Making Quebec Health Care User-Friendly (again)

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by: Michael J. Hamelin, President of Alliance Quebec, Lynden Bechervaise, President of the Committee for Anglophone Social Action, Robina Goodwin, President of the Council for Anglophone Magdalen Islanders, Maurice King, President of the Chateauguay Valley English-Speaking Peoples Association, Scott Buckle, President of the Coasters' Asspociation, Bob May, President, Outaouais Alliance and Léon Jackson, Executive-Director of the Voice of English Quebec

Seeking the signatures of all Regional Association Presidents and all who took part on stage at the Centaur February rally.

When people go to the hospital they may need a blood test but they certainly don't need a language test. Lucien Bouchard, March 1996.

I can assure you that these (access to English-language service) plans will not be approved by Cabinet as they are. Bernard Landry, July 1997.

The change in attitude from the conciliatory stance of the Premier, expressed a year ago, to the threats of the Vice-Premier two weeks ago should force all Quebecers to pause and wonder.

We should wonder because the need has never been greater for a balanced, focused, well-managed health-care and social service system to meet the needs of all Quebecers.

Introducing arbitrary language rules to end English-language services for some people and to diminish them for all would be an end to the good will and fair play, between the English and French-speaking health-care communities that has served Quebecers so well in the past.

Who does that benefit?

No one that we can see.

Extent of English services

A great deal of misinformation is being spread about the use of English in health services. It's time the excess of rhetoric was replaced by hard facts. Then, we can start discussing the issue in what Parti Québecois ministers like to refer to as an "atmosphere of serenity." •

The facts of English-language health-care services are easily reported. Of the hundreds of health institutions and social services in Quebec, only 79 are designated to operate in English as well as French. From among all the other institutions, 170 are assigned to provide some services in English.

This is the "institutional bilingualism" that the Vice-Premier condemns. However, without the guarantee of institutional services, Quebecers would be left with a ridiculous choice:

a) no services for English-speaking people who live in every corner of Quebec

b) a parallel English network of institutions or

c) enforced bilingualism focused not on health institutions but on individuals

Legal guarantees of English service •

The Charter of the French Language itself gives the assurance of English institutions. An employer is also allowed under the Charter to require an employee have skills in a language besides French in some cases.

In more than 80 per cent of cases now, the reality is that French professionals offer their services in health care voluntarily in the English language. This voluntarism is the most important, and the most humane guarantee offered to Quebec's English-speaking communities.

This is not some dangerous accommodation to the dominance of the English language, as some would cry. It is, rather, the recognition that in health-care, language is a means of communications and not a political totem.

Simply, put, it is more important for the doctor to understand the patient and have the patient understand the doctor than it is to be politically correct on matters of faith and language.

Regional health-care norms •

Since 1994, the Ministry of Health and Social Services (MSSS) has assured all Quebecers that they can receive health care in their own region. To ensure those services are used, it restricts the transport of patients out of their own regions for treatment.

Under these rules, English-speaking patients must be served in their own language, in their own region. To jump from that to the conclusion that all services and all health-care workers will be "bilingual" is absurd.

The question is not whether there are too many services offered in English but whether the services offered in one region ought to differ materially from those offered elsewhere in Quebec. Is there to be discrimination among regions in Quebec? That's illegal!

Who benefits from that?

No one at all.

New concerns in health

Regionalization is not the only new concept in health care and social services. There is also the effects of the downswing of service, the loss through voluntary early retirement of a whole generation of health care professionals. •

There is the loss of existing institutions, especially in urban areas like Montreal and Quebec City. Services at these institutions which disappear have to be re-allocated elsewhere. •

Plans for using CLSCs more extensively as community health institutions remain in many cases only plans, not concrete realities of today's health care. •

All the while, the budget allotted for health care declines. Some money is being spent to make the changeover from yesterday's system to tomorrow's. While not wasteful spending, it is spending that is non-productive.

The additional burden of a language conflict is the last thing that our health-care system needs. So is the threat to force all health boards in each region to back up and revise the already completed access plans for English services. The ones that are now before Cabinet are the result of three years of hard work and tough negotiating.

It's about time there were more people saying, "this is no time for further waste." It's about time some of those people came from other communities beyond English-speaking Quebec.

What is needed is co-ordinated effort by all members in all communities to ensure that health-care services in these most difficult times are the best they can possibly be for all concerned.

Who benefits from that?

We all do.

• 1980 Sherbrooke Street West Suite 830 •
• Montreal, Quebec H3H 1E8 •
• Phone: (514) 932-3292 • FAX: (514) 932-3917 •
Webmaster
alliance
quebec