IMPROVING ACCESS TO HEALTH AND SOCIAL SERVICES FOR QUEBEC'S ENGLISH-SPEAKING POPULATION

DEVELOPMENT PRIORITIES 2013-2018

A document based on a consultation with personnel of organizations working to improve the health and well being of Quebec's English-speaking population

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Santé Canada Health Canada

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EXECUTIVE SUMMARY

The Government of Canada is preparing to renew its program to support Official Language Minority Communities, known as the *Roadmap for Canada's Linguistic Duality 2008-2013: Acting for the Future* (the Roadmap), for the period 2013-2018. In this context, Health Canada has called for a series of inputs to help inform their contribution. The current report was commissioned by the Community Health and Social Services Network (CHSSN) to present views gleaned from the experience of implementation of the Networking and Partnership Initiative (NPI). The initiative is one of the community development strategies intended to increase access to health and social services in English, coordinated in Quebec by the CHSSN and funded by Health Canada. Under the NPI program, community organizations (referred to as Network Sponsors) commit to establishing community networks: a formal grouping of community, institutional and other partners of the health and social services network. The shared goal of the NPI network is to improve access to health and social services in English for the English-speaking population of the region served. The coordinators of the NPI networks are uniquely placed to know what the priorities are for their communities and for continuing the work of improving access to services in English.

The report describes the how the Quebec Ministry of Health and Social Services' (MSSS) public health and social services network is organized, and how regional Access programs determine the way in which services in English are offered since they are not universally available. It describes how initiatives funded by the Roadmap are harmonized with and integrated into the public network.

The report also considers some key demographic characteristics (drawn from the 2006 Census) of Quebec's English-speaking population, which can have an impact on the demand for and the delivery of services, such as:

- Two thirds of the 994,720 English-speaking Quebecers resided in the Montreal-Laval regions, while the remaining third were dispersed unevenly in semi-urban, rural and remote regions, sometimes in very small numbers.
- The global percentage of seniors 65 years and over in both the English and French-speaking communities was about 13%. But outside of urban areas the percentage was much higher; over 20% in some regions.
- Newcomers from outside of Quebec and Canada comprised 10% of the English-speaking community, making it the most racially and ethnically diverse official language community in Canada. Those who left the community tended to have higher levels of educational attainment and income, while those who stay have lower levels.
- While seniors continued to have higher levels of educational attainment than their French-speaking co-citizens, the same was no longer true of the younger generations.
- English speakers were more likely to live below the low income cut-off (LICO) than French speakers; more had annual incomes under $10,000, and more were unemployed.

The NPI networks are active in 13 of Quebec's 18 administrative regions, and on the territories of 55 of Quebec's *Centres de santé et de services sociaux*, the key public institution delivering front line services and organizing access to secondary and tertiary services. Fifty-five percent of Quebec's English-speaking population reside in those territories. The NPI networks often interact with the English School Boards of Quebec, the network of Community Learning Centres, the regional staff of the Community Economic Development and Employability Corporation, the members of the Community Network Table (in the greater Montreal area), and the CHSSN itself. The coordinators of all 19 NPI networks were interviewed, as were leaders of the groups they often interact with. The NPI Network Sponsors and the NPI networks also interact with components of the McGill Training and Retention of Health Professionals Project, the other major program in Quebec funded under the Roadmap by Health Canada.

Population priority groups identified by interviewees are:

- The aged
- Caregivers (of the aged, and of others with chronic handicaps and/or conditions)
- Young people with difficulties, young people in general, and young families in which the parents have low socio-economic status and low educational attainment
- Visible minorities and new immigrants
- Those suffering mental health problems
- Those with dependence and substance abuse problems

Interviewees also identified priorities related to continuing the work to improve access to health and social services in English:

- Increased number of personnel in public institutions able and available to offer their services in English
- Continued availability of financial resources to sustain the work of the Network Sponsors
- Better data about the English-speaking community
- Centralization of and better access for English-speakers to information about services available in English
- Increased activities related to health promotion and prevention
- Continuing development of community leadership
- Increased availability of and use of distance technology
- Better transportation systems in rural regions, better supports for interregional travel to access specialized services and organized orientation service in English in host institutions for travelling patients

The report concludes by examining how these priorities converge substantially with the priorities identified by ordinary English-speaking citizens in *The Health and Social Service Priorities of Quebec's English-speaking population 1013-2018* published in 2012 by the Quebec Community Groups Network (QCGN). It further examines how both of these are compatible with the MSSS's Strategic Plan for 2010-2015 and with the regional Access programs.

1. The Purpose of this Report

This report has been prepared at the request of the Community Health and Social Services Network (CHSSN). It is intended for presentation to Health Canada in the context of the renewal of the Federal Government's commitments to official language minority communities (OLMCs) for the period 2013-2018. The report presents development priorities for the improvement of access to health and social services in English for Quebec's English-speaking communities as identified by the personnel of organizations working on this issue.

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2. Introduction

Studies have confirmed that language barriers affect access and quality of care for linguistic minority communities. Obstacles to communication can reduce recourse to preventative services; increase consultation time, including the number of tests and the possibility of diagnostic and treatment errors; affect the quality of services requiring effective communication such as social services; reduce the probability of treatment compliance and reduce users' satisfaction with the services received. For these reasons both of Canada's OLMCs and different levels of government have made it a priority to improve access to services in the language of the minority.

In 2003 the Government of Canada launched the *Action Plan for Official Languages* committing the federal government to enhancing the vitality of OLMCs, including Quebec's English-speaking communities. A five-year investment of $30.1 million through Health Canada supported measures in Quebec's health and social services system and English-speaking communities to improve access to services in English. The success of the first action plan led to a second federal program announced in 2008. The *Roadmap for Canada's Linguistic Duality 2008-2013: Acting for the Future* (the Roadmap) has committed $43.5 million until 2013 through Health Canada to support Quebec's initiatives to continue to improve access to services in English.

The Health Canada Contribution Program supports a range of projects implemented through agreements between community-designated organizations and the Quebec *Ministère de la Santé et des Services sociaux* (MSSS). These agreements ensure that the investments are integrated into English-speaking communities and the health and social services system in a manner consistent with the Quebec government's responsibility to plan, organize and deliver health and social services. The two community designated organizations that manage Health Canada investments are the Community Health and Social Services Network (CHSSN) and McGill University, which is responsible for the Training and Retention of Health Professionals Project (known as the McGill Project).

The McGill Project is mandated to: provide language training in English and French to health professionals; provide distance support to encourage English-speaking students in the health professions to integrate into French language working environments and create research and dissemination opportunities regarding strategies and best practices to address the health concerns of minority language communities.

The aim of CHSSN is to contribute to the vitality of English-speaking communities of Quebec by building strategic relationships and partnerships within the health and social services system to improve access to services. Funding to CHSSN has supported initiatives carried out via community organizations, such as the Networking and Partnership Initiative (NPI) and Community Health Promotion Projects (HPP). These

community organizations play a key role in the constellation of other programs funded under the Roadmap. They participate in the Adaptation projects of the *Agences* , the MSSS funded planning and coordinating body in each region. The organizations are also engaged with the Institut national de santé publique du Québec (INSPQ) in the development of tools and best practices to support the community organizations in their development of community health and social services networks. Many of these networks are at the heart of the McGill Project's measure to support the community role in promoting student internships and complementing the system's efforts to recruit and retain professionals in the regions. The community organizations also administer a bursary program for English-speaking students leaving their region for professional training and who intend to return upon graduation.

NPI has been at the heart of these efforts. It is a program designed to support Quebec's minority English-speaking communities in improving and maintaining access to the full range of health and social services. Community organizations (referred to as Network Sponsors) commit to establishing community networks: a formal grouping of community, institutional and other partners of the health and social services network. A community network aims to improve access to health and social services through partnership initiatives, cooperation with and participation in the public system, provision of information about community needs, support for the volunteer and community resources sector, and the promotion of services adapted to the needs of English-speaking people. The NPI Sponsor organizations and the NPI networks interact with the various components of the McGill Project. For the purpose of implementing the NPI program, CHSSN enters into partnership agreements with the sponsoring organizations mandated to develop the local community health and social services networks. In this way, the program supports the capacity of Quebec's English-speaking communities to ensure their vitality through cooperation and partnership with the health and social services system.

In order to determine the priorities for improving access to services for English-speaking Quebecers for 2013-2018, the Quebec Community Groups Network (QCGN) was invited by Health Canada to conduct a series of consultations of citizens in selected English-speaking communities between January and August of 2011. Via community networks, members of English-speaking communities were invited to participate. The resulting report, based on the sample of English-speaking Quebecers interviewed, presented the experiences and views of typical community members as they accessed health and social services in English, for themselves and members of their families, across a range of medical and social conditions, and across their lifespan. Their comments portrayed their individual priorities and permitted the consultants to identify broad areas of priorities. The resulting report entitled *The Health and Social Service Priorities of Quebec's English-Speaking Population 2013-2018* is posted on the QCGN web site at: www.tinyurl.com/a8lbpw8

To complement the views of typical community members, CHSSN decided, with the support of Health Canada, to seek the views of the NPI coordinators about priorities. The coordinators have a wealth of experience implementing measures and developing partnerships focussed on improving access to services in English. While not alone, they both design and implement improvements to access. They see what results have been produced, possess detailed knowledge of the people and the network of services in the communities in which they are involved and have a unique point of view on what the development priorities are for the period 2013 and 2018. The development priorities identified by them will be presented to Health Canada to assist it in the preparation of a new contribution program for Quebec's English-speaking communities.

3. Methodology

To capture these views, the CHSSN engaged two consultants to interview key informants using a semi-structured interview guide (See Appendix I). Two groups of key informants were identified. The first were the people who are formally identified as coordinator of an NPI network. At the time of this consultation there were 19 networks recognized and financed by the CHSSN. Since two networks were coordinated by

the same person, 18 coordinators were interviewed. NPI coordinators had the latitude to invite other staff from their sponsoring organizations to be present if they could add information. Several did so. A total of 30 people participated in these interviews. They were met in 17 distinct interviews; the two coordinators of both networks sponsored by the Townshippers' Association elected to be interviewed together.

The work of the NPI coordinators and the networks they animate requires their frequent interaction with other organizational actors concerned with the English-speaking population in Quebec. A selection of six of these groups was made. They were anticipated to have a perspective on some of the development priorities with respect to access to health and social services in English, given the clientele their mandate covers. A second category of 27 key informants were drawn from this group. They were met individually or in groups in a total of six distinct interviews. The same interview guide was used in these interviews. In all, a total of 57 people participated in 23 interviews about the development priorities.

4. Demographic Characteristics of Quebec's English-speaking Population

Interviewees sometimes referred to issues related to specific characteristics of Quebec's English-speaking population. To provide context, some highlights are presented here which are primarily drawn from the 2006 Canadian Census as reported in the CHSSN Baseline Data Reports (2003-2011) and the CHSSN Socio-Economic Profiles, both available at www.chssn.org. Information drawn from other sources is noted.

4.1 Population Size and Geographic Distribution

Across Quebec there were 994,720 English speakers who comprised Quebec's English-speaking communities. They represented 13.4% of Quebec's total population. The distribution of the English-speaking minority population across the provincial territory differed from that of the French-speaking majority. According to the 2006 Census, 66.8% of Quebec's English speakers resided in the urban Montreal-Laval regions compared to 23.1% of the total population of French speakers. In contrast to English speakers, the majority of French speakers (76.9%) were located throughout the regions outside of Montreal-Laval.

4.2 Age Structure

Canada's OLMCs, both inside and outside of Quebec, were characterized by a large proportion of seniors. Provincially, the age structure of the English-speaking and French-speaking populations is similar. For example, the percentage of seniors (65 years and over) was similar for both groups, at around 13%. However, when these groups are examined at a regional level, notable variances arise between language groups. For example, in 2006 a full 21.9% of Eastern Townships English speakers were 65 years or older. In the French-speaking community in the same region only 13.4% were in this age range.

4.3 Mobility Patterns and Diversity

Quebec's English-speaking community was composed of a significant percentage of newcomers from outside the province of Quebec and outside Canada. Across Quebec there were 101,175 English speakers who arrived from outside of Quebec between 2001 and 2006. In 2006 this in-migrant group represented 10.7% of the English-speaking population compared to only 2.6% of the French-speaking group.

Out-migration among English speakers has resulted in a decline in numbers for many of Quebec's regional communities. A study of migration patterns in recent years reveals that "...the gap between leavers and stayers has grown considerably as those who leave are much more likely than those who stay to be in the high income bracket and less likely to be in the lower income bracket than those who

stay" [1]. In contrast to those who leave, the English speakers who stay also displayed a lower tendency to have post-secondary schooling.

Mobility patterns have led to a demographic context where the English-speaking communities of Quebec are more ethno-culturally diverse than their French-speaking counterparts and are the most diverse of Canada's provincial OLMCs. English-speaking Quebec is composed of a greater percentage of members of visible minorities, a greater percentage of individuals of non-Christian religious affiliation and more individuals born outside of Canada than other OLMCs within Canada.[2] This diversity is most evident in the urban Montreal region.

4.4 Education

Historically, the English-speaking communities of Quebec have been distinguished by their high levels of educational attainment. In 1971, English speakers in Quebec had higher levels of education than other Quebecers and other Canadians. Consequently, English-speaking Quebecers aged 65 or older are, on average, somewhat better educated than French speakers of their generation. The 2006 provincial statistics show that the educational advantage of English speakers is disappearing and is now largely the result of high levels of educational attainment within the older demographic group. Younger English speakers are not achieving the same high level of educational accreditation as their predecessors. Across Quebec, there were 373,040 English speakers (age 15+) with a high school diploma or less as their highest level of educational accreditation. This group accounted for 44.7% of this segment of the English-speaking population.

4.5 Income and Labour Force Activity

Low-income and high unemployment are increasingly evident among Quebec's English-speaking communities across all regions of the province. The rate at which the low-income group relies on public resources, the type of resources they use, and their patterns of use concerning information access, all differ from the high income group. They are also less likely to have insurance or health plans from their workplace, and private care offerings are often beyond their financial reach.

4.5.1 According to the 2006 Census, 218,835 English speakers were living below the low income cut-off (LICO), which represented 22% of the total provincial English-speaking population. In relative terms, they were 38% more likely to be living below LICO than the French-speaking majority population.

4.5.2 In the Montreal region, 172,690 or 26% of English speakers lived below LICO, which is higher than the provincial rate for Quebec's English-speaking communities.

4.5.3 There were 230,365 English speakers, aged 15 and over, representing 27.6% of the total English-speaking population in this age group, with an annual individual income of under $10,000. In relative terms, English speakers were 18% more likely than French speakers to be in this income bracket.

4.5.4 According to the 2006 Census, 47,645 Anglophones (age 15+) or 8.8% of the total English-speaking provincial population were unemployed. Compared to the French-speaking population, English speakers were 33% more likely to be unemployed.

[1] Floch, W., & Pocock, J. (2008). "Emerging trends in the socio-economic status of English-speaking Quebec: Those who left and those who stayed." In Bourhis, R.Y. (Ed.) *The Vitality of the English-speaking Communities of Quebec: From Community Decline to Revival*. Montreal: CEETUM, Université de Montréal, p. 59.

[2] Pocock, J. (2009). *Language, gender and generation: The social economy approach to health and the case of Estrie's English-speaking communities.* Unpublished doctorate: Ottawa: Carleton University.

4.6 Summary

Based on the 2006 Census, the demographic characteristics of Quebec's English-speaking population differ from those of the linguistic majority with whom they share the province and from other official-language minority populations across Canada. The size, immigration patterns, economic status and age structure of this population are among some of the demographic traits that shape its health and social services needs. For example, needs for services for the elderly and their caregivers continue to be more pressing among English-speaking communities, especially in rural and remote areas. Perhaps most noteworthy among these traits are lower income and education as they are underlined by Health Canada and health organizations around the world as conditions that have profound influence on the overall health of individuals and communities.[3]

5. Context

The Quebec government has developed a system for the management and delivery of the health and social services it funds. Access to these services in English is the object of specific legislative provisions.

5.1 The Organization of Quebec's Health and Social Services System

Because interviewees often referred to institutions in the public institutional network of Quebec's health and social services system, a brief outline is provided here. The system has three levels:

- The Ministry (MSSS) responsible for:
  - "…planning, funding, allocating financial resources, follow up and evaluation."[4]
- *Les Agences*[5] "…responsible for coordinating the establishment of services in their respective territories."[6] Eighteen Agencies cover the entire province.
- The public institutions that serve all or part of a territory. The categories are:
  - *Les Centres de santé et de services sociaux* (CSSS)[7]
  - Hospital Centres
  - Residential and Long Term Care Centres (for the elderly)
  - Rehabilitation Centres (with sub-categories for specific health or social problems)
  - Youth Centres (Youth Protection, Young Offenders, etc.)
- Also present in every territory are individual professionals, private institutions and clinics and community organizations—all contributing to the local health and social services network.

The CSSS is considered a key player in this system. In addition to providing "…a wide range of primary care services, including public health services, and…the establishment of mechanisms of referral and follow up to ensure access to secondary and tertiary care…"[8], the CSSS has significant coordination responsibilities regarding the population of, and the services dispensed on its territory.

- *"At the local level, the local health and social services networks bring together all partners, including family physicians, in order to collectively share a responsibility for the population of a territory. At the*

[3] Health Canada lists some twelve health determinants that have been demonstrated to have a strong influence on the health status of a population. Income and education are ranked among the most influential of these. For further discussion see Raphael, D. (ED) (2008). *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholar's Press. See also WHO, Social Determinants of Health website: www.who.int/social_determinants/en/

[4] Ministère de la Santé et des Services sociaux (2008). *In Brief: The Québec Health and Social Services System*. Retrieved from publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-731-01A.pdf

[5] Translated as the Agencies.

[6] Ministère de la Santé et des Services sociaux (2008). *In Brief: The Québec Health and Social Services System*.

[7] Translated as Health and Social Service Centre.

[8] Ministère de la Santé et des Services sociaux (2008). *In Brief: The Québec Health and Social Services System*.

heart of the local network of services, the health and social services centre (CSSS) is the basis for an integrated provision of services and ensures accessibility, case management, follow up and coordination of services for this population."[9]

Further, it is part of the mandate of the CSSS is to:

- *"...coordinate the services offered by all providers working in the local territory;"*[10]

Because of their responsibilities related to access and coordination, NPI networks and other actors frequently interact with the CSSS of a given territory. There are 94 CSSSs located across the 18 regions of Quebec.

5.2 The Organization of Access to Services in English in Quebec's Health and Social Services System

Quebec's Health and Social Services Act guarantees access to health and social services in the English language to English-speaking persons. The guarantee is not universal. It is conditional and based on several articles in the Act:

- Article 15 expresses the guarantee and ties it to the contents of regional 'Access programs';
- Article 348 requires each regional 'Agency' (a regional coordinating body) to develop a regional Access program in collaboration with the institutions of the region;
- Article 510 requires each Agency to establish a regional Access Committee to advise it on the evaluation, modification and adoption of its Access program;
- Article 509 requires the government to establish a provincial committee to advise it on the provision of English language health and social services and on the approval of the regional Access programs, and finally;
- Article 508 provides that certain institutions can be required to make their services available in English.

A total of 42 of the roughly 200 public institutions in Quebec have been required by cabinet decree to make their services available in English (as well as in French). The majority are in or near Montreal and are institutions which were traditionally identified with English-speaking communities. The other approximately 160 institutions serve a predominantly French-speaking population. To make a regional Access program as complete as possible, many of these other institutions are asked and offer to contribute by making some, and occasionally all of their services available in English. Their ability to do this depends on the capacity of their staff members—most of whom have French as their mother tongue—to offer services in English. This manner of functioning explains how it can happen, as reported in the comments of some consultation participants, that English-speaking persons can come into contact with institutional personnel and programs unable to serve them in English and having no obligation to do so unless identified in an Access program.

When a regional Access program is complete, it identifies the institutions required to make all of their services available in English and the others in which some of the services are to be available in English. In some of the more remote regions, by agreement, the Access program identifies institutions in other regions to which patients must travel. Regional Agencies must consult with their regional Access committees before adopting their Access programs. These programs are then submitted to the government, accompanied by an official recommendation of the Provincial Committee for the delivery of health and social services in the English language. Each regional Access program must be approved by a cabinet decree and is revised every three years. The guarantee expressed in Article 15 of the Act is not univer-

[9] Ibid.
[10] Ibid.

sal; it is with respect to what is identified in the Access programs.

Individual health and social services professionals are regulated by their professional orders. It is a condition of membership that each professional demonstrate he/she can provide services in French. Members of professional orders are not required to provide services in English. Their decision to do so is usually based on their linguistic ability.

5.3 The Links Between Roadmap Initiatives and Quebec's Health and Social Service System

As mentioned, in Quebec Roadmap funded initiatives in the health and social service sector are carried out via the McGill Project and CHSSN programs. In order to respect Quebec's prerogative to plan, fund and coordinate a public health and social service network, initiatives undertaken by the McGill Project and CHSSN related to that public network are guided by the implementation agreements and coordination mechanisms both McGill and CHSSN have established with the MSSS. One of the key objectives of these arrangements is to assure that initiatives are coherent with the regional Access programs. This maximizes the complementarity of the community actions with those of the public network.

6. Profile of Interviewees

6.1 NPI Network Coordinators

At the time of the consultation there were 19 NPI networks established in 13 of Quebec's 18 regions. Their activities take place on 55 of Quebec's 94 CSSS territories. Using the 2011 Census figures for the number of persons reporting English as their first official language spoken (EFOLS), fifty-five percent of Quebec's English-speaking population reside in these 55 territories. The coordinators are experienced community organizers who have considerable knowledge about the English-speaking population in their region, the community and not-for-profit organizations active in their region, and the region's institutional network of service governed by the MSSS. The following table illustrates the links between the networks and the CSSS territories:

13 Regions	Regional Name	**55 CSSSs** (% of the region's English-speaking population in the listed CSSS territories - 2011 Census)	18 NPI Network Sponsors (19 NPI Networks)
01	Bas-Saint-Laurent	CSSS de la Mitis CSSS de Matane CSSS de Rimouski-Neigette (62%)	Heritage Lower Saint-Lawrence (HLSL)
03	Capitale-Nationale	CSSS de la Vieille-Capitale CSSS de Charlevoix CSSS de Portneuf CSSS de Québec-Nord (100%)	Jeffery Hale Community Partners (JHCP)
04	Mauricie-et-Centre-du-Quebec	CSSS d'Arthabaska-et-de-L'Érable (13%)	Megantic English-Speaking Community Development Corporation (MCDC)
05	Estrie	CSSS de la MRC-de-Coaticook CSSS Granit CSSS du Haut-Saint-François CSSS de Memphrémagog CSSS des Sources CSSS du Val-Saint-François CSSS-IUGS Sherbrooke (100%)	Townshippers' Association-Estrie
06	Montréal	1. CSSS de Saint-Léonard et Saint-Michel CSSS Lucille-Teasdale CSSS de la Point-de-l'Île CSSS d'Ahuntsic et Montréal-Nord 2. CSSS de Dorval-Lachine-LaSalle 3. CSSS de la Montagne CSSS Cavendish CSSS de Dorval-Lachine-LaSalle CSSS de l'Ouest-de-l'Île CSSS du Sud-Ouest-Verdun (29%)	1. East Island Network for English Language Services (REISA) 2. Catholic Community Services (CCS) 3. African Canadian Development and Prevention Network (ACDPN)[11]
07	Outaouais	CSSS de Papineau CSSS de Gatineau CSSS des Collines CSSS de la Vallée-de-la-Gatineau CSSS du Pontiac (100%)	English Network of Resources in Community Health (ENRICH) The NPI network is known as the Outaouais Health and Social Services Network (OHSSN).
08	Abitibi-Témiscamingue	CSSS de Rouyn-Noranda CSSS de la Vallée-de-l'Or CSSS des Aurores-Boréales CSSS Eskers de Abitibi CSSS du Témiscamingue (100%)	Neighbours Regional Association of Rouyn-Noranda. The NPI network is known as the Neighbours English Health Partnership Network (NEHPN).

[11] The ACDPN NPI network serves only the Black English-speaking population of the territories listed.

13 Regions	Regional Name	55 CSSSs (% of the region's English-speaking population in the listed CSSS territories - 2011 Census)	18 NPI Network Sponsors (19 NPI Networks)
09	Côte-Nord	1. CSSS de la Basse-Côte-Nord 2. CSSS de Sept-Iles CSSS de Port-Cartier CSSS la Haute-Côte-Nord CSSS de Manicouagan CSSS de l'Hématite CSSS Minganie CLSC Naskapi (100%)	1. Coasters Association The NPI network is known as the Lower North Shore Coalition for Health (LNSCH). 2. North Shore Community Association (NSCA)
11	Gaspésie-Îles-de-la-Madeleine	1. CSSS du Rocher-Percé CSSS de la Baie-des-Chaleurs 2. CSSS de La Côte-de-Gaspé 3. CSSS des Îles (99%)	1. Committee for Anglophone Social Action (CASA) 2. Vision Gaspé–Percé Now (VGPN) 3. Council for Anglophone Magdalen Islanders (CAMI) The NPI network is known as the Magdalen Islands Network Association (MINA).
12	Chaudière-Appalaches	CSSS de la région de Thetford CSSS du Grand Littoral CSSS de Beauce CSSS des Etchemins CSSS de Montmagny-L'Islet (100%)	Megantic English-Speaking Community Development Corporation (MCDC)
13	Laval	CSSS de Laval (100%)	Youth and Parents AGAPE Association Inc.
15	Laurentides	CSSS du Lac-des-Deux-Montagnes CSSS des Pays-d'en-Haut CSSS des Sommets CSSS de Saint-Jérôme CSSS de Thérèse-De Blainville CSSS d'Argenteuil (98%)	4 Korners Family Resource Centre The NPI network is known as the Laurentian English Service Advisory Network (LESAN).
16	Montérégie	1. CSSS de la Haute-Yamaska CSSS la Pommeraie 2. CSSS Pierre-Boucher CSSS Champlain CSSS Jardins-Roussillon 3. CSSS de Vaudreuil-Soulanges (84%)	1. Townshippers' Association-Montérégie Est 2. Assistance and Referral Centre (ARC) 3. Réseaux Emploi Entrepreneurship (REE)

6.2 Other Key Informants

As mentioned in Section 2, other key informants were selected from organizations concerned with the English-speaking population in Quebec and which interact with NPI networks. They are:

- The Executive Director of the Quebec English School Board Association (QESBA). QESBA supports the nine English public school boards in Quebec.
- The Administrators of Complementary Educational Services (ACES) of the nine Quebec English school boards. The complementary services of school boards work with students who have a wide range of learning, developmental and social problems. They are also often in contact with the families and other partners in the community involved with the same youth. Nine participants were present at the interview.
- The Provincial Coordinator of the Community Learning Centres (CLCs). The CLCs are an initiative of Quebec's *Ministère de l'Éducation, du Loisir et du Sport* (MELS). The funding is one of the streams committed under the umbrella of the Roadmap. Community Learning Centres are partnerships that provide a range of services and activities, often beyond the school day, to help meet the needs of learners, their families, and the wider community. Local CLCs and NPI coordinators and networks deliberately collaborate together over the use of CLC videoconferencing facilities, contribution to CLC's Healthy Schools initiatives, and in some cases, over school and community portraits.
- The Executive Director and the Provincial Development Officer of the Community Economic Development and Employability Corporation (CEDEC). CEDEC is also financed through funding under the Roadmap. It is focussed on community economic development and employability, primarily among Quebec's English-speaking communities. Some NPI networks have collaborated with CEDEC on social economy projects.
- The Community Network Table (CNT), an informal grouping of 10 community health and social services networks and other stakeholder organizations working together with the English-speaking population in the Greater Montreal region. Nine representatives were present at the interview. The members are:
  - East Island Network for English Language Services
  - Catholic Community Services
  - Youth and Parents AGAPE Association
  - African Canadian Development and Prevention Network
  - Assistance and Referral Centre
  - AMI-Québec
  - NDG Senior Citizens' Council
  - Batshaw Youth and Family Centres
  - Italian Canadian Community Services
  - Head and Hands
- The CHSSN staff. The CHSSN has provided a community support program for the NPI coordinators and has implemented other measures aimed at improving access to health and social services in English. Five staff attended the interview.

7. Interview Results

For each interview a summary including a brief profile of the organization and the main points identified by the interviewees was prepared. These summaries are in: *Improving Access to Health and Social Services for Quebec's English-speaking Population, Development Priorities 2013-2018: A Companion Document*. Population data used in the companion document is from the EFOLS counts as reported in the 2011 census. Based on the content of the interviews an analysis was prepared and is presented in the next two sections.

8. Priority Population Groups

Interviewees were asked to identify population groups that will be a priority in the period 2012-2018 and were invited to define them, whether by age, health status or in some other way. The following groups and conditions were identified as priorities by many informants:

8.1 The Aged

Almost all informants commented with concern on the isolation and vulnerability of seniors still living independently. Informants see them as having more fragile support systems, especially outside of urban areas. Their children are elsewhere in Quebec or beyond. A sudden illness or crisis can overwhelm seniors' ability to cope. They are often reluctant to make contact with services, in part because they lack French language skills, leading to avoidance of needed services. They also lack knowledge of how the service system works should they try to navigate it. Informants view the provision of homecare services in English as a priority for this population.

Some informants added to their priorities about the aged, the availability of placement resources in which the client can use English. The availability of such resources seems to vary from one region to another. For some regions this is definitely a priority.

8.2 Caregivers

Some informants were concerned about those caring for the aged or younger family members with conditions that place stress on caregivers (e.g., intellectual handicap or autism, mental illness, physical handicap or medical condition requiring intensive care). Therefore, one priority is the provision of respite for such caregivers in order to sustain their ability to continue to give care. Respite is not widely available and less so in English. The other concern is about the age of some caregivers. Several times informants referred to 70-year-olds taking care of 90-year-olds. While respite is an issue for these caregivers, there is an overarching concern about and a priority regarding care planning for the future for both groups. Informants pointed out that if the 70-year-old caregiver suddenly needs care, then the 90-year-old may be left in a situation that can deteriorate rapidly.

Informants see many of these citizens as having minimal contact with the institutional and volunteer networks. To the extent informants have a plan about such citizens, it is to be aware when such situations exist, monitor them, and build links to extended family and the institutional and volunteer networks before a crisis occurs. The high proportion of English-speaking aged in general and the greater concentration in rural and remote areas, heightens the pressure related to this priority.

8.3 Young People and Young Families

8.3.1 Youth with Difficulties

Youth with difficulties and special needs (due to intellectual handicap, developmental delay, physical handicap, language delay or handicap, learning problems, behavioural problems) were identified as a priority group by many key informants. For some of these needs, the general population has limited access to services. The service is even more of a challenge to find when it is required in English. Speech therapy and psychology are most frequently mentioned in this category. The informants who are coordinators of complementary services in English school boards were emphatic in their views that access problems make this an area of need that generates great stress for young people themselves, their parents and for school personnel. School personnel often feel they must try to respond to needs that go beyond their resources and expertise. They can find few partners in the community or the institutional network who can provide real help. The parents of

some of these young people come under the concern about caregivers mentioned earlier.

8.3.2 Youth in General

Many informants also identified priorities about young people in a more global manner. In some parts of the province key informants reported that the high school dropout rate among young English speakers is higher than the provincial average, already a source of societal concern. This is directly linked to the demographic profile of the younger English-speaking population with respect to educational attainment referred to in Section 4. The dropout rate varies from one region to another. Informants also considered it a priority to support young people to become qualified in the professional skills that are in short supply to the English-speaking population of the region. This involves risk because often the young person must leave the region to obtain qualifications. The challenge is to get these young people to return. Some informants referred to the positive effect of the supports provided by the McGill Project for such young people.

Some informants also spoke about parents and schools being in a state of denial about the rate of alcohol and substance consumption, abuse, and for some, dependence among young people. Supporting these young people to complete an education and acquire employable skills is a priority according to many informants. In rural areas, bussing to regional schools poses particular challenges to young peoples' connections to their community when they spend a substantial part of their day on a bus and/or in another geographic location.

8.3.3 Young Parents

The priorities identified above are related to another concern about young English-speaking families. Many informants spoke about how they are seeing a cohort of young English-speaking parents who are the opposite of a long-standing stereotype of Quebec's English-speaking population. These young parents are less educated than the average since they emerged from a cohort with a higher dropout rate. They tend to place a lower value on education, which can lead to transmitting similar values to their children, perpetuating the cycle. Some are viewed by informants as not possessing good parenting skills, which has implications from before birth through to adulthood.

Many, because of low educational attainment, are unemployed or under-employed. For some, alcohol and drug use are significant, and the values parents pass on to their children, sanctioning consumption, trouble some informants. These families tend to have below average incomes and may be economically disadvantaged. The prevalence of this cohort varies from region to region. They are among that part of the English-speaking population described in Section 4 as having lower educational attainment, more likely to be living below LICO and to be unemployed.

All these factors taken together speak of a group living in relative material and social deprivation for which the determinants of health are weighted in a negative direction, now and possibly in the future, producing a greater likelihood of physical, psychological or social problems. For many observers, the concern about these families and their children makes the focus on educational and skill acquisition mentioned earlier an even more pressing priority.

8.4 Visible Minorities and New Immigrants

Several interviewees, mainly from regions in or near Montreal, remarked on the significant presence of visible minorities, some of whom are long established in Quebec society, and others who are newly arrived immigrants. They identified two priorities related to these groups. The first is the challenge of making the broader community organizations relevant to these populations. The second is that of promoting adaptations on the part of the institutional network. Some population groups and the institutional network have minimal contact. Their needs are little known.

8.5 Mental Health

This was a frequently mentioned priority. Availability of sufficient mental health services to the general population is viewed as inadequate. Further, many remarked that if a patient's condition required second or third level intervention in English, which can be very hard to access depending on region of residence, it could mean leaving the region or not receiving services. The availability of adequate first-line services in English is uneven according to informants' comments. Conditions such as depression, suicidal behaviour and psychosis were among the types of problems mentioned. Informants commented that often people with substance dependence and abuse problems also have associated mental health problems.

8.6 Dependence and Substance Abuse

Dependence and substance abuse problems were identified by key informants in connection with other conditions (youth at risk; young parents with limited education, income and prospects; people with mental health problems). Nonetheless, they were mentioned often enough to constitute a distinct priority.

9. Priorities About Improving Access

Interviewees were also asked to identify priorities regarding *how* access can be improved in the period 2013-2018. Informants' comments surface several priorities concerning how to work on the population priorities.

9.1 Human Resources and the English Language

Most informants mentioned that a key obstacle to accessing service in English, aside from the scarcity of certain professions, is the limitation on the ability of French-speaking professionals and personnel to give service in English. It is a priority to increase the number of professionals who can offer service in English. Some informants mentioned the positive results of the language training for professionals and the supports for field placements provided by the McGill Project.

The priority applies not only in the region of residence, but also in centres to which English-speaking clients/patients are referred if they live in rural or remote regions (e.g., Sept-Îles, Rimouski, Quebec). The level of participation in language training offered to network personnel is thought to show a strong interest and willingness on the part of many to acquire or improve their English. Many informants identified this as an important priority, with an increased emphasis on opportunities for integration so that language acquired in the classroom can be more readily transferred into the workplace. The priority mentioned in Section 8.3—that of getting young English speakers trained in health and social services professions and back working in their regions—is another goal that will also contribute to addressing this priority.

The priority concerning language training goes beyond the institutional network. Several informants spoke about community organizations that exist for the whole population, but which have difficulty offering their services to English speakers because of limitations on the ability of their staff to use

English. It is part of the priority about language training to see it extended to staff and volunteers of these organizations wanting to serve both linguistic communities. This, together with an increasing ability of English speakers to use French, can increase the supports available to vulnerable members of English-speaking communities and diminish the extent to which a crisis precipitates the need for support from the institutional network.

9.2 Resources

The top priority related to resources is the continued availability of financial resources to support the capacity of community organizations to undertake their activities. Without these resources all NPI coordinators said it would be nearly impossible to achieve the improvements in access they have seen to date. In particular, it would be nearly impossible to let the community become a credible and trusted partner to the network of public institutions.

9.3 Information

Key informants considered three types of information as essential for working on the population priorities:

9.3.1 Information About the English-speaking Community

Many informants mentioned that the institutional network views them as a valuable partner in understanding the needs and priorities of the English-speaking community. They identified maintenance of their data base about the community as a priority. For newer networks, improvement of the data base is the priority.

9.3.2 Information About the Institutional Network and Services in English

Many informants spoke about a type of illiteracy they observe in the English-speaking community concerning how the institutional network functions, which services are available in English and their location. They see it as a priority to have all this information in one place, kept up to date, and promoted so as to develop the reflex in the community to always use that resource first when seeking services.

9.3.3 Information Related to Health Promotion

Many informants spoke about the health promotion programs already delivered. It is a priority to continue and expand this work, the goal of which is a healthier community. In particular, it assures that the information will be available in English. Second, using the platform of English-speaking community organizations allows practitioners from the MSSS network, whether located in the region or from other regions, to reach citizens via videoconferencing. Key informants mentioned that some citizens avoid the network institutions out of apprehension they will not receive information and services in English.

9.4 Community Leadership

Many informants said it is a priority to have community members participate in and sustain their organization. They use events and media to increase visibility, reach out to the community and demonstrate the organization's relevance. They consider it important that the organization exercise leadership in the community. This priority also refers to the continual development of leadership inside the community organizations. It includes training members in leadership in order to sustain both the organizations themselves and enhance their capacity to be seen as credible partners by the institutional network.

9.5 Distance Technology

Informants outside of urban areas often identified the expanded use of distance technology as a priority in the delivery of information concerning health and social services. They referred to the success of programs delivered by the CHSSN using such technology. They see this as a way to share information and in some cases professional expertise, quickly and inexpensively. Some wonder if speech therapy or other therapies using distance technology might be possible.

9.6 Transportation and Access to Health and Social Services

Many informants mentioned that the absence of public transport or the presence of a very basic public or volunteer transportation system within a region is an obstacle to accessing service. This is particularly true for some segments of the population such as seniors, youth and economically disadvantaged parents.

Many also identified the cost of interregional travel, for which existing government contributions never cover the full amounts, as another obstacle. This affects the whole population, not just those seeking services in English. Unilingual or less bilingual English speakers using public transportation to access services in other regions can face discomfort and uncertainty, which adds to the challenge of accessing services.

Rural and remote CSSSs have budgets to support interregional travel. However, the real costs outstrip the size of these budgets. None of the Network Sponsor organizations foresee making transportation part of their own health and social service activities. However, they identify transportation as a social priority, whether for a municipality, a social economy enterprise or a volunteer service, because of its direct impact on access to health and social services.

10. Comparisons of Priorities Concerning Access to Services in English

The interviews which are the basis for the current report were not the first attempt to solicit perceptions about priorities for the improvement of access to health and social services in English in the context of preparations for renewal of the Roadmap. In May 2012 the QCGN submitted a report to Health Canada that identified priorities drawn from interviews with ordinary English-speaking Quebecers and key informants from community organizations. These priorities were organized in a list of specific priorities identified by participants and five broad areas the report authors identified which are presented in full in Appendix II.

The following table illustrates the convergence between the priorities identified in this report (column 1) and those in the QCGN report (columns 2 and 3). The relevant section numbers from each document are provided for each topic. Not all priorities correspond, but there is considerable convergence.

Priorities Identified in this Report	QCGN Report: Specific Priorities	QCGN Report: Broad Priorities
Priority Population Groups		
8.1 The Aged	6.2 The elderly	7.2 Adaptation of Local Services to Local Needs
8.2 Caregivers	6.2 Priorities concerning the elderly	7.2 Adaptation of Local Services to Local Needs
8.3 Young People and Young Families 8.3.1 Youth with Difficulties	Mentioned frequently in focus groups	7.2 Adaptation of Local Services to Local Needs
8.3.2 Youth in General	Ø	Ø
8.3.3 Young Parents	Ø	Ø
8.4 Visible Minorities and New Immigrants	First Nations and immigrants mentioned in some focus groups	7.2 Adaptation of Local Services to Local Needs
8.5 Mental Health	6.1 Mental health	7.2 Adaptation of Local Services to Local Needs
8.6 Dependence and Substance Abuse	6.3 Dependency services	7.2 Adaptation of Local Services to Local Needs

Priorities About Improving Access		
9.1 Human Resources and the English Language	6.3 More bilingual staff	7.1 Adaptation of Human Resources
9.2 Resources	6.3 The need for support for community organizations	7.5 Involvement of Community
9.3 Information 9.3.1 Information About the English-speaking Community	Ø	7.4 Creation of a Continuing Knowledge Base About English-speaking Users
9.3.2 Information About the Institutional Network and Services in English	The need for this was mentioned frequently in focus groups	7.3 Availability of Information About Services in English
9.3.3 Information Related to Health Promotion	6.1 More prevention	7.2 Adaptation of Local Services to Local Needs
9.4 Community Leadership	Exercising leadership in the community and institutional network regarding the need for services in English	7.5 Involvement of Community
9.5 Distance Technology	The burden of travel and the need for supports were mentioned frequently in focus groups	7.2 Adaptation of Local Services to Local Needs
9.6 Transportation and Access to Health and Social Services	Ø	7.2 Adaptation of Local Services to Local Needs

The QCGN document containing the specific and broad area priorities was submitted to the MSSS for an opinion. The full text of the opinion, in translation, is presented in Appendix III.

In the opinion conveyed by Associate Deputy Minister Michel Fontaine, he wrote "Our own analysis found that the concerns of English-speaking people presented in your study as well as its priorities and areas for action coincide with the priorities and actions described in the MSSS's 2010-2015 strategic plan (see appended document). The problems that English-speaking people face are, for all practical purposes, the same as those faced by French-speaking people. This perception is shared by a number of agencies. It is rather the solution to these problems that, in certain circumstances or in certain regions, is at times unpleasant for English-speaking individuals, due to the scarcity of resources to meet their needs in English."

Concerning the five broad areas, M. Fontaine continued, "In terms of the 'areas for future action' and the 'five broad areas for future action,' there is a consensus between us on the relevance of four of them, i.e., the adaptation of human resources (training, field placements, etc.), the adaptation of local services to local needs, the availability of information about services in English, and the involvement of the community. "

The area the MSSS had reservations about concerned the creation of a knowledge base regarding English-speaking users. About this M. Fontaine wrote: "While acknowledging the merit of developing this bank of information, the MSSS believes that the process for creating it requires further thought."

Concerning the actions undertaken based on Roadmap funding, M. Fontaine wrote: "The MSSS, the Provincial Committee, and regional authorities recognize the relevance of investments in these four sectors of activity [mentioned above] that are in line with Quebec's strategic planning and that facilitate access to services in English for English-speaking people. Consequently, we strongly recommend the renewed enhancement of the Official Languages Health Contribution Program under the aegis of Health Canada."

The fact that the priorities link well to MSSS planning and are carried out with MSSS consent and in the light of the Access programs, heightens the pertinence of the priorities identified in the QCGN document. The fact that the priorities identified by NPI coordinators and other key informants link well with those in the QCGN document is an indicator that they also align well with MSSS planning and Access program priorities.

Concluding Remarks

Key informants familiar with Quebec's English-speaking communities and Quebec's institutional network were able to identify some priority population groups which will need attention in the period 2013-2018. They were also able to identify clear priorities regarding the means to address these population groups and to continue the partnerships developed with the MSSS's institutional network. The priorities of these key informants are consistent with the broad priority areas identified after a consultation of a representative sample of 'ordinary' English-speaking Quebecers which the MSSS has identified as consistent with its strategic priorities. Actions based on such priorities are carried out after agreement with MSSS and in the light of specific needs indicated in regional Access programs.

APPENDIX I - Interview Guide

Priorities for Development of Access from the Perspective of Community Organizations

Key Informant Interview Guide 31.07.12

Preamble: Health Canada is preparing for renewal of its programs to support official linguistic minorities in the period 2013-2018. It has called for a range of inputs from the English-speaking communities of Quebec to determine the focus of its programs in 2013-2018 to continue supporting better access to health and social services in English in Quebec. This interview, along with those of other key informants about English-speaking communities of Quebec, will be part of that input. It will be used in a document reflecting the priorities for development of access from the perspective of community organizations that have carried out programs and projects funded by Health Canada.

A. RESPONDENT BACKGROUND

1. **What territory and population does your organization serve?**

2. **What is or are your organization's role or roles vis-à-vis the English-speaking community in your territory?**

    - For example: Service provision? Networking? Brokering? Advocacy?
    - Do you belong to multiple organizations and if so, how are they connected to each other?

B. PRESSING ISSUES AND PRIORITY ACTIONS

In answering the next questions please consider all the information available to you, as an observer of the community and as someone who works with and for the community, about:

- Your community's strengths and needs
- How you expect the health of the English-speaking population will evolve in the next five years

1. **What are the most pressing issues to act on to ensure the best possible health situation of the English minority in your territory five years from now?**

    - Issues for what ...

        ¤ Client groups
        - Age groups, social or economic condition, cultural communities, life circumstances

        ¤ Health, social problem areas
        - Prevention, acute illness, chronic illness, physical or mental disability, mental health, addiction, adaptation

        ¤ Access to services and practitioners
        - Distance, waiting times, costs, language
        - Public, private

2. **How did you arrive at these as your most pressing issues?**

    - What information did you consider?
    - Who was consulted/provided input?

3. **How should action be taken on the issues you consider most pressing to ensure the best possible future health situation of the English-speaking minority?**

4. **How did you arrive at these actions on your most pressing issues?**

    - What information did you consider?
    - Who was consulted/provided input?

Health Canada Objectives

- ✓ Prevent and reduce risks to individual health and the overall environment
- ✓ Promote healthier lifestyles
- ✓ Ensure high quality health services that are efficient and accessible
- ✓ Integrate renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection
- ✓ Reduce health inequalities in Canadian society
- ✓ Provide health information to help Canadians make informed decisions

MSSS Strategic Issues: 2010-2015

- ✓ Upstream action (prevention) and reducing inequities
- ✓ Reasonable wait times
- ✓ Service quality and innovation
- ✓ Health human resources
- ✓ System costs and management
- ✓ Primary care in an integrated hierarchical context
- ✓ Provide health information
- ✓ Strengthen community action

Clienteles with Special Needs

- ✓ People suffering from chronic diseases or cancer
- ✓ Youth in difficulty
- ✓ People with mental health problems
- ✓ People who are addicted
- ✓ People with a disability and their families

Population Health Determinants

- ✓ Income and social status
- ✓ Social support networks
- ✓ Education and literacy
- ✓ Employment/working conditions
- ✓ Social environments
- ✓ Physical environments
- ✓ Personal health practices and coping skills
- ✓ Healthy child development
- ✓ Biology and genetic endowment
- ✓ Health services
- ✓ Gender
- ✓ Culture

APPENDIX II - Extracts from the QCGN Priorities Report

Extracts from The Health and Social Service Priorities of Quebec's English-Speaking Population 2013-2018, produced by the Quebec Community Groups Network in 2012.

6. Specific Priorities Identified by Consultation Participants

Focus group participants and key informants were asked about their priorities in the next five years concerning access to health and social services in English. Some priorities they identified were not always language-based. Some were focussed on the part of the service system that most preoccupied the respondent at the moment, as opposed to priorities that take into consideration the overall service picture. Not all priorities are objectives that fall within the scope of *Canada's Roadmap for Linguistic Duality*. The following is a summary.

6.1 Priorities Regarding Health and Social Services in General

- More family doctors;
- Better access to tests;
- Better access to specialists;
- More clinics and longer clinic hours to avoid long waits and use of emergency units;
- Avoidance of having one doctor alone on duty. A major case paralyzes the service;
- Better arrangements to assure that follow-up medical care is well handled, particularly the links between clinics and emergency units, and specialist;
- Some participants suggested that computerization could streamline the management of referrals, whether in the medical or social service domain;
- Increased number and scope of nurse practitioners: allow them to do more kinds of tasks, they relieve the pressure on doctors, thus rendering them more available, they give quality services, and they are often bilingual.
- More prevention;
- Better interprovincial transportability of access to services;
- Shorter waits for Info-Santé;
- Better supports for network staff to counter stress;
- More mental health services;

First Nations participants had a specific set of concerns that include:

- Better complementarity between services given on-reserve funded by Health Canada, and services given on and off reserve by the Quebec service system;
- Attention to a specific set of problems, the severity of which is perceived by key informants as accelerating rapidly:
  - ¤ Addictions
  - ¤ Cancer
  - ¤ Mental health
  - ¤ Suicide
  - ¤ Diabetes
  - ¤ Coronary disease
  - ¤ Family crises: family violence, elder care and abuse, child placement
  - ¤ Renal failure
  - ¤ Access to safe drinking water

6.2 *Priorities Concerning the Elderly*

Many of these priorities would also apply to services to the elderly given in French:

- More services for the elderly, including services to support basic fitness and wellness;
- More home care for the elderly;
- More supports for caregivers.

6.3 *Priorities Regarding Access to Services in English*

- More bilingual staff, especially professionals in contact with patients/clients;
- More emphasis on bilingualism at the reception desk to help orient people;
- Better access to dependency services in English;
- Organize a 'reception' service, in cities and towns that receive English speakers from elsewhere to access specialized medical services. Help them negotiate the town, find lodging, and access the institution where they will receive services;
- In institutions where it is known that English speakers will seek service, organize a translation service;
- Participants identified different ways they think it worthwhile to 'speak up' about access to services in English:
  - ¤ Individually
  - ¤ As a collectivity
  - ¤ In communities
    - By speaking with individual service providers and teams
    - Through contact with, and participating in the leadership of the institutional network
    - By supporting and/or becoming involved in community organizations focused on advocacy for English-speaking communities in Quebec

7. *Five Broad Priority Areas for Future Action*

Based on the consultation of individuals and the survey results, five broad strategic priorities for the future were identified.

7.1 *Adaptation of Human Resources*

The availability of English-speaking human resources in the network who can respond to the needs of English-speaking Quebecers seems key to improving their satisfaction. Existing initiatives in language training have been welcomed. Participants and key informants reflected their awareness that training has taken place and have identified it as a factor contributing to service improvement. Considering the rate of turnover and mobility in the network, language training will likely be a continuing need.

In the long run, institutions need to be supported in their ability to recruit staff, from whatever linguistic community, that can respond to the needs of the English-speaking population. Measures such as adapted field placements for students from English-language professional training programs, is an example. Others need to be identified and pursued.

7.2 *Adaptation of Local Services to Local Needs*

The network of health and social services and its institutions do not all face exactly the same problems when it comes to assuring access to services in English. The wide variation in experiences reported by consultation participants supports this view. The regional Access Plan is a tool by which regional Agencies can plan their services to English-speaking citizens. A periodic review of this plan

affords a mechanism for adjustment. Agencies need some flexibility to pilot adaptations of services to improve access for English speakers that take into account local conditions. Flexibility can permit Agencies to focus on at least two areas that emerged as problematic in the consultation.

The first is the smoother integration of the services accessible to First Nations residents. One might think that First Nations people have an advantage in being the clear beneficiaries of two systems (federal and provincial). However, problems in the coordination of the two systems and the lack of adaptation of local services to First Nations needs, among other issues, can turn into a disadvantage.

The second is that very long wait times, and in some circumstances, the complete inaccessibility of service in English for some types of conditions, can constitute a real and serious compromise to the health and well-being of citizens. In general, access to services in English is somewhat easier for health services than it is for other types of services in which the principal tool is language (e.g., mental health and other psychosocial services, social services, language therapies). Agencies need flexible support to address these access gaps where they exist.

7.3 *Availability of Information About Services in English*

On many occasions consultation participants mentioned their difficulty finding up-to-date information on the availability of services in English. Some information is still transmitted by word of mouth. The information in question concerns the services of the public network of institutions, the professional in private practice, and the services available from community organizations. Individuals and communities are continually updating their resource and contact lists. Beyond the actual availability of service in English, the consistent availability of information about it is probably the greatest determinant of whether service is obtained in English. This need for information about services in English could be addressed by a structured and durable intervention that allows the sources of information (service providers) and citizens who need the information to interact in a reliable and widely known manner. Online platforms for such information already exist in the MSSS web pages and those of such organizations as the CHSSN, the QCGN and the English advocacy groups in the various regions.

7.4 *Creation of a Continuing Knowledge Base about English-Speaking Service Users*

There is currently no single source of information and analysis that permits an overview of the evolving needs of the English-speaking population, their use of the health and social services system, and the outcomes of that use. Client information systems do not capture service use by English speakers. Service use data cannot be analyzed using linguistic factors. Such a source of information would be useful to both system planners and community leaders. More specifically, it could allow for faster identification of service areas where access problems have evolved from inconvenient to harmful.

This need for this knowledge base is not restricted solely to the portrait of service needs and access. It applies also to satisfaction, since that is evidently important to English speakers, and is an important phenomenon recognized and studied in the literature about health and social services system delivery. While this consultation did not do so, it could be interesting to compare institutions recognized as providing satisfaction to English-speaking users. This may clarify the minimum specifications of satisfaction regarding access to services in English that could lead to articulating a model of institutional behaviour that will elicit user satisfaction. This might also be helpful to other organizations seeking to produce the same outcome. Part of such an effort is the ability to document the capacity of the health and social services network to provide service in English. Such information would be useful for human resource planning and in the development of access plans. It could

also help an understanding of the extent to which English speakers are employed in the network, an important factor in the provision of service in English.

A complement to such an examination would be to identify the minimum needs of English-speaking patients/clients, which, if met, will produce the reaction and experience of satisfaction. Identifying minimum needs can provide an operating model of the components of satisfaction for the user when it comes to language of service.

7.5 *Involvement of Community*

Consultation participants said much about the benefits of community representation, whether through individuals or organized groups, in the improvement of access to services in English. The expression of need for service in English from individual users of the system is important. However, that expression is enhanced by community facilitation and collaboration with the public system. Examples were described where community organizations can accomplish more quickly and efficiently, the distribution of information about various diseases and other problems. Community groups are a source of volunteers and other community resources helping institutions meet users' needs. The role they can play in helping institutions identify problems and find adaptations and solutions was mentioned several times during the consultation. The importance of a source of support to sustain infrastructure was also emphasized. Participants explained that such support holds the potential for a win-win effect.

English-speaking citizens have opportunities to participate on the boards of public institutions in the health and social services network. The MSSS has emphasized the importance of the roles played by boards, and the desirability of the participation of a representative cross section of Quebec society including English-speaking Quebecers. The Act Respecting Health Services and Social Services defines the role board members are asked to play in the administration of the affairs of each type of institution and it determines the mechanisms whereby interested persons can be elected or named to a board. Interested persons from English-speaking communities have the opportunity to be named or elected by any of these mechanisms. Community organizations in English-speaking communities have been instrumental in informing and supporting English-speaking citizens in their efforts to participate in these important governance structures. This support will continue to be needed and should be intensified during the election and nomination process.

APPENDIX III – MSSS Opinion and Strategic Plan

BY E-MAIL

Quebec City, February 17, 2012

Sylvia Martin-Laforge
Director General
Quebec Community Groups Network
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Subject: MSSS's opinion of the document "The Health and Social Services Priorities of Quebec's English-Speaking Population 2013-2018, A discussion document based on a consultation of Quebec's English-speaking population, October 2011"

Dear Ms. Director General:

This opinion is in response to your request of November 30, 2011, on the above-mentioned topic. To be able to respond to your request, we asked for the opinion of the Provincial Committee for the Delivery of English Language Health and Social Services. We also solicited the opinion of regional authorities and sought the views of members of their regional access committees on services in English. Our efforts also led us to make the link between the priorities identified in your discussion document and those retained by our department in its 2010-2015 strategic plan. To date, agencies from the following 13 regions have submitted opinions: Saguenay–Lac-St-Jean, Capitale-Nationale, Mauricie and Centre-du-Québec, Estrie, Montréal, Outaouais, Abitibi-Témiscamingue, Côte-Nord, Nord-du-Québec, Gaspésie–Îles-de-la Madeleine, Laval, Laurentides, and Montérégie. The opinion of the *Ministère de la Santé et des Services sociaux* (MSSS) is presented in the following pages. This opinion is the outcome of all our consultations.

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Structure of the discussion document

Your discussion document would be clearer if the priorities that emerged from the various consultations and information sources (i.e. English-speaking population, informants, key individuals, surveys, etc.) were presented by order of importance and by client program. It would also be important to establish a link between these priorities and the 2013-2018 action plan described in the current text of Chapter 7: "Five Broad Areas for Future Action."

Method of consultation

Considering the limited number of participants (a total of 222 people), the number of regions represented (6 regions out of a total of 18), and the method of selecting or inviting the individuals reached during your consultations, the validity of your document could be called into question.

Target clientele

The definition that you retained in the discussion document for an English-speaking person – "person for whom English is the official language used most regularly" – differs significantly from that commonly used to designate these individuals in the context of delivering health and social services, i.e. "an English-speaking person is he or she who, in their relation with an establishment providing health or social services, feels more at ease expressing their needs in English and receiving services in that language." In the context of a province whose language of work is French, the definition retained, which refers to people who use English "more regularly," automatically excludes a good number of English-speaking people who deal with their fellow citizens in French on a daily basis. Thus, the definition retained for this consultation could lead to a certain bias in the text. It should be noted that the Provincial Committee on the Dispensing of Health and Social Services in the English Language has used the concepts of mother tongue and first official language spoken.

Quebec's linguistic context

As you know, Quebec has had a Charter of the French Language for over 30 years. Today, this Charter governs the language affairs of the province in such a way as to restore and maintain a certain linguistic peace. Any activity carried out in the language domain must take this important legislation into account.

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The language context in Quebec has as much impact on the delivery of health and social services in English as does the demographic context of English-speaking communities. The text of your discussion document should reflect this reality and therefore be nuanced, without censuring the legitimate remarks expressed by participants. As an example, the lack of signs in English is strictly regulated in institutions that are not recognized under section 29.1 of the Charter.

Comments on the content

Our own analysis found that the concerns of English-speaking people presented in your study as well as its priorities and areas for action coincide with the priorities and actions described in the MSSS's 2010-2015 strategic plan (see appended document). The problems that English-speaking people face are, for all practical purposes, the same as those faced by French-speaking people. This perception is shared by a number of agencies. It is rather the solution to these problems that, in certain circumstances or in certain regions, is at times unpleasant for English-speaking individuals, due to the scarcity of resources to meet their needs in English.

In terms of the "areas for future action" and the "five broad areas for future action," there is a consensus between us on the relevance of four of them, i.e. the adaptation of human resources (training, field placements, etc.), the adaptation of local services to local needs, the availability of information about services in English, and the involvement of the community. The MSSS, the Provincial Committee, and regional authorities recognize the relevance of investments in these four sectors of activity that are in line with Quebec's strategic planning and that facilitate access to services in English for English-speaking people. Consequently, we strongly recommend the renewed enhancement of the Official Languages Health Contribution Program under the aegis of Health Canada.

In terms of the creation of a knowledge base regarding English-speaking users, opinion is divided. There is a fear of stigmatizing English-speaking people, and there is doubt about the usefulness of the data that could be compiled. The Provincial Committee has indicated to us its wish to take advantage of the computerization of user files to add a mandatory field that would indicate the language in which the user would like to receive services. We already know that the *Régie de l'assurance maladie du Québec* has statistics on individuals who have expressed the wish to receive correspondence from it in English.

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It is the Provincial Committee's opinion that gathering statistics from the files of English-speaking users would indicate to us their patterns of using health services and enable the system to better target its future efforts. While acknowledging the merit of developing this bank of information, the MSSS believes that the process for creating it requires further thought.

We retain one point that was brought to our attention by the Provincial Committee: the participation of English-speaking people in the governance of Quebec's health and social services institutions. This theme is not addressed in your discussion document, but would have been relevant under the topic "involvement of community." There is room for the involvement of individuals from English-speaking communities on the boards of directors of public institutions.

Boards of directors are where institutions' decisions are made, priorities set, budgets allocated, orientations adopted, and senior administrators hired. Boards of directors are privileged places for influencing the governance of the institution and drawing attention to the needs of fellow citizens. The involvement of English-speaking individuals in the governance of institutions merits the consideration of the Quebec Community Groups Network prior to finalizing its process and merits being included in the document's final version.

We thank you for your commitment to health and social services for your fellow English-speaking citizens. We remain at your disposal for any additional information.

Sincerely,

Michel Fontaine
Associate Deputy Minister

Encl.

cc: Pierre Laflamme, Assistant Director General
Marjorie Goodfellow, Chair, Provincial Committee for the Delivery of English Language Health and Social Services

[appended document]

Provincial Committee for the Delivery of English Language Health and Social Services

2010-2015

Strategic Plan

Ministère de la Santé et des Services sociaux and the link with priorities expressed by the English-Speaking Population

January 2012

INTRODUCTION

The Quebec Community Groups Network (QCGN) was mandated by Health Canada to identify the priorities of members of Quebec's English-speaking communities. This process was undertaken in preparation for the renewal of the Official Languages Health Contribution Program and the *Roadmap for Linguistic Duality in Canada 2008-2013*.[12] The QCGN is aware that the provision of health and social services falls within Quebec's jurisdiction. It wishes to validate the perception that emerged from consultations conducted in 2011 and that are presented in the discussion document *The Health and Social Services Priorities of Quebec's English-Speaking Population 2013-2018*[13] with Quebec's authorities, i.e. the *Ministère de la Santé et des Services sociaux* (MSSS).

The information contained in this discussion document was obtained from direct consultations with English-speaking people from various communities throughout Quebec, a survey commissioned by the Community Health and Social Services Network (CHSSN), and the observations of consultants hired to carry out this project.

Furthermore, the MSSS wishes to involve Quebec authorities set up to ensure that the delivery of health and social services meets the needs of English-speaking Quebecers. As per its mandate, the MSSS asked the Provincial Committee for the Delivery of English Language Health and Social Services to provide its opinion on the document submitted by the QCGN. To do this, the MSSS asked the Provincial Committee to take into account the opinions of the *Agences de la santé et des services sociaux* and their regional access committees.

The present Provincial Committee document links elements in the MSSS's 2010-2015 strategic plan[14] with information in the QCGN's discussion document. In a second phase, the Provincial Committee will compile the opinions of the *Agences* and ensure consistency with the same strategic plan. For each challenge identified in the strategic plan, links with priorities in the "English-speaking population" are presented in an italicized list.

[12] Government of Canada, Department of Canadian Heritage, Status of Women and Official Languages, Department of the Francophonie, *Roadmap for Linguistic Duality in Canada 2008-2013: Acting for the Future*, 2008

[13] Quebec Community Groups Network, *The Health and Social Services Priorities of Quebec's English-Speaking Population 2013-2018, A discussion document based on a consultation of Quebec's English-speaking population October 2011*.

[14] Government of Quebec, Ministère de la Santé et des Services sociaux, *Plan stratégique 2010-2015*

ACTIONS

CHALLENGE 1
Undertaking efforts before problems occur and reducing inequalities in health and well-being

Objective 1.1
Act in a concerted manner on the key determinants of health and well-being

- "The presence of community organizations is an important element in the improvement of access to services in English," p. 9.
- Certain prevention campaigns can enhance their effectiveness through community organizations, p. 9.
- Prevention and screening programs are well established throughout Quebec, although less so for First Nations residents, p. 5.
- Mammograms, anti-smoking campaigns, and anti-bullying campaigns have been reported to be much more available in English in urban regions and less or not at all available in rural and remote regions, p. 49.

Area of focus: Prevention in continuums of service

1.1.1 Ensure the implementation of the promotion, prevention, and protection activities provided for in the provincial public health program (*Programme national de santé publique* or PNSP).*

1.1.2 Support the inclusion of prevention in front-line clinical services, giving priority to the following issues:
- ✓ sexually transmitted and blood-borne infections;
- ✓ lifestyles and chronic diseases;
- ✓ falls among older people;
- ✓ suicide.

Area of focus: Intersectoral action

1.1.3 Enhance cooperation with partners from other activity sectors to act on the key determinants of health and well-being (lifestyles and safe behaviour, education, employment, lodging, etc.).

1.1.4 Enhance support to workers and managers involved in developing healthy communities.

CHALLENGE 2
The primacy of front-line services in terms of including and prioritizing services

Objective 2.1
Improving access to general front-line services

- Improving access to services for the entire population, for example with more physicians, longer clinic hours, and more prevention, p. 7.
- Expanding the scope of activity of nurse practitioners: allow them to perform a broader variety of tasks; they would thus lighten the pressure on physicians, making them more available; nurse practitioners provide quality services and are often bilingual, p. 61.
- Certain members of First Nations communities encounter rejection in CLSC or CSSS clinics. They are told that they have their clinics on the reserve and that's where they should go, p. 41.

Area of focus: Medical and nursing services

2.1.1 Ensure the registration and case management of people by a family physician.
2.1.2 Promote the group, comprehensive, and interdisciplinary practice of family medicine through the establishment of family medicine groups (FMGs) (or equivalent models).
2.1.3 Enhance the availability of specialized nurse practitioners (SNPs) in front-line care.

Area of focus: Psycho-social services

2.1.4 Provide rapid telephone access to consultations in terms of psycho-social services (information, interventions, referrals, guidance, professional opinions, and advice) by CSSS professionals in psycho-social intervention, 24 hours a day, 7 days a week.

Objective 2.2
Ensure ongoing interdisciplinary follow-up/monitoring of client groups with particular needs

- Attention to very specific problems, whose gravity is perceived by key informants (First Nations participants) as accelerating rapidly: substance abuse, cancer, mental health, suicide, diabetes, coronary disease, family crises: family violence, care of the elderly and violence towards them, placement of children, kidney failure, access to drinking water, p. 62.

Area of focus: People suffering from chronic diseases or cancer

2.2.1 Encourage self-management and the rehabilitation of people suffering from chronic diseases in a continuum of care.
2.2.2 Improve the coordination of oncology care and services for people diagnosed with cancer and their loved ones.

Area of focus: Youth in difficulty, people with mental health problems, and people who are addicted

- Outside of urban areas, mental health services are not easy to access, generally speaking, p. 28.
- For more chronic conditions, such as depression, among others, waiting lists are long, p. 28.
- Participants spoke of the difficulty of accessing services for alcoholism, legal and illegal drug addiction, and gambling problems, p. 28.
- In semi-urban, rural, and remote areas, participants often reported limited access to services for troubled youth, which becomes more limited the further one is from an urban area, p. 46.
- Participants reported the limited number of English-speaking foster families, especially in rural and remote regions, p. 46.

2.2.3 Act in a concerted way to reduce the difficulties experienced by youth and families, including issues of negligence and behavioural disorders, as per the aims regarding troubled youth.
2.2.4 Promote continuity of care and stability of relationships for children placed under the Youth Protection Act.
2.2.5 Provide people who need them with front-line mental health services through an interdisciplinary team.
2.2.6 Provide access to community integration services for adults with serious mental disorders.
2.2.7 Facilitate access to front-line services in drug addiction and gambling for people at risk of abuse or addiction.

Area of focus: People with a disability and their families
2.2.8 Ensure the coordination of services provided by a number of institutions to people with a disability and their families

- A large number of parents involved reported difficulty obtaining the appropriate service after the initial assessment. It seems that services are generally limited, especially in rural and remote regions, and that these services are even rarer in English, p. 47.
- Participants whose children need services in cases of speech, language, and hearing impairments spoke of the difficulty of accessing them, especially in English, p. 47.

Objective 2.3
Meet the needs of an aging population

- In terms of care for older people: improve direct services and well-being initiatives, intensify the level of care offered at home, and expand support for natural caregivers, p. 8.
- Natural caregivers assume a heavy burden with limited support to find the time required and cope with the stress related to the medical and psycho-social needs of their family members, p. 4.
- English-speaking natural caregivers who take care of older people are less present in rural and remote areas, p. 5.

Area of focus: Integrated service networks

2.3.1 Continue the development of integrated service networks for people experiencing age-associated loss of autonomy (RSIPA) in each local area, promoting their implementation as defined in the *Ministère's* guidelines.[15]

Area of focus: Service adaptation

2.3.2 In hospitals, promote the adoption of organizational and clinical practices adapted to the particular needs of older people.

Objective 2.4

Promote support at home for people with disabilities

- Youth with special needs (ex. troubled youth, children with developmental delays or disorders) face long wait times for assessments and services, which at times risks compromising their future development, p. 4.
- Their parents also encounter problems due to isolation and lack of social support to cope with the impact of providing care to children who have such pronounced needs; the long-term perspectives are rather dismal for the child and parents, p. 4.
- Access to mental health services is limited, especially further from urban centres, p. 4.

Area of focus: Home care services

2.4.1 Define the home care services available for all client groups likely to require these services, including families and caregivers, based on the profiles of needs and living environments, specifying the ways in which users contribute.

2.4.2 Ensure overall availability of long-term home care services to adapt to the increasing needs of all client groups, including families and caregivers.

Area of focus: Diversification of living environments

2.4.3 Increase and diversify the availability of living environments accessible to people with significant and persistent disabilities (older people experiencing loss of autonomy, people with disabilities, people with mental health issues, and others).

[15] Support and assist the individual and his/her caregivers: a clearer idea of services available and make the public aware of them.

CHALLENGE 3
A reasonable timeframe for accessing services

Objective 3.1
Ensure access to services within acceptable timeframes

- A number of suggestions aiming to improve access to services for the entire population, such as more doctors, longer clinic hours, and more prevention, p. 7.

Area of focus: Social and rehabilitation services

3.1.1 Provide people with disabilities access to the services they need within set timeframes:
  - ✓ For people for whom the request is at the urgent priority level: three days;
  - ✓ For people for whom the request is at the high priority level: 30 days in a CSSS and 90 days in a rehabilitation centre;
  - ✓ For people for whom the request is at the moderate priority level: 1 year.

3.1.2 Provide access for people with an addiction to specialized assessment services within a timeframe of no more than 15 working days.

Area of focus: Medicine and surgery

3.1.3 Provide people registered in the central system with access to surgery within a six-month timeframe.
3.1.4 Provide people with cardiovascular disease with services within the set timeframes.
3.1.5 Provide people with cancer with services within a 28-day timeframe.

Area of focus: Emergencies

3.1.6 Provide an acceptable duration of stay in emergency for people on stretchers.

Area of focus: Mental health

3.1.7 Provide people with mental health problems with access to:
  - ✓ specific front-line services offered by CSSSs within 30 days;
  - ✓ specialized secondary and tertiary services within 60 days.

Area of focus: Referrals to specialized medical services

- For patients from remote areas, access to specialized medical services is often synonymous with travelling long distances for all patients, at times by plane, regardless of the language of service desired, p. 43.

3.1.8. Improve access to diagnostic services and medical specialists for people with symptoms of certain clinical conditions and referred by a family doctor:
  - ✓ Percentage of CSSSs having established a mechanism for access to diagnostic services and medical specialists for people presenting clinical conditions of a subacute or semi-urgent nature and referred by a family doctor.

CHALLENGE 4
Service quality and innovation

Objective 4.1
Ensure the quality and safety of care and services

- Participants generally agreed that quality is one of the system's strong points. They stated that once access obstacles are overcome, the quality of service is generally good or very good, p. 17.

Area of focus: Integrated quality process

4.1.1 Develop a quality assurance policy that leads to:
- ✓ providing an integrated vision of quality assurance;
- ✓ harmonizing the various quality evaluation and assessment mechanisms;
- ✓ specifying the procedures for implementing and monitoring established standards.

Area of focus: Practice guides

4.1.2 Support the implementation of clinical standards and practice guides in the health and social services network.

Area of focus: Control of hospital-acquired infections

4.1.3 Maintain the rates of hospital-acquired infections subject to provincial surveillance below or equal to the established thresholds.

Objective 4.2
Enhance the value placed on the university mission within the health and social services network

- The availability of health care and social services in English depends above all on the ability of the network's professional staff and employees to use English and the success of the efforts to support language training, as well as the ongoing recruitment and retention of bilingual staff, p. 8.

Area of focus: Niches of expertise and training

4.2.1 In each institution, identify niches of expertise in health and social services in terms of complementarity among institutions with a university mission.

4.2.2 Provide training and ensure the availability of adapted and diverse internship settings, in particular for basic disciplines in Quebec's regions.

Area of focus: Evaluation and knowledge transfer

4.2.3 Promote the transfer of knowledge from research intended for and adapted to the health and social services network.

4.2.4 Ensure the evaluation of health and social services technologies and intervention (or practice) methods in institutions with university designation.

Objective 4.3
Ensure the incorporation and circulation of clinical information

- Computerization could simplify the management of referrals to another specialist, whether in the area of medical or social services, p. 61.
- Better provisions to ensure effective follow-up of medical care, especially with respect to the link between clinics and emergency services with the specialist, p. 61.
- The creation of an ongoing knowledge base regarding English-speaking users in the health and social services network, p. 65.

Area of focus: Computerized clinical files

4.3.1 Support the use of electronic medical files (EMF) in medical clinics and computerized clinical files (DCF) in institutions.

4.3.2 Implement the Quebec Health Record (QHR) and incorporate it in the network's computerization strategy.

CHALLENGE 5
The attraction, retention, and optimal contribution of human resources

Objective 5.1
Ensure balance between the offer of and demand for a qualified work force

- *The availability of health care and social services in English depends above all on the ability of the network's professional staff and employees to use English and the success of the efforts to support language training, as well as the ongoing recruitment and retention of bilingual staff, p. 8.*
- *Enhance the bilingualism of professionals and employees in institutions and clinics, p. 8.*
- *Measures such as adapted practical internships for students who are taking professional training programs in English are an example of this. More must be found and efforts made to put them in place, p. 64.*

Area of focus: Availability of medical work force
5.1.1 Ensure an equitable distribution of residency positions between general practice and specialized medicine.
5.1.2 Ensure an equitable distribution of family doctors and specialists in all Quebec regions.

Area of focus: Availability and optimal use of the network's work force
5.1.3 Produce and annually update the work force plan at the local, regional, and provincial levels in such a way as to identify and implement strategies to ensure a balance between the required and available staff.
5.1.4 Ensure optimal use of staff competencies by rallying institutions to conduct a concerted approach to review processes regarding care and services and work organization.
5.1.5 Reduce the time worked as overtime in all activity sectors.
5.1.6 Reduce reliance on self-employed workers in clinical activity sectors.

Area of focus: Availability of management staff and evolution of management practices
5.1.7 Implement innovative initiatives regarding the role and responsibilities of managers to improve their working conditions and support.
5.1.8 Put in place a new-generation, senior-level, management staff program (director general and assistant director general) on a province-wide scale.

Objective 5.2
Offer attractive and rewarding working and practice conditions

- *Users of the system worry about the staff working there, due to the great pressure the departments place on them, the limited support given to staff, and the impression given by young professionals entering the network that they are not as devoted to their tasks, p. 5.*

Area of focus: Retention and enhanced well-being at work
5.2.1 Implement measures to improve the work climate and promote the health and well-being of staff in the network and the *Ministère* by relying on programs like *Entreprise en santé*.
5.2.2 Promote the adaptation of new-generation professionals to the profession and the work environment.

CHALLENGE 6
Efficient, effective, and accountable management

Objective 6.1
Improve the performance of the health and social services system

- *There is no central source of well-documented, up-to-date information on the health and social services needs of English-speaking populations, p. 9.*
- *Such a source of information would be useful for both the system's planners and community leaders, p. 65.*

Area of focus: Optimization of the use of resources

6.1.1 Implement structured projects on the optimization of the use of resources leading to enhanced performance for the health and social services network, focusing on:
   - ✓ The rationalization of the processes of delivering clinical services (ex. operating rooms, imaging core facilities, etc.), administrative services, and ancillary services (ex. laundry, procurement, storage, and purchasing);
   - ✓ The rationalization of technological and computer infrastructure.

6.1.2 Develop comparative productivity improvement indicators in certain sectors.

Area of focus: Performance monitoring and feedback

6.1.3 Assess the performance of the health and social services system and provide feedback on the results.

Objective 6.2
Ensure more accountable governance

- *The Agences – need more latitude and resources to support the adaptation of services on a local scale for purposes of increasing access in English. They would thus be able to meet especially pressing regional needs, such as better integration of the two health systems (federal and provincial) offered to First Nations populations, p. 8.*

Area of focus: Sharing responsibilities and accountability rules

6.2.1 Clarify the sharing of responsibilities among provincial, regional, and local levels, as well as the accountability rules, from the perspective of subsidiarity.

Area of focus: Review of administrative processes

6.2.2 Lighten the administrative standards and rules in effect.

OTHER CHALLENGES 7

Canada-Quebec Agreement

Objective 7.1
Accessibility of information on services offered in English

- *A pressing need is being felt to centralize and more broadly disseminate up-to-date information on the location of services available in English, p. 8.*
- *Consultation participants repeatedly mentioned difficulty finding complete, up-to-date information on services that exist in English. The information in question relates to services in the public network of institutions, professionals in private practice, and services offered by community organizations, p. 65.*

Area of focus:

7.1.1 Promote the implementation of information campaigns on the accessibility and delivery of health and social services in English related to:
  - ✓ Access programs 2011-2014

7.1.2 Encourage the sharing of up-to-date clinical documents available in English among institutions, community organizations, etc.

7.1.3 Promote access to clinical software tools in English for English-speaking users (Internet and information systems).

Support for community organizations

Objective 7.2
Reception and support services

- ✓ *Organize social support in English in cities that English-speaking people have to go to receive specialized services, p. 8.*
- ✓ *Organization of a reception service in cities and towns where English-speaking people go for specialized medical services, p. 62.*

Area of focus: Revision of administrative processes

7.2.1 Promote the implementation of reception and support services in Quebec City, Sherbrooke, and Montreal.[16]

[16] Social support or reception services.