary general for the federal party;

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

15. the Consultative Committee will hold biannual meetings in Montreal, Quebec and will conduct conference calls approximately four times a year, as required.

**Responsibility for costs**

16. The National Co-ordination Bureau for Official Language Minority Communities, Health Canada will pay the administrative costs of the biannual meetings and conference calls.
Appendix 2

Definition of terms

The purpose of the present document is to support a reasoned approach to the recommendation of specific measures aimed at improving and consolidating access to health and social services in English for Quebec’s English-speaking minority communities. In order to ensure a common understanding of the terminology used, it is appropriate to begin with a definition of a number of the terms that appear in the text.

**Access Program**

The Frame of reference document developed by Quebec’s Ministère de la santé et des services sociaux in preparation for the first review of the access programs defines an access program as “the sum of health and social services dispensed in the English language by health and social services institutions” (Frame of reference, Program of Access to Health and Social services in English for English-speaking Quebecers, MSSSQ, 1994, p. 9).

The purpose of the access plan is to “make the right of all English-speaking persons to receive health and social services in the English language operational to the extent specified in section 15 of the Act”; it is a “mandatory measure in addition to others designed to further access to services in the English language (emphasis added) (ibid, pp 27, 28).

To the extent that these services are captured in a decree approved by the government pursuant to section 348 of the Act respecting health and social
services, these services comprise those to which English-speaking clients have a legal right.

It is important to note that community organizations, certified private resources (typically private residences for seniors), ambulance services and other resources which serve English-speaking persons are excluded from the access plan. (ibid, p.12)

The steps identified by the Frame of reference document for the development of an access program are as follows:

The regional boards:

- Are responsible for developing the access program for their region;
- Work with the institutions in their region;
- Compile information and data on English-speaking persons and their needs with respect to the accessibility of health and social services in the English language;
- Assess their current access programs;
- Do an inventory of services accessible in the English language at the local and regional levels as well as outside the region;
- Develop an access program;
- Ensure that English-speaking persons in their region have access to the services they need in the English language or, as the case may be, develop jointly with other regional boards, such a program in the centres operated by the institutions of another region;
- Consult their regional committee about the access program;
- Recommend their region’s access program for submission to the Government.

Ibid, page 18
Active offer of service
When service in English is spontaneously offered by a service provider, either simultaneously with the offer of service in French or immediately following the client’s first intervention. This term implies that the client did not have to explicitly request that the service be offered in English.

Anglophone (recognized, designated) health and social service institution
An Institution which is recognized in virtue of section 29.1 of the Charter of the French language and, normally, under section 508 of the Act respecting health and social services.

Decree
The step by which the services identified in an access program developed by the region become the object of a legal guarantee: the final step in rendering operational section 15 of the Act.

English-speaking person
A person who, in his or her relations with an institution which dispenses health or social services, expresses the desire to receive services in the English language or feels more comfortable expressing his or her needs in English. (ibid, page 27). In the case of a minor under the age of 14, the parent expresses the choice on behalf of the child. (Régie régionale de Montréal-Centre, resolution of the Board of directors, February, 1994)

Institution
“Any person or partnership carrying on activities inherent in the mission of one or more of the centres mentioned in section 79” (An Act respecting Health and Social Services, chapter S-4.2, section 94).
Level of service
The Frame of reference establishes the following analytical framework for assessing level of service in English required:

0. No direct involvement of the English language or of a speaker of English required

1. Information must be available in English but the involvement of a speaker of English is not required

2. The presence of a speaker or speakers of English at the point of the client’s access to services is entailed

Milieu de vie
A substitute living environment, normally provided by a public or private care provider for an individual or individuals who are unable to live alone. The most common categories of service are the elderly and people with a physical or intellectual handicap.

a. The present of a proficient speaker or speakers of English at the point of the client’s access to services is entailed

b. Consultation with a speaker or speakers of English knowledgeable about the English-speaking community and its culture is entailed

c. The presence, at the point of the client’s access to services of a proficient speaker or speakers of English knowledgeable about the English-speaking community and its culture, is entailed
Service in English
Provision of service to the satisfaction of both the client and the professional, at a level of fluency which is defined as a function of the nature of the intervention. The concept includes both knowledge of the English language and, under certain circumstances, knowledge of the English-speaking community.

Linguistic accessibility “can be considered as the mechanism to avoid that “an existing resource accessible to some could be inaccessible to others” because of, among other reasons, a language barrier” (Frame of reference, op. cit., page 26, quoting from H. Ouellet and J. Roy, “L’accessibilité aux services Sociaux in F. Dumont, S. Langlois, Y Martin, Traité des problèmes sociaux, Institut Québécois du recherche sur la culture, 1994, pp 867-888).
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