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Make the Case Report

Access to Senior Care in English in Quebec

A research analysis of English language rights in Quebec health care and access to the SAPA program for English-speaking seniors in Quebec

March 31, 2023

ACCESS TO JUSTICE IN ENGLISH

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Contents

Abbreviations and Terminology

ABBREVIATION	FULL FORM	ENGLISH TRANSLATION
ESSs	English-speaking Seniors	---
FSSs	French-speaking Seniors	---
SAPA	Soutien à l'autonomie des personnes âgées	Support for the Autonomy of Elderly People
LTC	Long-term care	---
CHSLD(s)	Centre(s) d'hébergement de soins de longue durée	Long-term Care Home (in Quebec)
RI(s)	Ressource(s) intermédiaire	Intermediate Resource(s)
RTF(s)	Ressource(s) de type familial	Family-type Resource(s)
CISSS(s)	Centre(s) intégré(s) universitaire de santé et de services sociaux	Integrated Health and Social Services Center(s)
CIUSSS(s)	Centre(s) intégré(s) de santé et de services sociaux	Integrated University Health and Social Services Center(s)
MSSS	Ministère de la Santé et des Services sociaux	Ministry of Health and Social Services
OQLF	Office québécois de la langue française	Quebec Office of the French Language
CFL	La Charte de la langue française	Quebec's Charter of the French Language
AHSSS	Loi sur les services de santé et les services sociaux	Act Respecting Health Services and Social Services
AMHSSN	Loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux notamment par l'abolition des agences régionales	Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies

Terminology

Unless otherwise indicated, the terms "**government**," "**administration**," or "**ministry/ministries**" refer to the government of Quebec and its ministries. Terms "**province/provincial**" refer to Quebec.
An "**English-speaking**" person is defined as someone who, in their relations with the government, feels more at ease expressing themselves and receiving services in English.

Introduction

The Access to Justice in English Project ("the AJEQ Project") of the Quebec Community Groups Network (QCGN) identifies and researches areas where the English-speaking community are experiencing difficulty accessing their rights, with a strong focus on community access to public services. It leverages information as a strategic resource to understand and improve access to justice in English in Quebec.

This report discusses and details one of the AJEQ Project's candidate issues of research: **access to senior health care services in English in Quebec's SAPA program (*Soutien à l'autonomie des personnes âgées*)**. The issue was selected on the basis of prior research conducted by the AJEQ Project, including a population survey of 1,601 English-speaking Quebecers conducted by Quorus Consulting Group in September 2021, which revealed that hospitals and CLSC care were among the most widely accessed provincial government services by English-speaking Quebecers, and that more than one in three English-speaking Quebecers who had accessed these services in the past two years found it difficult to do so in English. The issue of senior care was under close scrutiny at the time the issue was selected, in the wake of the COVID-19 pandemic and the subsequent coroner's inquiry into pandemic-related deaths at seniors' residences across Quebec.

The Access to Justice project acknowledges that the pandemic posed a unique set of circumstances that extended beyond language, and that other pressures on the health care system in general and on senior care services in particular can result in limited services for all Quebec seniors, regardless of language preference. At the same time, our research has found that a combination of policy, organizational, budgetary, and demographic circumstances has resulted in multiple concrete challenges to accessing care services in English, which may well be exacerbated in years to come. This report aims to outline the current state of access to senior care services in English in Quebec, providing relevant information to English-speaking seniors, their caregivers, and stakeholders operating in the community and health care spaces.

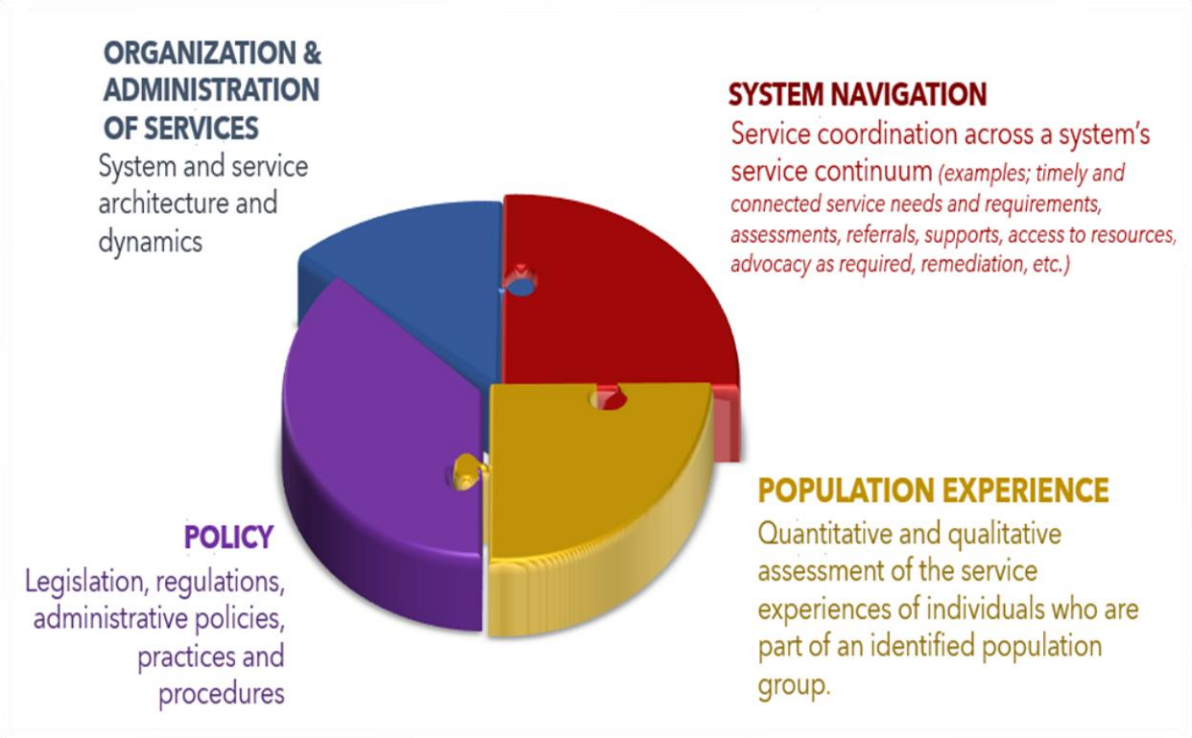
Our research methodology included a thorough investigation of the issue along four main lines of inquiry: the relevant policy and legal framework; the internal organization and administration of services; how English-speaking seniors and their caregivers navigate the SAPA program's assorted senior care services from at-home care to placement in long-term care; and firsthand population experience obtained through quantitative and qualitative research. This investigation uncovered several **systemic barriers to English-speaking seniors and their caregivers accessing SAPA services in English in Quebec**, in CLSCs, long-term care facilities, and other health care institutions across Quebec. We then validated these findings through a series of in-depth interviews with community organizations and CI(U)SSS users' committees, and an online survey of seniors and caregivers.

Methodology

Our findings are based on a mixed methodology combining the following strands of research:

- A review of the existing framework of law and policy pertaining to provincial health care services and official language minority rights;
- An external legal opinion submitted by Ménard Martin Avocats on June 13, 2022;
- An analysis of available literature focusing on the organizational, administrative, and systemic practices of Quebec's MSSS and health care institutions;
- A series of 16 qualitative interviews conducted by the AJEQ Project team of community-based organizations and CI(U)SSS users' committees across various regions of Quebec that provide assistance to seniors and their families; and
- A quantitative survey of N=923 English-speaking seniors aged 60+ (n=633) and caregivers to a senior aged 60+ (n=290) across Quebec, commissioned by the AJEQ project and conducted by Léger from November 29, 2022 to January 17, 2023.

These findings served to complete the four dimensions of the information strategy that governs the structure of the final report: Organization & Administration of Services, System Navigation, Population Experience, and Policy.



Policy: Regulation / Legislation / Case Law / Recourses, etc.

Introduction

To properly assess the reality of Quebec's aging English-speaking community with respect to the health care services they are able to receive in their language, this report must first illuminate the legal foundation on top of which these services can be granted. The first section of this report lays down the scope of English-language rights in Quebec and how they operate with respect to the provincial health care system. It also outlines the recourses currently available in situations where these rights are not respected, as well as Quebec government policies that address or implicate the rights to access health care in English in Quebec.

Legal Framework

The Canadian Constitution and Scope of Language Rights

The *Constitution Act, 1867* outlines the division of powers that split various responsibilities between the federal and provincial legislatures. Subsection 92(7) grants control over the "Establishment, Maintenance, and Management of Hospitals" to the provinces. This means that decisions regarding matters of health care administration in public health institutions fall within the authority of the provincial governments. Accordingly, senior care in Quebec falls under provincial jurisdiction. However, the laws, regulations and policies enacted by the Quebec government with respect to senior care (and health care more broadly) in Quebec must be nonetheless consistent with the Constitution of Canada, including the *Charter of Rights and Freedoms*, and other applicable federal and provincial legislations and regulations.

The Act Respecting Health Services and Social Services

All health care users benefit from fundamental rights and protections contained in sections 4 to 16 of the *Act Respecting Health Services and Social Services* (*AHSSS*). Sections 13 and 15 of the *AHSSS* are of particular importance, the latter establishing the right for English-speaking persons in Quebec to access public health care services in English:

> **13**. The right to health services and social services and the right to choose a professional and an institution as provided in sections 5 and 6 shall be exercised within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material, and financial resources at its disposal.
>
> **15**. English-speaking persons are entitled to receive health services and social services in the English language, in keeping with the organizational structure and human, material and financial resources of the institutions providing such services and to the extent provided by an access program referred to in section 348.[1]

[1] See Act respecting health services and social services, CQLR c C-4.2 [AHSSS].

The right is framed within the "organizational structure" and "human, material and financial resources" of the health care institutions in which it is to be exercised. More precisely, the right to access English-language health care services is explicitly limited by the availability of resources, and its interpretation has been shaped by subsequent jurisprudence. For example, the Quebec Human Rights Tribunal has ruled that while health care institutions may choose to provide English-language translations of evaluation reports (checkups, medical test results, diagnostics, etc.) if they possess the budgetary means, they are not legally required to do so.[2]

The limits set forth in sections 13 and 15 on the right to health care in English have also been analyzed by the Office Québécois de la langue française (OQLF) in its decision *Regroupement des orthophonistes de La RessourSe v. Center de réadaptation La RessourSe*.[3] In its judgment, the OQLF held that section 15 of the *AHSSS* states that offering health services in English must take into consideration the organization and the human, material and financial resources of the institutions that provide these services, and that as such, "[…] the right to services in English does not immunize English-speaking users from shortages in resources or personnel that afflict the entirety of healthcare users" in Quebec.[4] A given health care institution, even those designated as bilingual or indicated to provide certain services in English (see page 11 for further explanation), will therefore not violate section 15 of the *AHSSS* by not providing health care and services in English if it has:

1) A shortage of English-speaking personnel (a limitation in human resources);
2) A lack of information or documents in English (a limitation in material resources); or
3) If offering such services is too costly (a limitation in financial resources).[5]

Section 15 of the *AHSSS* does not prescribe a minimum amount of "human, financial and material resources" that must be devoted to English-language services in each health care institution in Quebec. However, the institution must take into consideration the resources already available when creating its Access Program, to ensure that it will be able to provide the planned services in English.

Furthermore, in accordance with section 108 of the *AHSSS*, it is possible for an institution to opt for the adoption of a service agreement with a public institution, a private institution, or a family medicine group (FMG) that is capable to provide services in English. These institutions must have an insufficient number of bilingual employees to respond to the demand for health and social services in English in order to use the option under section 108. The service agreement must specify the nature of the services required in English, the clientele concerned, and the human,

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[2] See Commission des droits de la personne et des droits de la jeunesse c Le Centre jeunesse d'Estrie, 2005 CanLII 19307 (QC TDP) at paras 42–43; and Charter of the French Language, CQLR c C-11, s 27 [CFL].

[3] See Regroupement des orthophonistes de La RessourSe c Centre de réadaptation La RessourSe, 2000 QCOLF 2 [La RessourSe].

[4] See *ibid* at para 100 ("[…] le droit à des services en anglais n'a pas pour effet d'immuniser les usagers de langue anglaise à l'égard des carences en ressources ou en personnel qui affligent l'ensemble des usagers.") [translated by the author].

[5] See Alexandra Éthier, "'I don't think that's the way healthcare for an 85 and an 88-year-old should be done' : L'accès aux services de santé et aux services sociaux des aînés anglophones vivant hors Montréal – état de la situation" (Master's Thesis, University of Sherbrooke, 2020) at 3.

financial and material resources required.[6] As a result, either the English-speaking health care professional will travel to the English-speaking patient to provide the needed services, or the client will have to go to the professional.

In addition to section 108, the following provisions of the *AHSSS* also delineate the legal framework for health care services in English in Quebec:

> **348**. Each agency, in collaboration with institutions, must develop a program of access to health services and social services in the English language for the English-speaking population of its area in the centres operated by the institutions of its region that it indicates or, as the case may be, develop jointly, with other agencies, such a program in centres operated by the institutions of another region.
> Such an access program must take into account the human, financial and material resources of institutions and include any institution in the region designated under section 508.
>
> The program must be approved by the Government and revised at least every three years.
>
> **349**. Each agency must, in concert with the bodies representing the cultural communities and the institutions of its region, facilitate accessibility to health and social services in a manner which is respectful of the characteristics of those cultural communities.
>
> **508**. The Government shall designate from among the institutions recognized under of section 29.1 of the Charter of the French language (chapter C-11) those which are required to make health services and social services accessible in the English language to English-speaking persons.

Sections 348 and 508 of the *AHSSS* establish the obligation for every CI(U)SSS – referred to as "agencies" in the *Act* - to create, adopt, and implement an Access Program that describes all services available in English. This obligation is undertaken through the creation of regional and provincial Access Committees tasked with evaluating and enforcing the Access Programs for their respective institutions (see page 38 for more detailed information). The composition and mandates of these committees are governed by governmental regulations, such as the *Regulation respecting the formation of regional committees for programs of access to health services and social services in the English language*[7] and the *Regulation respecting the Provincial Committee on the dispensing of health and social services in the English language*.[8]

[6] See *AHSSS*, *supra* note 1, ss 108, 349.3.
[7] See CQLR, c S-4.2, r 14 [Regional Access Committee Regulation].
[8] See CQLR, c S-4.2, r 4 [Provincial Access Committee Regulation].

Impact of the 2015 Reform

The current situation regarding the accessibility of health and social services in English can best be studied through the lens of the significant structural reform of the health care system overseen in 2015 by the Liberal government led by Premier Philippe Couillard.[9] With the adoption of the *Act to modify the organization and governance of the health and social services network, in particular, by abolishing the regional agencies* (*AMHSSN*),[10] the Quebec health system underwent a profound transformation that had a significant impact on the organization of health and social services offered by public institutions.[11]

Section 76 of the *AMHSSN* implemented the components of section 348 of the *AHSSS*, adding a requirement for institutions to consider language knowledge and skills when recruiting or assigning staff to provide services to English-speaking patients.[12]

Although one of the main objectives of this structural reform of the health care system was to ensure continuity of services to patients throughout the health care system, its practical effect has been quite different. English-speaking patients have been significantly impacted by this restructuring. A direct consequence of the 2015 reform was the reduction of formerly guaranteed English-language services to English-speaking people by designated and indicated institutions:

> Following the structural reform, certain target clienteles previously directly served by an institution—such as fragile elderly persons or those with physical or intellectual deficiencies residing in a CHSLD—were no longer eligible for the services provided by these institutions. Instead, this clientele began to receive sociosanitary services due to an expansion of RIs and foster families. None of these service providers possessed the legal status of a healthcare institution, nor did they become designated or indicated facilities with the meaning of Access Programs [under the *AHSSS*]. In consequence, the legal right to receive these services in English was no longer guaranteed. Although some of these host agencies and organizations had signed contracts with the institutions to provide services in English, some no longer offered all their services in English.[13]

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[9] See Comité provincial pour la prestation de services de santé et des services sociaux en langue anglaise, *Rapport d'activités 2018-2019* (Québec: Ministry of Health and Social Services) at 3.

[10] See Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, CQLR c O-7.2 [AMHSSN].

[11] See *Guide pour l'élaboration du programme d'accès aux services de santé et aux services sociaux en langue anglaise* (Québec: Ministry of Health and Social Services, 2018) at 5, online(pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2018/18-406-01W.pdf> [*Guide*].

[12] See *AMHSSN*, *supra* note 10, s 76.

[13] See Heather Clarke & Iannick Martin, Programme régional d'accès aux services de santé et aux services sociaux en anglais pour les personnes d'expression anglaise de Montréal 2012-2015 (Quebec: Montreal Health and Social Services Agency, 2011) at 3 ("À la suite de la réforme structurelle, certaines clientèles cibles qui étaient auparavant desservies directement par un établissement — comme les personnes âgées fragiles ou celles ayant une déficience physique ou intellectuelle logées dans un CHSLD — n'étaient plus admissibles aux services fournis par ces établissements. Au lieu de cela, cette clientèle a commencé à recevoir des services sociosanitaires grâce à une expansion des ressources intermédiaires et des familles d'accueil. Aucun de ces fournisseurs de services n'avait le statut juridique d'un établissement, et ils ne sont pas non plus devenus une installation désignée ou indiquée au sens du programme d'accès. En conséquence, le droit légal de recevoir ces services en anglais n'était plus garanti. Bien que certaines de ces agences ou organisations d'accueil aient signé des contrats avec l'établissement pour fournir des services en anglais, certains de ces fournisseurs de services de santé n'offraient plus tous leurs services en anglais.") [translated by the author].

This transfer of services to third-party providers has also applied to CLSCs, whereby at-home care services are sometimes shifted over to agencies that may not be beholden to the same language regulations (such as Access Programs) with respect to the right to access these services in English. The resultant consequence is that certain services once provided in English may be no longer offered to English-speaking seniors in the given area.

Further, despite the MSSS *Guide for developing Access Programs for health services and social services in English* (*Guide*) encouraging creative partnerships to provide services in English[14], qualitative evidence obtained by the Access to Justice Project suggests that the 2015 reform may have actually weakened links between CI(U)SSS leadership and groups representing the English-speaking community. In an interview, one such group told the Project:

> "Since 2015, it's been really hard to communicate with the CISSS and get anything done. Before that, our relationships with the old Agences were excellent. We've never recovered since the restructuring. The CISS itself has never recovered its stability – it has gone through other restructurings since 2015 as well."[15]

The Charter of the French Language and Bill 96

As mentioned above, the obligation to provide health services in English exists only for institutions identified in a CI(U)SSS Access Program, with each listing "designated" and "indicated" health care facilities within its jurisdiction. While a designated facility is obliged to all its health services in both French and English, indicated health care institutions are only required to provide in English those services listed in their Access Program. The scope of these obligations also extends to the accessibility of health care services in English for ESSs living in a given CI(U)SSS territory.

Subsection 29.1(3) of the *Charter of the French Language* (*CFL*) states that its administrative enforcer, the Office québécois de la langue française (OQLF), will officially "recognize" health care facilities as bilingual (i.e. able to provide service in both French and English) if the majority of the population served by said institution speaks English.[16] The Quebec government can then "designate" from among these OQLF-recognized bilingual institutions which must provide all their services in both French and English to its population.[17]

According to the CFL, English-language services in designated health care facilities only include:

- Signage and posters (so long as French remains predominant); and
- Internal and inter-facility communications.[18]

The obligations of the provincial Government and public health service providers outlined above must be read in tandem with the provision of the *AHSSS* requiring CI(U)SSSs that oversee these

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[14] See *Guide*, *supra* note 11 at 23
[15] In-depth interview with regional community healthcare organization, September 23, 2022.
[16] See *CFL*, *supra* note 2, s 29.1.
[17] For a complete list of all healthcare institutions designated as bilingual by the Quebec government, see *Order in Council respecting institutions designated under section 508 of the Act respecting health services and social services*, CQLR c S-4.2, r 9.
[18] See *CFL*, *supra* note 2, ss 24, 26.

designated facilities to develop Access Programs to provide its English-speaking populations with health care services in English.[19] If the CI(U)SSS manages a facility which is "recognized" as bilingual by the OQLF[20] and designated by the Quebec government to give all of its services in English as well as French[21], such designated institutions must appear in Access Programs.[22]
The Access Programs must outline the English-language services that are available in each of these health care institutions. They must also detail the English-language skills required by staff and personnel working at these bilingual facilities.[23] Under these Access Programs, designated institutions are allowed to factor in a reasonable level of English-language proficiency as a criterion for employment within these bilingual institutions, in accordance with section 46 of the *CFL*.

Lack of Monitoring Mechanism or Data Collection

The earliest edition of the *Guide for developing Access Programs for health services and social services in English* (*Guide*),[24] published in 2006, did not explicitly guarantee that health care services transferred to third-party service providers (which do not have the legal status of a designated or indicated health care institution) would continue to be offered in English.

After the adoption of the *Guide*, no monitoring mechanism was put in place to ensure that services offered outside a given institution (and by extension, beyond the scope of its Access Program) were offered in English.[25] Furthermore, an update to the *Guide* in 2018 did not correct this shortcoming. To this day, there are no mechanisms in place to monitor and follow up on services offered to English-speaking people in situations where certain services are transferred to resources that are not covered by an Access Program. No guarantees have been put in place to ensure the maintenance of health and social services in English in case of organizational restructuring.[26]

The 2019-2020 Activity Report of Quebec's Committee for the Delivery of Health Services and Social Services in English[27] (hereinafter "the Committee") reported that the Ministry of Health and Social Services (MSSS) had not sufficiently updated its administrative provisions since the 2015 reform to ensure the continuity and development of services in English in the provincial health care network. The Committee specifically pointed out the *Guide* published in 2018, criticizing the MSSS for its negligence of Access Programs, which it said contributed to the erosion of health services in English. In addition, the Committee lambasted the MSSS for its alarming lack of quantitative data on how the English-speaking population used the services of the health care system:

> The Committee worries that without this data, the MSSS and public institutions will not know whether the development and subsequent implementation of future Access

[19] See *AHSSS*, *supra* note 1, s 348.
[20] See *CFL*, *supra* note 2, s 29.1.
[21] See *AHSSS*, *supra* note 1, s 508.
[22] See *ibid*, s 348.
[23] See *AMHSSN*, *supra* note 10, s 76(2).
[24] Known in French as the Guide pour l'élaboration du programme d'accès aux services de santé et aux services sociaux en langue anglaise [translated by the author].
[25] See Clarke & Martin, *supra* note 13 at 4.
[26] See *ibid* at 5.
[27] Comité provincial pour la prestation de services de santé et des services sociaux en langue anglaise [translated by the author].

> Programs will meet the objectives of the *AHSSS* regarding the English-speaking community, and more specifically whether they will meet the identified needs of certain vulnerable clientele.[28]

In light of these clear gaps, there is a significant need for monitoring mechanisms and better data to assess the extent to which the goals under section 15 of AHSSS are met in the current structure of the health care system.

Recourses Based on Fundamental Rights

Right to equality under section 10 of the Quebec Charter

Section 10 of the Quebec *Charter of Human Rights and Freedoms* enshrines the right to equal recognition and exercise of rights and freedoms, regardless of certain listed personal characteristics such as one's language. A person or group claiming a violation of section 10 must establish three elements on a balance of probabilities:

(1) They have experienced differential treatment;
(2) This treatment is based one of the personal characteristics listed in section 10 (such as language); and
(3) This treatment impairs the full and equal exercise or recognition of a freedom or right guaranteed by the Quebec *Charter*.[29]

The third element involves demonstrating that the differential treatment to which a person or group is subjected has caused them harm, such as limiting access to opportunities or benefits available to other individuals or groups in society.[30] For example, in *Lachine General Hospital v Quebec (Attorney General)*,[31] the appellants claimed that the decision to revoke the licence of the Queen Elizabeth Hospital, an English-language institution, was discriminatory against the English-speaking community of Montreal and violated section 10 of the Quebec *Charter*. The Court of Appeal indicated that the closure of the hospital did not infringe the right to equality of the English-speaking population because the restructuring had had a minimal impact on the resources allocated to bilingual hospitals. In this case, the appellants therefore did not successfully prove the discriminatory effects of the hospital closure.

If the three abovementioned elements are established, the burden then falls on the defendant to adequately justify their discriminatory actions.[32] In that vein, Quebec and Canadian case law

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[28] See Comité provincial pour la prestation de services de santé et des services sociaux en langue anglaise, *Rapport d'activités 2019-2020* (Québec: Ministry of Health and Social Services, 2021) at 5 ("Le Comité provincial craint que sans ces données, le MSSS et les établissements publics ne sachent pas si l'élaboration et la mise en œuvre ultérieure des programmes d'accès à venir répondront aux objectifs de la loi sur les soins de santé concernant la communauté d'expression anglaise, et plus précisément si elles répondront aux besoins cernés de certains groupes de clientèle vulnérable.") [translated by the author].

[29] See Quebec (Commission des droits de la personne et des droits de la jeunesse) v Bombardier Inc (Bombardier Aerospace Training Center), 2015 SCC 39 at para 35.

[30] See Christian Brunelle & Mélanie Samson, "Les droits et libertés dans le contexte civil'' in *Collection de droit : Droit public et administratif* (Quebec: Barreau du Québec, 2021-2022) at 43.

[31] See *Lachine General Hospital Corporation v. Québec (AG)*, 1996 CanLII 5944 (QCCA), 142 DLR (4th) 659.

[32] See Brunelle & Samson, *supra* note 28 at 79; and *British Columbia (Public Service Employee Relations Commission) v BCGSEU*, [1999] 3 SCR 3 at para 3, 176 DLR (4th) 1.

recognize that institutions have a duty to reasonably accommodate individuals or groups, but not past the point of undue hardship.[33] Institutions who thus intend to justify a discriminatory measure must demonstrate that it is based on a valid objective and that the measure "incorporates every possible accommodation to the point of undue hardship, whether that hardship takes the form of impossibility, serious risk or excessive cost".[34]

The duty to accommodate requires both parties to discuss in good faith to find a reasonable solution to otherwise potential discrimination.[35] For there to be undue hardship, the accommodative measure must have a significant impact on the organization's ability to provide quality public services.[36] Three criteria must be present: (1) the impact of the measure on human, material and financial resources; (2) the impact on the functioning and organization of work; and (3) the risk of harm to rights of other users and employees.[37] The analysis to determine whether an accommodation constitutes undue hardship is therefore done on a case-by-case basis.

Right to equality under section 15(1) of the Canadian Charter

Unlike the Quebec *Charter*, subsection 15(1) of the *Canadian Charter of Rights and Freedoms*, which protects the right to equality before and under law and equal protection and benefit of law, does not expressly enumerate language as a prohibited ground of discrimination. A person or group claiming a violation of subsection 15(1) must establish on a balance of probabilities:

(1) They have experienced differential treatment;
(2) The treatment is based on an enumerated or analogous ground; and
(3) The treatment creates a disadvantage by perpetuating prejudice or stereotyping.[38]

The enumerated grounds (such as race, sex, and religion, to name a few) explicitly listed in subsection 15(1) are not exclusive.[39] In fact, the Quebec Superior Court has held that one's mother tongue is tied to one's ethnicity and nationality and thus constitutes an analogous ground of discrimination under subsection 15(1) of the *Charter*.[40] While it has not officially recognized language as an analogous ground, the Supreme Court has declared that language is not excluded from the scope of subsection 15(1).[41]

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[33] See Hydro-Québec v Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ), 2008 SCC 43.
[34] See British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights), [1999] 3 SCR 868 at para 32.
[35] See Delphine Roigt, "L'obligation d'accommodement dans le milieu de la santé et des services sociaux : moins d'accommodement et plus de personnalisation" in *Accommodements raisonnables et rôle de l'État : un défi démocratique*, eds Christian Brunelle & Patrick A Molinari (Montreal: Canadian Institute for the Administration of Justice, 2008) at 9.
[36] See Ministry of Justice, *Lignes directrices portant sur le traitement d'une demande d'accommodement pour un motif religieux* at 11, online (pdf) : *Justice Québec* <www.justice.gouv.qc.ca/fileadmin/user_upload/contenu/documents/Fr__francais_/centredoc/publications/ministere/dossiers/neutralite/PL62-lignes-FR.pdf>.
[37] See *ibid*.
[38] See *Withler v Canada (AG)*, 2011 SCC 12 at para 71.
[39] See *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143 at 175, 56 DLR (4th) 1.
[40] See e.g. *Quebec (AG) v Entreprises WFH Ltée*, 2000 CanLII 17890 (QC CS) at paras 221–26, [2000] RJQ 1222; and *Reference re Use of French in Criminal Proceedings in Saskatchewan (1987)*, 1987 CanLII 204 (SK CA), 36 CCC (3d) 353 at 373.
[41] See *Gosselin (Tutor of) v Quebec (AG)*, 2005 SCC 15 at paras 11–12.

If a violation of section 15 is established, the defendant then has an opportunity to demonstrate it is reasonably justifiable. Under section 1 of the Canadian *Charter*, a limitation of a charter right is allowed if it constitutes a reasonable limit in a free and democratic society. The Supreme Court has ruled that if a governmental law or policy infringes on a *Charter* right, it may remain in force if it can be demonstrated that the infringement is justifiable. To justify a violation of section 15 of the Charter, the government would have to establish the following factors:

First, the objective of the legislation must be pressing and substantial. Second, the means chosen to attain this legislative end must be reasonable and demonstrably justifiable in a free and democratic society. In order to satisfy the second requirement, three criteria must be satisfied: (1) the right's violation must be rationally connected to the aim of the legislation; (2) the impugned provision must minimally impair the *Charter* guarantee; and (3) there must be a proportionality between the effect of the measure and its objective so that the attainment of the legislative goal is not outweighed by the abridgement of the right. In all s. 1 cases the burden of proof is with the government to show on a balance of probabilities that the violation is justifiable.[42]

It is within the framework of this analysis that the Court will determine whether the government or one of its institutions has accommodated the complainant's needs to the point of undue hardship.[43] However, the defence under section 1 of the Canadian *Charter* is only available if the source of the violation of the Charter right is "prescribed by law". For non-designated or non-indicated health care institutions, the decision to not provide health services in English may not be considered to be prescribed by article 15 of the *AHSSS*, given the provision's allowance for denial of English-language service in the absence of the requisite resources.[44]

Landmark Case: Eldridge

In the Supreme Court's judgment *Eldridge v British Columbia (Attorney General)*, the appellants were deaf individuals who communicate by sign language. They claimed that they were discriminated against based on their physical disability contrary to section 15(1) of the Canadian *Charter* because hospitals failed to provide them paid sign language interpreters. The Court unanimously agreed that the plaintiffs had been denied the equal protection and benefit of the publicly funded health care system. In Justice LaForest's view, "to receive the same quality of care [as hearing persons], deaf persons must bear the burden of paying for the means to communicate with their health care providers, despite the fact that the system is intended to make ability to pay irrelevant".[45]

In its reasoning, the Court stressed the importance of communication as an integral part of the provision of medical services, noting that miscommunication could lead to misdiagnoses or improper compliance with a recommended treatment, writing "adequate communication is

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[42] See *Egan v Canada*, [1995] 2 SCR 513 at 605, 124 DLR (4th) 609, citing *R v Oakes*, [1986] 1 SCR 103 at 138–39, 26 DLR (4th) 200.
[43] See *Eldridge v. British Columbia (AG),* [1997] 3 SCR 624 at para 94, 151 DLR (4th) 577.
[44] See *ibid* at paras 24, 34.
[45] See *ibid* at para 71.

essential to proper medical care is surely so incontrovertible that the Court could, if necessary, take judicial notice of it".[46]

The evidence at trial established that the quality of care received by deaf persons was inferior to that available to hearing persons. This absence of publicly funded sign language interpretation thus discriminated against the appellants by denying them the same benefits of the health care system. Moreover, the *Eldridge* case illustrates that the intensity of the obligation to reasonably accommodate a user correlates to their vulnerability.[47]

Other Recourses

The Act respecting Health Services and Social Services

Beyond Quebec or Canadian *Charter* remedies, recourse under sections 5, 6 and 15 of the *AHSSS* may also be possible if a health care institution refuses to provide some services in English or to offer an English-speaking person a place in a designated bilingual facility.

Section 5 of *AHSSS* states that "[e]very person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate."

Section 6 of the *AHSSS* provides that every person is entitled to choose the institution from whom he wishes to receive health services.

These rights, however, are not absolute, and are tempered by the limitations set forth in section 13 of the *AHSSS*.

When an English-speaking user of the provincial health care network files a motion before the courts formulated under sections 5 or 6, claiming their right to access to health services in English has not been respected, the government will systematically rely on the defence based on article 13 to narrow the purview of its obligations. In doing so, the courts will consider the following criteria to determine if section 13 constitutes a meaningful defence:

1) The discrepancy between the needs of the health care user and the resources available to the health care institution;
2) The impact of the exercise of the user's rights upon the rights of other users;
3) The concern to consider alternative measures that minimize infringement of the user's rights;

[46] See *ibid* at para 69.
[47] See *ibid* at para 82.

4) The contextual and serious nature of the budgetary impact, as opposed to simply its apprehended and minimal nature, on the user's rights.[48]

As part of this analysis, the courts will take into account the needs of the user and their particular vulnerability, as well as constraints imposed by the health care institution's available resources.[49] The burden ultimately falls upon the health care institution to show the limits of resources and the efficient management thereof in order to avail itself of the section 13 defence.[50] However, the existence of reasonable alternatives that would make it possible to limit the infringement of the user's rights may dismiss this defence.[51]

Administrative Complaints Mechanisms

An inability to obtain health care in one's own language can lead to communication problems, misunderstandings, and negative impacts on the patient's experience of care. It would be possible for an English-speaking user to file a complaint with the Complaints Commissioner of the health institution[52] if they are not satisfied with the services rendered and received. Any user who is unable to obtain services in English under an Access Program could file a complaint against the institution, a staff member, or a health care professional.[53] The Commissioner would determine whether the situation resulted in the failure to respect the rights of one or more users. If so, the Commissioner could issue recommendations to the institution's board of directors. The scope of these recommendations can range from individualized (limited to one service, one instance or one service provider) to organizational (one program or one organization) to systemic (programs involving more than one organization).[54]

If the institution's Complaints Commissioner rejects the user's complaint, the patient will then have the right to file a complaint with the Ombudsman.[55] The Complaints Commissioner can also involve the Ombudsman directly if their recommendation interferes with a law that compromises a user's rights. The Ombudsman has authority over all ministries and public organizations, allowing it to intervene on aspects of the complaint that go beyond the strict respect of users' rights.[56] A

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[48] See Robert Kouri & Catherine Régis, "La limite de l'accès aux soins définie par l'article 13 de la Loi sur les services de santé et les services sociaux : véritable exutoire ou simple mise en garde ?" (2013) 72 R du B 177 at 208 ("(1) l'inadéquation des besoins de l'usager avec les ressources disponibles de l'établissement; (2) l'impact de l'exercice des droits de l'usager sur ceux des autres usagers; (3) le souci d'explorer des alternatives qui minimisent l'atteinte aux droits des usagers; et (4) la nature contextuelle et sérieuse, plutôt que simplement appréhendée et minime, de l'impact budgétaire.") [translated by the author].

[49] See Patrice Deslauriers, "La limitation des ressources : circonstance atténuante ou aggravante en matière de responsabilité médico-hospitalière" in *Développements récents en droit de la santé* (Montreal: Yvon Blais, 2019) at 38-41.

[50] See Kouri & Régis, *supra* note 46 at 100.

[51] See *ibid* at 206; Anaïs Martini & Marie-Nancy Paquet, "La responsabilité civile des établissements de santé et de services sociaux en temps de pandémie" in *Développements récents en droit de la santé* (Montreal: Yvon Blais, 2021) at 110; and *BH v Centre hospitalier régional de Baie-Comeau*, 2009 QCCS 585 at paras 40-49.

[52] See *La RessourSe*, *supra* note 3 at para 33.

[53] See "Porter plainte à l'égard des services de santé et des services sociaux" (2022), online: *Éducaloi* <educaloi.qc.ca/capsules/porter-plainte-a-legard-des-services-de-sante-et-des-services-sociaux>.

[54] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux*, Cadre de référence : Le pouvoir d'intervention du commissaire aux plaintes et à la qualité des services* (Québec: Ministry of Health and Social Services, 2008) at 22, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2007/07-723-02.pdf> [*Commissaire aux plaintes*].

[55] See Act respecting the Health and Social Services Ombudsman, CQLR c P-31.1, s 8.

[56] See Commissaire aux plaintes, supra note 52 at 32.

Vigilance and Quality Assurance Committee (*Comité de vigilence et de la qualité*) is responsible for following up on the recommendations of the Complaints Commissioner or the Ombudsman.[57]

Throughout this complaint process, the user can obtain the assistance of their regional Users' Committee, whose role is to ensure the defence of the rights and interests of users of the health care system. The committee will be able to assist the user in filing a complaint with the Ombudsman or Commissioner, listen to the user's concerns and grievances, as well as answer the user's questions. However, it will not be able to receive and process the user's complaint.[58] Each year, the Users' Committee submits to its CI(U)SSS a list of issues and recommendations for improving the quality of care and services. Health care institutions operating under the CI(U)SSS must, moreover, consult these committees and consider their concerns as part of continuous improvement of the quality of services.[59]

In addition to assisting individuals, Users' Committees are also responsible for promoting collective rights and interests. For example, a User Committee can request information or action from an establishment on behalf of caregivers as a collective group.[60] It is therefore important for Users' Committees to inform the health care institutions of the problems related to accessibility of health and social services in English, to put additional pressure on the institutions and improve services offered in said language.

The user can also be assisted in the complaint process by a Centre for Assistance and Accompaniment for Complaints (*Centres d'assistance et d'accompagnement aux plaintes* or CAAPs).[61] These centres inform users of their rights, help them formulate a complaint, assist in drafting required documents, and accompany them to meetings held as part of the complaint handling process.

A user who considers that they experienced discrimination based on language could also submit a complaint with the Commission des droits de la personne et des droits de la jeunesse. Depending on the results of their investigation, the Commission could facilitate mediation to resolve the issue; recommend measures to redress the issue; make recommendations to the government regarding laws that infringe upon rights; or represent the user before the Commission.

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[57] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, Lignes directrices relatives au comité de vigilance et de la qualité et au commissaire aux plaintes et à la qualité des services dans les agences de la santé et des services sociaux (Québec: Ministry of Health and Social Services, 2006) at 4, online (pdf): MSSS <publications.msss.gouv.qc.ca/msss/fichiers/2006/06-603-07.pdf> [Lignes directives relatives au comité de vigilance].

[58] See "Régime d'examen des plaintes du réseau de la santé et des services sociaux" (last updated 1 October 2021), online: *Gouvernement du Québec* <www.quebec.ca/sante/systeme-et-services-de-sante/droits-recours-et-plaintes/regime-d-examen-des-plaintes>.

[59] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Des milieux de vie qui nous ressemblent : Politique d'hébergement et de soins et services de longue durée* (Québec: Ministry of Health and Social Services, 2021) at 42-43, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2020/20-814-01W.pdf> [*Politique d'hébergement*].

[60] See "Comités des usagers CLSC - CHSLD de Sherbrooke - IUGS, Rapport d'activité 2020-2021" at 6, online (pdf): *Santé Estrie* <www.santeestrie.qc.ca/clients/SanteEstrie/A_propos/Comites/Comite-usagers/2020-2021/Rapp_CU_CLSC-CHSLD-S-IUGS_20-21.pdf>.

[61] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux*, Cadre de référence sur l'exercice des fonctions à assumer par les membres des comités des usagers et des comités de résidents* (Québec: Ministry of Health and Social Services, 2006) at 28, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2006/06-603-02.pdf>.

To reassure prospective complainants, Quebec's *Act to combat maltreatment of seniors and other persons of full age in vulnerable situations* protects any person who has filed a complaint of maltreatment from any form of reprisal or retaliation. The legislation defines maltreatment as "a single or repeated act, or a lack of appropriate action, that occurs in a relationship where there is an expectation of trust, and that intentionally or unintentionally causes harm or distress to a person".[62]
This relationship can be between a senior and their caseworker, an administrator, a doctor, nurse, orderly, volunteer, or any other person who provides services to a senior on behalf of a health care institution (including CLSCs, CHSLDs, RIs, RTFs, and private seniors' residences).[63]

Canada Health Act

The *Canada Health Act* (*CHA*) aims to ensure necessary funding for the country's health care institutions and equitable access to health care services for all Canadians, regardless of their financial situation or socioeconomic status. Section 3 of the *CHA* states the legislation's primary objective: to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers".

To achieve this purpose, the *CHA* provides criteria that must be met for a province to receive the federal cash contribution and puts in place means of control and sanctions for noncompliance with these criteria by the provinces.[64] As set out in section 5, these five criteria are: portability; accessibility; universality; comprehensiveness; and public administration.[65]

Two of these five criteria are of particular importance in the context of this mandate: universality and accessibility. The condition of universality is explained in section 10 of the *CHA*: "[i]n order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions".

The expression "on uniform terms and conditions" refers to the requirements of registering for a provincial health insurance plan, or the necessity of a card or government-issued document to have access to free health care services.[66] In Quebec, this would translate into registration with its public Health Insurance Plan with the Régie de l'assurance maladie du Québec (RAMQ) and issuance of a Health Insurance card.[67] A linguistic barrier in having access to services could conceivably be argued as a obstacle to ensuring universality of health care services in Quebec.

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[62] See Act to combat maltreatment of seniors and other persons of full age in vulnerable situations, CQLR c L-6.3, s 2.
[63] See *ibid* (under "health services and social services provider").
[64] See *Canada Health Act*, RSC 1985, c C-6, ss. 4-5, 7 [*CHA*]; and Patrick A Molinari, " L'interprétation de la Loi canadienne sur la santé : repères et balises, étude préparée pour le Gouvernement du Québec" (November 2007) at 13-14, online (pdf): *Ministère des finances* <www.groupes.finances.gouv.qc.ca/financementsante/fr/etudes/pdf/Etude_PMolinari.pdf>.
[65] See *CHA*, *supra* note 62, ss 7-12.
[66] See Molinari, *supra* note 62 at 35.
[67] See "Health Insurance" (last accessed 13 September 2022), online: *RAMQ* <www.ramq.gouv.qc.ca/en/citizens/health-insurance>.

The criterion of accessibility is set out in section 12 of the *CHA*. Under this provision, a provincial health plan must provide all insured persons with a reasonable access to hospital services and medically necessary services without any charge or other restrictive measure. Use of the expression "whether by charges made to insured persons or otherwise" suggests that the financial dimension of accessibility is not the only one that must be taken into consideration. Contextual factors, which are often the matter of political choices and other structural barriers, must also be entertained.[68]

As mentioned above, the *CHA* is strictly a funding law. If it is determined that a province's health insurance plan does not respect the criteria in the *CHA*, the province may not receive the full cash contribution from the federal government or, in extreme cases, it may not receive any contribution at all. This prospect of reduced funding may in turn lead to concrete changes by the provincial governments.

International Law

Within international law, health is understood as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[69] For a human being, the possession of the highest attainable standard of health, regardless of race, religion, political opinion, economic or social condition, is a fundamental right.

Canada is a party to several international treaties and covenants which regard health care as a human right, including the *Universal Declaration of Human Rights*[70], the *International Covenant on Economic, Social and Cultural Rights*[71] (*ICESCR*) and the *International Covenant on Civil and Political Rights*[72] (*ICCPR*). These two covenants are each supplemented by regulatory guidelines known as Optional Protocols.[73]

Under the *ICESCR*, signatory states have an obligation to respect, protect and fulfil the right to health and must, among under actions, adopt measures to ensure its materialization. Health facilities, goods and services must be available, accessible without discrimination, affordable, acceptable and of high quality.[74] States must also ensure that health services are culturally appropriate and that health care personnel are trained to identify and meet the special needs of vulnerable or marginalized groups.[75] It should be noted that although the *ICESCR* considers the

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[68] See Molinari, *supra* note 62 at 38.
[69] See Frank P Grad, "The Preamble of the Constitution of the World Health Organization" (2002) 80:12 Bull World Health Organization 981 at 983–84, online (pdf): *WHO* <apps.who.int/iris/bitstream/handle/10665/268688/PMC2567705.pdf?sequence=1&isAllowed=y>.
[70] See *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71.
[71] See United Nations General Assembly, *International Covenant on Economic, Social and Cultural Rights*, RES 2200A, 16 December 1966.
[72] See United Nations General Assembly, *International Covenant on Civil and Political Rights,* RES 2200A, 16 December 1966.
[73] See United Nations General Assembly, *Optional Protocol to the International Covenant on Civil and Political Rights*, RES 2200, 19 December 1966, Treaty Series, vol 999 at 171.
[74] See *ibid*.
[75] See UNCESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health* (Art. 12 of the Covenant) (11 August 2000) E/C at para 37.

limits due to available resources, signatory States nonetheless carry an immediate obligation to ensure that the right to health is exercised without discrimination.[76]

However, the Committee on Economic, Social and Cultural Rights provides a nuance to better identify situations where the conduct of the State constitutes a violation of the right to health and a contravention of its obligations. According to the Committee, a distinction must be made between incapacity and lack of will. If the State is unwilling to make maximum use of the resources at its disposal to give effect to the right to health, then the State is in breach of its obligation under Article 12 of the *ICESCR*. On the other hand, if a state cannot meet its obligation due to a scarcity of resources, the State must then demonstrate that it has made every effort to fulfil its obligations.[77]

Similarly, the *ICCPR* provides a mechanism to monitor compliance with signatory states' obligations to protect the right to health by reporting to the United Nations Human Rights Committee (UNHRC).[78] The purpose of these reports is for the State party to present the measures taken to give effect to the rights recognized in the *ICCPR* and the progress made in the application of those rights. The signatory state should submit such a report whenever requested by the UNHRC. Also, the ICCPR allows a signatory state to communicate if another signatory state is not fulfilling its obligations under the Covenant.[79]

Canada also ratified the *Optional Protocol to the International Covenant on Civil and Political Rights*,[80] which allows individuals to appeal to the UNHRC in the event of a violation of a right enshrined in the *ICCPR* once all other available internal remedies have been exhausted. In a complaint filed by Nell Toussaint, a permanent resident of Canada, in August 2018, after the Canadian government denied her health care coverage under its Interim Federal Health Benefit Program.

The UNHCR concluded that Ms. Toussaint's rights to life and non-discrimination had been violated, and that the notion of “right to life” should not be interpreted restrictively and may include the provision of essential health care.[81]

Thus, the right to life includes the right to be free from acts or omissions intending or likely to result in an unnatural or premature death and the right to live in dignity.[82] The UNHRC considers that signatory states have an obligation under article 6 of the *ICCPR* to ensure access to existing

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[76] See *ibid* at paras 30-31.
[77] See *ibid* at paras 30, 47.
[78] See *International Covenant on Civil and Political Rights*, 16 December 1966, arts 28, 40 (entered into force 23 March 1976), online (pdf): *OHCHR* <www.ohchr.org/sites/default/files/ccpr.pdf>.
[79] See *ibid*, art 41.
[80] See Optional Protocol to the International Rights Covenant on Civil and Political, RES 2200, 19 December 1966, Treaty Series, vol 999.
[81] See *Toussaint v Canada*, CCPR Dec/C/123/D/2348/2014, 2018 at paras 2.6-2.8, online (pdf): *ESCR* <www.escr-net.org/sites/default/files/caselaw/toussaint_judgment.pdf>.
[82] See *ibid* at para 11.3.

health services that are reasonably accessible when the absence of such services would expose a person to a reasonably foreseeable risk that could lead to death.

Following its verdict, the UNHRC required the Canadian government to: (1) compensate Ms. Toussaint for the suffering she incurred; (2) take the necessary measures to prevent this type of violation from recurring, particularly through legislative review; and (3) provide within 180 days information demonstrating the measures taken to do so and why. The decision ultimately highlights and recognizes the interdependence of all human rights, including the relationship between health care and the right to life.

The Canadian government's ratification of an international treaty is insufficient to give it legal effect within the country. The legislative power must adopt a law to implement it. However, this integration of international law into Canadian law takes place, to some extent, using international law by national courts, particularly when interpreting laws. Indeed, in *R v Hape*,[83] the Supreme Court of Canada stated that (1) federal legislation is presumed to conform to international law; (2) the federal legislature is presumed to act in compliance with Canada's obligations as a signatory of international treaties and as a member of the international community; and (3) is presumed to comply with the values and principles of customary and conventional international law.

Lastly, as a signatory member, Canada must fulfill its obligation under article 2, paragraph (1) of the *ICCPR* to "respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as […] language". Federal laws such as the *CHA* must comply with and uphold the right of equitable access to health care, regardless of language, as set out in international treaties like the *ICCPR*. Furthermore, the Parliamentary Research Branch of the Canadian Library of Parliament explains that "when an international treaty signed by the federal government affects areas of provincial legislative jurisdiction, the provinces must intervene and amend their legislation if necessary in order to give effect to that treaty."[84] Provincial governments, bound by federal law, must therefore indirectly adhere to the obligations of such international treaties.

Policy Considerations

Quebec's Ministry of Health and Social Services (MSSS) oversees the twenty-two integrated (university) health and social service centres known as CI(U)SSSs, which are responsible for providing health and social services to the peoples of Quebec. Its policies thus apply to all public health care institutions that fall under their jurisdiction, including service providers for the SAPA program (*Soutien à l'autonomie des personnes âgées*), such as all CLSCs, CHSLDs, and RIs.

Language policies

The MSSS language policy does not require any communication or service be provided in English. It does, however, offer situations where communications may be carried out in English. The policy

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[83] See 2007 SCC 26 at paras 53-56.

[84] See Daniel Dupras, *NAFTA: Implementation and Participation of the Provinces*, BP-324E, Catalogue No YM32-2/324-1993E-PDF (Ottawa: Library of Parliament, 1993), online (pdf): *Government of Canada* <publications.gc.ca/collections/collection_2008/lop-bdp/bp/bp324-e.pdf>.

also provides that users of Quebec's CI(U)SSSs should generally always have access to interpreters, anywhere in Quebec.[85]

Language of Oral and Written Communications

The MSSS implemented its Language Policy (*Politique du ministère de la Santé et des Services sociaux relative à l'emploi et à la qualité de la langue française*) to comply with the *CFL*. The general principle of this Policy places French as the primary language used by the MSSS in its oral and written communications. Communications in English are allowed under certain circumstances, and the decision to translate certain forms and documents into English is made case-by-case, based on the particular needs of the community each CI(U)SSS serves. With respect to oral and written communications with individuals, all personnel must first use French.[86] This rule applies to all health care, administrative, and other workers in CLSCs, CHSLDs, and RIs. The conversation can continue in a different language upon the individual's request.

Furthermore, the MSSS Language Policy specifies that only documents which target individuals can be translated into English. The decision to translate a document depends on the clientele the document is addressed to, and all the MSSS's documents must be categorized according to their intended clientele.[87] These documents must be written in French and can be translated by the MSSS with authorization and at their expense, if they are intended for English-speaking users. Publications, brochures, and public notices can be translated into English and provided upon an individual's request. English versions of posters and signs can be used only if necessary for public health and safety. They must be accompanied by the French version and be placed on a separate support.[88]

On the websites of all MSSS institutions, including those of CI(U)SSSs which provide information about SAPA services, the Language Policy states that content must be "majoritarily in French". Any translated portions must be placed in a separate section of the website. However, authorization to translate a section does not permit the translation of any documents included in the section.[89] Finally, many Inuit and First Nation individuals and institutions are exempt from the *CFL*: in their external communications, including with the MSSS, the use of French should be privileged, but another language can be used upon request.[90]

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[85] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, Orientations ministérielles concernant la pratique de l'interprétariat dans les services de santé et les services sociaux au Québec (Québec: Ministry of Health and Social Services, 2018) at 11, online (pdf): MSSS <publications.msss.gouv.qc.ca/msss/fichiers/2018/18-406-03W.pdf> [Orientations de l'interprétariat].

[86] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, Le français en santé : Politique du ministère de la Santé et des Services sociaux relative à l'emploi et à la qualité de la langue française (Québec: Ministry of Health and Social Services, 2016) at 5, online (pdf): MSSS <publications.msss.gouv.qc.ca/msss/fichiers/2016/16-121-03W.pdf>.

[87] See *ibid*.

[88] See *ibid* at 6.

[89] See *ibid* at 10.

[90] See *ibid* at 8-9.

Access to Interpreters

The use of interpreters is one of the main strategies to counter language barriers when attempting to access and navigate Quebec's largely Francophone health care system. The MSSS recognizes that interpreters offer a way to respect users' rights to services considering the cultural and linguistic diversity in Quebec.[91] Its policies emphasize that certified interpreters – who received training in interpretation – should be prioritized. Interpretation services can moreover be offered either in person or remotely (via telephone, videoconference, internet, etc.).

The MSSS recognizes that any person facing a language barrier in the health and social services network must have access to an interpreter whenever possible, if the language barrier would compromise the quality of the service offered and the ability to benefit from it equitably (for more information on access to interpreters for caregivers, see page 29).[92] These services are provided to users free of cost. The MSSS must prioritize accessibility to free interpreters twenty-four hours per day, seven days per week, in all regions of Quebec.[93] In this respect, health care institutions are responsible for informing users of the availability of interpreters.

In practice, however, access to interpreters for English-speaking seniors in Quebec is exceedingly rare. For more on this, see page 68.

Access Programs for health and social services in English

Access Programs create an obligation for Quebec's health care institutions, including those operating within the jurisdiction of CI(U)SSSs, to provide certain specified services in English. The MSSS Guide for Access Programs recognizes the importance of language for successful clinical outcomes. Communication barriers have medical and ethical implications, and they can increase the cost of providing services.[94] Access programs are mechanisms to apply the right to access health and social services in English. They are required for all public health care establishments pursuant to article 76 of the AHSSS. Each access program indicates the services which must be provided in English, taking into account any limitations of human, material, and financial resources.[95]

To develop an access program, each CI(U)SSS starts by creating a portrait of the characteristics and needs of the English-speaking population within its territory.[96] It will also produce an inventory of services currently accessible in English for each facility within its jurisdictional territory. For each service, the mode of access must be specified. The main modes of access are: (1) service provision in English by the establishment itself; (2) agreement with another agency to provide the service in English; or (3) the use of an interpreter (see page 39 for more information on Access Programs and

[91] See Orientations de l'interprétariat, supra note 83 at 2.
[92] See *ibid* at 8.
[93] See *ibid* at 11.
[94] See *Guide*, *supra* note 11 at 59.
[95] See *ibid* at 6.
[96] See *ibid* at 18-21.

Regional and Provincial Committees).[97] Then, an analysis will define the gaps that need to be addressed in order to achieve service accessibility and continuity objectives.[98]

In general, it seems that these health care institutions are only required to continue offering services that they already offer in English and list in their Access Programs. They must further analyze gaps between those English-language services that are listed versus those provided in each institution. However, nowhere in ministerial policy are these institutions explicitly required to resolve these gaps, as their obligations to English-speaking users are also subject to human, material, and financial resources. Existing gaps may be further exacerbated by an institution's ostensible ability to choose to not list any particular service provided in English on its updated Access Program.

The MSSS *Guide* also establishes certain parameters for developing these Programs. The burden rests not on the English-speaking user to navigate the system to receive services in English. Rather, the system is responsible for welcoming the user, clarifying their needs, proposing the most appropriate response, and orientating them to an adequate service. Thus, service providers must have sufficient knowledge of their establishment's access program. Also, each access program must result from a process that assures the participation of English-speaking communities and allows them to express their needs for services in English. The institutions are responsible for taking those needs into account in organizing and offering said services.[99]

Quebec's health care institutions are also responsible for monitoring and evaluating their Access Programs, as well as publicizing their provided services to English speakers in their regions.[100] The MSSS *Guide* requires that access programs be revised at least every five years since the enactment of the *AMHSSN*.[101] However, some establishments' websites link to access programs that are over five years old.[102] In 2019 and 2020, some 29 Access Programs were submitted to the Minister of Health and Social Services and are still awaiting adoption by the National Assembly as of November 2022.[103]

In its Access Program template, the Guide delineates the services that must or may be provided in English by designated or indicated SAPA facilities respectively. In CHSLDs, the listed SAPA services include:

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[97] See *ibid* at 21-24.
[98] See *ibid* at 24-25.
[99] See *ibid* at 12-14.
[100] See *ibid* at 15-16.
[101] See *ibid* at 7.
[102] See e.g. "Programme d'accès aux services de santé et aux services sociaux en langue anglaise pour les personnes d'expression anglaise du Bas-Saint-Laurent" (23 April 2008), online (pdf): *CISSS du Bas-Saint-Laurent* <www.cisss-bsl.gouv.qc.ca/sites/default/files/fichier/prog-dacces_avril_2008_en_revision.pdf>; and "Mise à jour 2016 du programme d'accès aux services de santé et aux services sociaux 2011-2014 de la Montérégie" (31 March 2016), online (pdf): *Santé Montérégie* <www.santemonteregie.qc.ca/sites/default/files/2018/10/programmeacces_monteregie_2016.pdf>.
[103] See e.g. "Access Program – CISSS des Laurentides" (last accessed 14 October 2022), online: *Santé Laurentides* <www.santelaurentides.gouv.qc.ca/english/access-program/>. See also "Access to Health and Social Services in English" (last updated 1 October 2022), online: *QCGN* <qcgn.ca/health-and-sociatreatyl-services/>.

- Admission and intake services;
- Long-term care and accommodation (laundry, hygiene and cleanliness services);
- Temporary care and accommodation (respite/convalescence);
- Rehabilitation services – physiotherapy, occupational therapy, and respiratory therapy;
- Psychosocial services – psychotherapy;
- Dietary/nutritional services;
- Dental services;
- Recreation and Leisure activities; and
- Palliative care.[104]

In CLSCs, the listed SAPA services include:

- Admission and intake services;
- Diagnostic evaluation;
- Medical clinic services;
- Nursing clinical services (including at-home);
- Rehabilitation services – physiotherapy (including at-home), occupational therapy, and respiratory therapy;
- Rehabilitation services – occupational therapy;
- Rehabilitation services – respiratory therapy;
- Psychosocial services – psychotherapy;
- Respite services for caregivers;
- Personal care; and
- Other services.[105]

Senior care policies

Governmental policies on senior care often acknowledge, or imply, that language should be a consideration for equitable service provision, for seniors' integration in the community, and for effective communication with caregivers. However, these recognitions are phrased as suggestions; the policies do not require service providers to consider language at any stage. Furthermore, there is no legal or policy obligation to group people according to their ethno-cultural profile. As it stands, linguistic preferences do not therefore constitute criteria for assigning a senior to a particular at-home care professional or to a particular residence.[106]

Long-term Residential Care for Seniors

The 2021 MSSS policy on residential and long-term care (*Politique d'hébergement et de soins et services de longue durée*) pushes for a personalized approach to senior care tailoring services, to cater to residents' personal characteristics. This policy encompasses long-term care facilities like

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[104] See *Guide*, *supra* note 11 at 70-71.
[105] See *ibid*.
[106] See Commission des droits de la personne et des droits de la jeunesse, *L'exploitation des personnes âgées vers un filet de protection resserré : rapport de consultation et recommandations* (October 2001) at 38, online (pdf): *CDPDJ* <www.cdpdj.qc.ca/storage/app/media/publications/exploitation_age_rapport.pdf>.

CHSLDs and RIs. It applies to all employees or health professionals who work around seniors and to all residence managers.

The pre-admission process, as well as life in long-term care, should conform as much as possible with the person's history and life experience, values, preferences, needs, culture, and language, while concurrently considering the constraints and obligations of the collective living environment.[107] According to the Action Plan to implement the policy, all service providers – including health care and administrative workers – must consider the residents' culture and language.[108]

These policies recognize that residents from diverse cultural backgrounds spent their life living among people who shared their language.[109] Integration into long-term residential care is especially difficult for residents for whom French is not the first language. Service providers, such as the administrators and health care professionals working within these long-term care facilities, must be able to communicate with each resident. This communication can be verbal or use any other appropriate strategy to avoid isolating the resident and make the environment welcoming to all.[110]

Two interventions are suggested to mitigate the language disparities in health care: (1) personalizing services; and (2) ensuring that services are sensitive to cultural and linguistic dimensions. Possible methods to personalize or culturally sensitive these services include:

(1) Training service providers to intervene with people from different cultural communities;
(2) Using the services of interpreters when necessary and to make sure that the person understood the information;
(3) Applying communication strategies to facilitate the transmission of information;
(4) Adapting to the level of literacy for people whose second language is French;
(5) Helping people practice and improve their French;
(6) Knowing the person's life story and
(7) Developing activities in partnership with ethnocultural groups.[111]

Quebec's long-term care policy proposes some interesting and important actions that can be taken, even though its suggestions remain non-obligatory. However, as mentioned above, article 5 of the *AHSSS* provides that "every person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate". This provision should be given a broad and liberal interpretation and applied to SAPA services like placement in CHSLDs and RIs (in accordance with values, linguistic

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[107] See Politique d'hébergement, supra note 57 at 59.
[108] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Pour le mieux-être des personnes hébergées : Plan d'action pour l'hébergement de longue durée 2021-2026* (Québec: Ministry of Health and Social Services, 2021) at 22, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2022/22-814-01F.pdf>.
[109] See Politique d'hébergement, supra note 57 at 59-60.
[110] See *ibid*.
[111] See *ibid*.

preferences, or cultural background, for example) to better personalize these services and reduce senior isolation and abuse.

Additionally, the MSSS's quality-of-life policy (*Un milieu de vie de qualité pour les personnes hébergées en CHSLD – Orientations ministérielles*) drafts a framework for CHSLDs residents' living environment and decision-making with respect to their care. Although it does not explicitly refer to language, many of its principles are unachievable without effective communication. The decision to admit a person into a CHSLD is based on an evaluation of the person's characteristics as well as available resources. Institutional housing is meant to be a last resort and all other options that keep the senior in their own home should be considered first.[112] Residents are assigned an intervenor as a resource person who will help personalize the interventions.[113] The services that the resident will receive must be clearly defined upon admission into long-term care. If a resident requires unavailable services, all possibilities must be explored (agreements with other establishments, purchasing the service, videoconferencing, etc.).[114] All these measures require nuanced and effective communication between the senior and their caregiver and the health care service provider.

Residents must feel integrated in community life; they have a fundamental need for belonging and human relationships. Their living environment should mirror as closely as possible to their previous life. Residents have a right to a living environment that respects their identity and that allows them to exercise self-determination. Residents must be encouraged to express their needs and wishes, and their daily activities must be connected to their modes of expression.[115] The policy states that micro-environments should be put in place to adapt to residents' particular needs and their need for socialization, where ten to fourteen residents are grouped into modules based on their needs.[116] These could potentially be used to connect seniors based on their shared language.

Services for Seniors experiencing a Loss of Autonomy

The MSSS has a precise policy for how to best care for seniors experiencing physical or cognitive decline. One of this policy's priorities is maintaining seniors' integration in their community and allowing them to stay in their habitual dwellings for as long as possible. Seniors clearly prefer to live at home, and this preference highlights the importance of accessible at-home care.[117] These services also help to alleviate the strain on Quebec's long-term care facilities, which have been long dealing with placement and staffing shortages.

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[112] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD - Orientations ministérielles* (Québec: Ministry of Health and Social Services, 2003) at 5, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2003/03-830-01.pdf>.
[113] See *ibid* at 12.
[114] See *ibid* at 15.
[115] See *ibid* at 10-11.
[116] See *ibid* at 22.
[117] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Orientations ministérielles sur les services offerts aux personnes âgées en perte d'autonomie* (Québec: Ministry of Health and Social Services, 2001) at 21, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2000/00-702.pdf> [*Personnes âgées en perte d'autonomie*].

The policy provides that the entry point for at-home and placement services should be adapted to regional characteristics.[118] To that end, a senior's case manager is responsible for representing the senior's interests and helping them and their caregivers access the entry points for the needed care services.[119] Certain key services must be available regardless of the senior's living situation or region.[120]

If required services are unavailable, a residence can enter into an agreement with the CLSC to make those services accessible. Given the vulnerability of seniors experiencing a loss of autonomy, the quality of services is essential. Quality standards are set by the notions of identity, control, privacy, security, and comfort.[121]

Policy on Caregivers

The MSSS caregiver policy (*Politique nationale pour les personnes proches aidantes*) defines a caregiver as any person who supports a senior suffering from temporary or permanent incapacity, be it physical, psychological, or psychosocial, and regardless of whether they share any family ties. This support is not offered in a professional capacity, and it can be continuous or occasional, short- or long-term.

The caregiver's objective, whether expressed or not, is to promote the senior's recovery or quality of life. Examples of support include transportation; aid with personal care and domestic work; emotional support; or coordination of services and care.[122]

The policy also states that one of the caregivers' primary needs is access to information and services in their language. The policy recognizes the difficulties in making appointments or accessing services for caregivers who do not speak or have limited knowledge of French.[123] It is unclear whether caregivers have the right to an interpreter within their senior's health care network.

However, MSSS policy makes clear that "all persons in need of an interpreter must have access to one, whenever possible, if the quality of the [health] service or the ability to benefit from said service is compromised by a language barrier".[124]

While caregivers for seniors are not the ones in need of the health care services, they are the individuals from whom access to these services is initiated and navigated for the senior. An inability of a caregiver to understand the nature or limitations of the services being offered could lead to

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[118] See *ibid* at 23.
[119] See *ibid* at 24-25
[120] See *ibid* at 28-32.
[121] See *ibid* at 35.
[122] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Politique nationale pour les personnes proches aidantes* (Québec: Ministry of Health and Social Services, 2001) at 25, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2021/21-835-01W.pdf>.
[123] See *ibid* at 20-21.
[124] See *Orientations de l'interprétariat*, *supra* note 82 at 8 ("Ainsi, le MSSS reconnaît : que toute personne ayant besoin d'un interprète doit y avoir accès, dans la mesure du possible, si la qualité du service offert et la possibilité d'en bénéficier équitablement sont compromises par une barrière linguistique") [translated by the author].

misinformed decisions made on the senior's behalf and have unintended negative consequences for the health of the senior.

Immigrant Seniors

Under an action plan for immigrant seniors, French language instruction is the primary recommendation to promote immigrant seniors' social inclusion. Learning to communicate in French can facilitate the development of socialization networks and access to available resources.

However, government measures to integrate non-Francophone seniors into Quebec's predominantly Francophone health care network should be sensitive to the unique challenges faced by immigrant populations. Research has shown that when bilingual seniors are in cognitive decline, regressing to use of their first language (in this case, a language other than French) "should be considered a possible early sign of cognitive impairment or development of dementia."[125]

Francization services should be improved to eliminate language barriers and allow seniors to engage fully in their living environment.[126] There is also a need to recognize that some seniors suffer from cognitive difficulties that may impair their ability to improve their French-language skills.

Key Insights

- MSSS language rules limit the availability of important documents in English, including forms needed to begin the process of accessing various health care services in Quebec.

- Users' Committees, in collaboration with regional community groups, can play a vital role in bridging these language barriers and gaps between the regions CI(U)SSSs and the English-speaking communities living within their jurisdictions.

- Finally, ministerial policy recognizes that language should be a consideration for the equitable delivery of services to users. However, with respect to the English-speaking community of Quebec, a recommendation has thus far not translated into substantive equity in access to health care services in English. The lack of a mechanism to monitor when and where these language barriers arise make it all the more difficult to assess where these problems exist and how to best correct them.

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[125] See McMurtray, Saito, et al. "Language Preference and Development of Dementia Among Bilingual Individuals." *Hawaii Med J.* 2009 October ; 68(9): 223–226.

[126] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Un Québec pour tous les âges - Le Plan d'action 2018-2023* (Québec: Ministry of Health and Social Services, 2018) at 44, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/ainee/F-5234-MSSS-18.pdf>.

Organization and Administration of Services

Introduction

Senior care in Quebec is organized through the SAPA program (*Soutien à l'autonomie des personnes âgées*, or Support for the autonomy of elderly people). This program is administered by each of Quebec's 22 Integrated Health and Social Services Centres, which comprise numerous facilities from hospitals to local community health centres to long-term care facilities. While the Ministry of Health and Social Services ultimately oversees the entire public health care network, decisions about what services are available for seniors under the SAPA program – and which are available in English – are made by the local CISSS or CIUSSS, depending on their human, material and financial resources available. This section begins by defining the structure of the health care system writ large, before examining the admnistration of the SAPA program and its components.

Health Care System: Governance

The Quebec health care governance structure has two tiers (see Figure 1). The Ministry of Health and Social Services (*Ministère de la Santé et des Services sociaux* (MSSS)[127] oversees a network of Integrated Health and Social Services Centres (*Centres intégrés de santé et services sociaux* – CISSSs) and Integrated University Health and Social Services Centres (*Centres intégrés universitaires de santé et services sociaux* – CIUSSSs),[128] which in turn administer public health and social services for the administrative region of Quebec in which they are based.

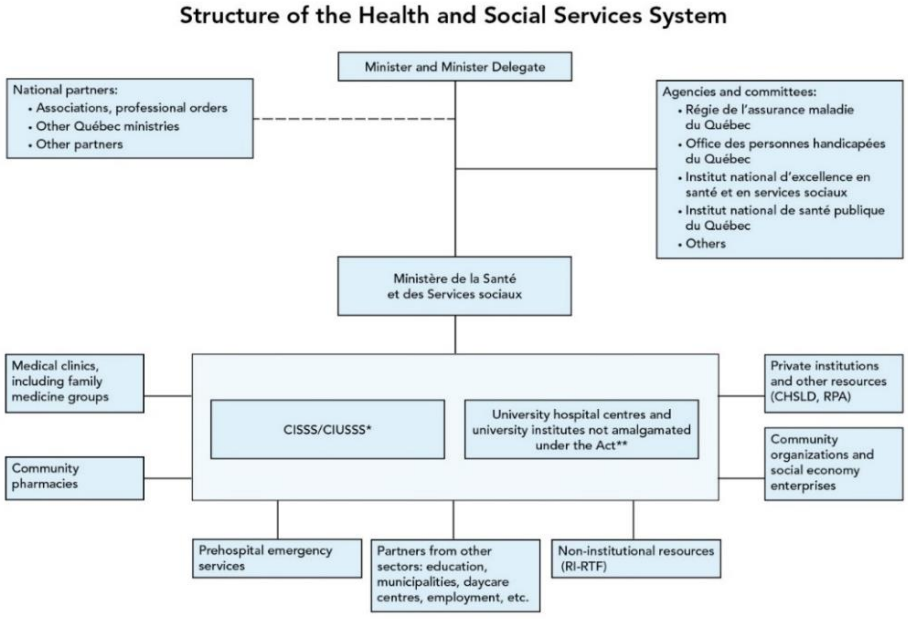

Figure 1- Structure of the Health and Social Services System [source: Québec.ca]

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[127] See "Health and Social Services System in Brief" (last updated 5 August 2015), online: *MSSS* <www.msss.gouv.qc.ca/en/reseau/systeme-de-sante-et-de-services-sociaux-en-bref/programmes-services-et-programmes-soutien/> [Health System in Brief].

[128] See *ibid*.

Ministère de la Santé et des Services Sociaux (MSSS)

The Ministry of Health and Social Services' (MSSS) mission is to maintain, improve and restore the population's health and well-being by providing access to a range of integrated and quality health and social services and thereby, contributing to the social and economic development of Quebec.[129] To do so, the MSSS has several responsibilities, including, among others, to:

- Regulate and coordinate the entire health and social services system;
- Determine health and welfare policies and set standards to manage the various resources (human, material, and financial) within the network;
- Allocate budgets to institutions;
- Ensure coordination of services; and
- Fulfill national public health functions such as the monitoring of population health, promotion of well-being and health, prevention of diseases, psychosocial problems and traumas, and health protection.[130]

The internal structure of the MSSS mirrors other Quebec ministries. Ministerial roles are filled by elected officials, while the role of Deputy Minister is appointed to a senior public servant.[131] The titular head of the MSSS is the Minister of Health. Reporting to the Minister of Health are the Minister responsible for Social Services and the Minister responsible for Health and Seniors. Prior to the October 2022 election, caregivers were formally recognized in the latter minister's title, as the Minister for Seniors and Caregivers. Other key civil servants of relevance to senior care within the MSSS are the Director of At-home Care, the Assistant Deputy Minister for Seniors and Caregivers; and a small team of MSSS researchers specializing in senior care.

The MSSS oversees a vast and sprawling health network and a range of related organizations and committees. In addition to its overseeing of the network of integrated (CISSS) and university (CIUSSS) health and social service centres, several other health bodies and entities also report to the MSSS, including:

- The Commission on end-of-life care (Commission sur les soins de fin de vie)
- The Commissioner for health and wellness (*Commissaire à la santé et au bien-être*);
- Héma-Québec – Quebec's blood and biological products supplier;
- National institute of excellence in health and social services (*Institut national d'excellence en santé et en services sociaux*, or INESSS);
- Quebec national institute of public health (*Institut national de santé publique du Québec*, or INSPQ);
- *Office des personnes handicapées du Québec* (OPHQ), which works to increase the social participation of disabled people living in Quebec;

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[129] See *ibid*.

[130] See *AMHSSN*, *supra* note 10, s 71.

[131] See "Organigramme du ministère de la Santé et des Services sociaux" (last updated 12 October 2022), online (pdf): *MSSS* <cdn-contenu.quebec.ca/cdn-contenu/adm/min/sante-services-sociaux/publications-adm/ORG_organigramme_MSSS_01.pdf?1665760804>.

- Régie de l'assurance maladie du Québec (RAMQ), which administers public health and drug insurance plans and pays health professionals;
- Corporation d'Urgences-santé, which provides ambulance and pre-hospital services in Montreal and Laval; and
- Bureau de la Modernisation, mandated with the modernization of Montreal's university hospital centres (the CHUM, CUSM, and CHU Sainte-Justine)[132]

The MSSS also oversees three advisory committees, including the Provincial Access Committee for Health and Social Services in English. For more information on this committee, see page 40. The other advisory committees that fall under the MSSS's remit include the National Committee on Transforming the Emergency Prehospital Care System, and the Provincial Committee for Healthcare and Social Services for People from Ethnocultural Communities.[133]

Integrated (University) Health and Social Services Centres (CI(U)SSSs)

Quebec's public health and social service network comprises 22 integrated health centres across 16 regions, seven (7) university hospitals and institutes with supra-regional mandates, and five (5) institutions serving Indigenous communities. The present research focuses on services provided to seniors by means of the SAPA program, which is managed by the integrated health centres known as CISSSs and CIUSSSs. Among Quebec's 22 integrated health centres, there are 13 CISSSs (integrated health and social service centres) and nine CIUSSSs (integrated university health and social service centres).

Together, the CIUSSSs make up the Integrated University Health and Social Services Network (*Réseau universitaire intégré de santé et services sociaux*, or RUISSS) which is divided between four universities: Université Laval, McGill University, Université de Montréal, and Université de Sherbrooke (see Figure 2).

[132] See "Organisations et ses engagements" (last updated 16 November 2021), online: *Gouvernement du Québec* <www.quebec.ca/gouvernement/ministere/sante-services-sociaux/organismes-lies/>.
[133] See *ibid*.

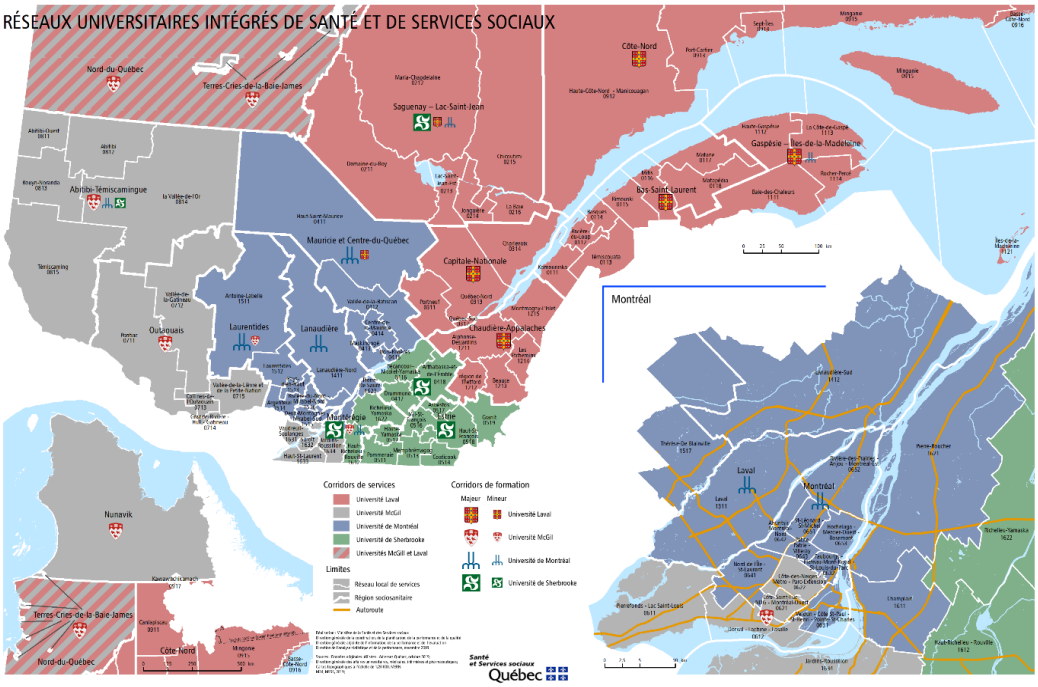

Figure 2- Map of Integrated University Health and Social Services Network in Quebec [source: msss.gouv.qc.ca]

The governance structures of CISSSs and CIUSSSs are comparable with one notable exception: the composition of the board of directors of each CIUSSS must includes two appointees selected from a list of names provided by the universities to which they are affiliated.[134] The board of each institution oversees the affairs of its institution and has the obligation to organize the institution's services in line with province-wide policies and guidelines.[135] They also have the obligation to distribute human, physical, and financial resources in an equitable, efficient, and economical manner, taking into account the characteristics of the population it serves.[136]

A president and executive director as well as an assistant and executive director head the executive governance of each integrated centre.[137] Together they are responsible for the administration and operation of their institutions. Each CI(U)SSS oversees a network of health institutions and facilities, including:

- Medical clinics and family medicine groups, known as GMFs *(Groupes de médecine de famille*);
- Community-based pharmacies and organizations and social economy enterprises;
- Local community service centres, known as CLSCs (*Centres locaux de services communautaires*);

[134] See *AMHSSN*, *supra* note 10, ss 9-11.
[135] See *ibid*, ss 28(1), 29(1)
[136] See *ibid*, s 29(2).
[137] See *ibid*, ss 32-33.

- Private establishments and other resources such as residential and long-term care centres (*Centres d'hébergement et de soins de longue durée* – CHSLDs) or private residences for seniors (*Résidences privées pour aînés*);
- Non-institutional intermediates and family-type resources (*Ressources de type familial* – RTFs);
- Unamalgamated university hospital centres and institutes that provide specialized or highly specialized services to the population;[138] and
- Partners from other sectors such as schools, municipalities, employment agencies, and others.[139]

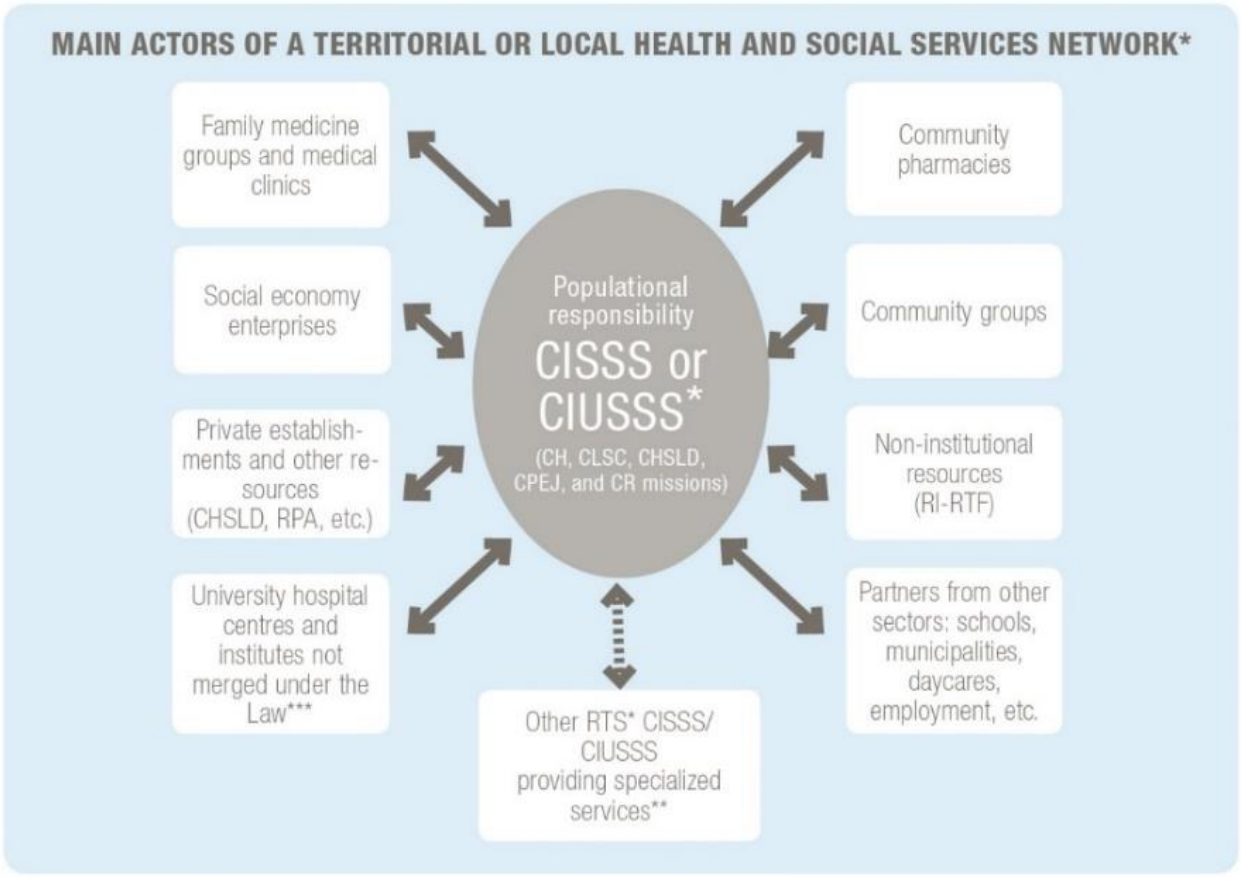

Figure 3 - Health and Social Services Network [Source: msss.gouv.qc.ca]

[138] See *ibid*, s 8 (the following are the unamalgamated university hospital centres and institutions: (1) Centre hospitalier de l'Université de Montréal (CHUM); (2) Centre hospitalier universitaire Sainte-Justine (CHU Sainte-Justine);(3) McGill University Health Centre (MUHC); (4) Institut de cardiologie de Montréal; (5) Institut Philippe-Pinel de Montréal; (6) CHU de Québec–Université Laval; and (7) Institut universitaire de cardiologie et de pneumologie de Québec–Université Laval (IUCPQ)).
[139] See Health System in Brief, *supra* note 124.

All institutions under the jurisdiction of a CI(U)SSS have certain responsibilities, including to:

- Provide quality health and social services that are accessible, ongoing, safe and respectful of individual rights;
- Ensure that users' rights are respected and complaints diligently treated;
- Distribute fairly the human, material and financial resources placed at their disposal, taking into account the characteristics of the population they serve, and ensure their economic and efficient use;
- Conduct teaching, research and assessment of intervention technologies and methods when the institution has a university mission; and
- Take charge of monitoring and accountability to the MSSS, based on the latter's expectations.[140]

In addition, CI(U)SSSs have specific responsibilities to:

- Enlist the public's participation in the network management;
- Ensure that health and social services are provided in a safe manner;
- Plan and coordinate services provided to the population within their territory;
- Put in place measures aimed at the protection of public health and the social protection of individuals, families and groups;
- Manage certain obligations regarding emergency services under the *Act respecting pre-hospital emergency services*;[141]
- Ensure management accountability in line with province-wide targets and recognized standards of accessibility, integration, quality, effectiveness, and efficiency;
- Establish any required regional or interregional service corridors and sign agreements with the institutions and other partners in their territorial service network so as to meet the needs of the population;
- Ensure the development and proper functioning of the local service networks within their territory; and
- Subsidize community organizations and allocate funding to required private resources.[142]

Where applicable, CI(U)SSSs may also collaborate with other established social services, such as a hospital centre, a child and youth protection centre or a rehab centre. This enables them to oversee and better execute a cross-regional mandate to provide specialized services to patients in the network.[143]

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[140] See *ibid*.
[141] See CQLR c S-6.2.
[142] See *AMHSSN*, *supra* note 10, s 71.
[143] See *ibid*, ss 39-40.

Health Care System: Institutions and Facilities

In Quebec, health and social services are divided in five types of institution centres: (1) local community service centres (CLSCs); (2) hospital centres; (3) child and youth protection centres; (4) residential and long-term care centres (CHSLDs); and (5) rehabilitation centres.[144] Each centre has its own mission, as outlined in sections 80 to 84 of the *AHSSS* respectively.

In addition, the health care system is divided in nine service and support programs. There are two general programs:

(1) Public health, which aims to promote, prevent and protect the health and well-being of the population by monitoring population health; and
(2) General services, clinical and assistance activities, which pertains to frontline care.[145]

The other seven programs deal with more specific issues, including support for seniors:

(1) Support for independent seniors;
(2) Persons living with physical disabilities or impairments related to hearing, vision, language, speech, and motor activities;
(3) Persons living with intellectual disabilities and autism spectrum disorders;
(4) Youth with difficulties;
(5) Persons living with dependencies (i.e., alcoholism, drug addiction, and compulsive gambling);
(6) Mental health; and
(7) Physical health, including emergency services, specialized services, continuous services (i.e., for chronic illnesses), and palliative care.[146]

Accessing Services in English

In accordance with section 15 of the *AHSSS*, English speakers have a right to access health care services in English in Quebec. As mentioned above, however, this right is limited in two key ways: (1) by the internal limit regarding the availability of human, material, and financial resources,[147] and (2) by the operationalization of the right through access programs.[148]

The MSSS's 2018 Guide for developing Access Programs for health services and social services in English defines an English-speaking person as follows:

> An English-speaking person is they who, in their relations with an institution that provides health and social services, feels more at ease expressing their needs in English and receiving services in that language.[149]

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[144] See *AHSSS*, *supra* note 1, s 79.
[145] See Health System in Brief, *supra* note 124.
[146] See *ibid*.
[147] See *AHSSS*, *supra* note 1, s 15.
[148] See *ibid*, ss 348, 508.
[149] See *Guide*, *supra* note 11 at 11 ("La personne d'expression anglaise est celle qui, dans ses relations avec un établissement qui dispense des services de santé ou des services sociaux, se sent plus à l'aise d'exprimer ses besoins en langue anglaise et de recevoir les services dans cette langue.") [translated by the author].

Under the Guide, for a health or social service to be considered "accessible" in English, it must be provided in English within a reasonable time after it has been requested.[150]

Access Programs and Regional and Provincial Committees

An Access Program is a list of services and facilities that are accessible in English within a specific administrative region (i.e. within a specific CI(U)SSS's jurisdiction, see Figure 4). Access Programs can apply to designated institutions (i.e., that are required to offer all their services in both French and English) and indicated institutions (voluntarily listed as providing certain services in English).[151] Once a service is listed in a CISSS or CIUSSS's Access Program, all health care institutions that fall within the authority of the CI(U)SSS in question must provide these services in English. This documentation in turns facilitates filing of complaints if a listed service is not offered in English.

Provincial and Regional Access Committees are the bodies tasked with reviewing the Access Programs. These Provincial and Regional Access Committees are described in sections 509 and 510 of the AHSSS, respectively:

> **509**. The Government shall, by regulation, provide for the formation of a provincial committee entrusted with advising the Government on
>
> (1) the dispensing of health and social services in the English language;
>
> (2) the approval, evaluation and modification by the Government of each access program developed by an agency in accordance with section 348.
>
> The regulation must provide for the composition of the committee, its rules of operation and internal management, the manner in which its affairs are to be conducted and its functions, duties and powers.
>
> **510**. The Government shall, by regulation, provide for the formation of regional committees entrusted with
>
> (1) advising the agency concerning the access programs developed by that agency in accordance with section 348;
> (2) evaluating the access programs and suggesting modifications to them where expedient.

[150] See *ibid*.

[151] See "Services à la population d'expression anglaise et Services aux personnes issues des communautés ethnoculturelles" (last updated 15 August 2018), online: *MSSS* <www.msss.gouv.qc.ca/en/ministere/saslacc/services-a-la-population-d-expression-anglaise/>.

The agency concerned shall determine by by-law the composition of its regional committee, its rules of operation and internal management, the manner in which its affairs are to be conducted and its functions, duties and powers.

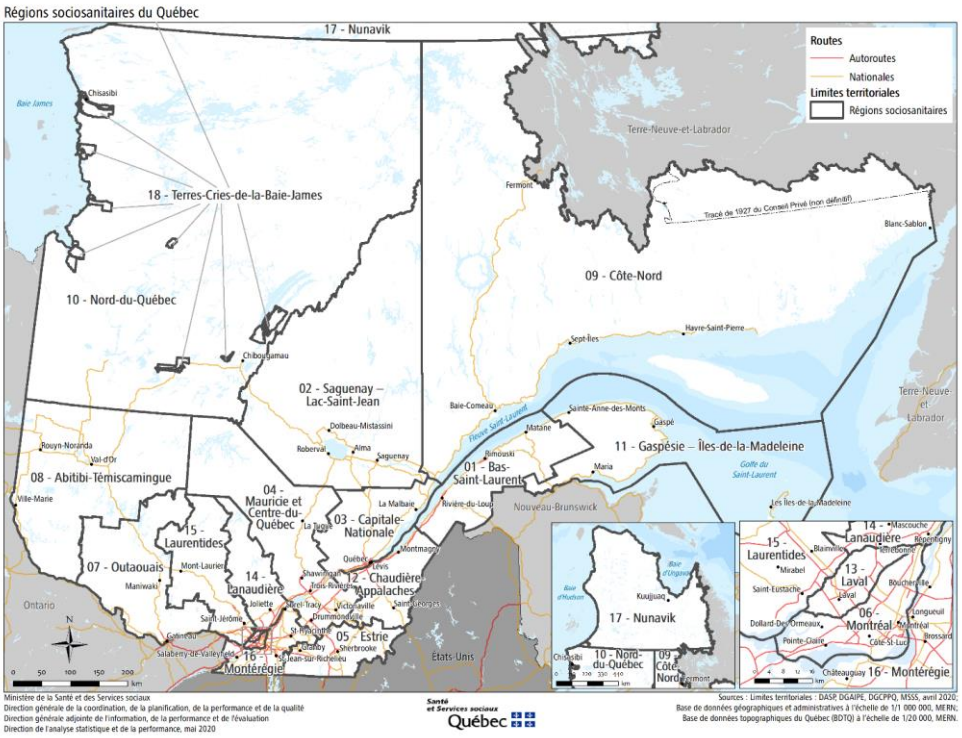

Figure 4 - Map of Administrative Sociosanitary Regions in Quebec [Source: MSSS]

There are 16 Regional Access Committees (RACs, one for each administrative region of the province, see Figure 5) and one Provincial Access Committee (PAC).[152] They are tasked with: (1) ensuring that services listed in the Access Programs are being provided in English; (2) monitoring for any discrepancies between the services listed and those provided in English; and (3) recommending ways to improve access to listed services in English. While Access Programs are first drafted by the institution centre or facility to which they will apply, they are then assigned to their respective regional committee for review. RACs may then provide feedback and recommendations to modify the Access Program in the form of an opinion to the attention of the board of directors of the institution in question. The health care institution may then adjust as needed before sending the draft Access Programs and the RAC's opinion to the MSSS for approval.

The MSSS collects all drafts of the Access Programs and opinions from RACs and refers the matter to the PAC. The latter has the mandate to advise the government on "the dispensing of health and social services in the English language" and "the approval, evaluation and modification by the Government of each access program".[153] The PAC must then submit its own opinion on the draft

[152] See Regional Access Committee Regulation, supra note 7; Provincial Access Committee Regulation, supra note 8; and AMHSSN, supra note 10, s 76.
[153] See *AHSSS*, *supra* note 1, s 509.

Access Programs, which is then submitted to the MSSS with recommendation for approval. Once the MSSS issues a decree approving all the drafted and revised Access Programs, they become enforceable by law.[154] Finally, Access Programs must be revised at least every five years.[155] However, the reality remains that several Access Programs, updated in the mid-2010s, are still awaiting final approval from the MSSS as of the writing of this report.

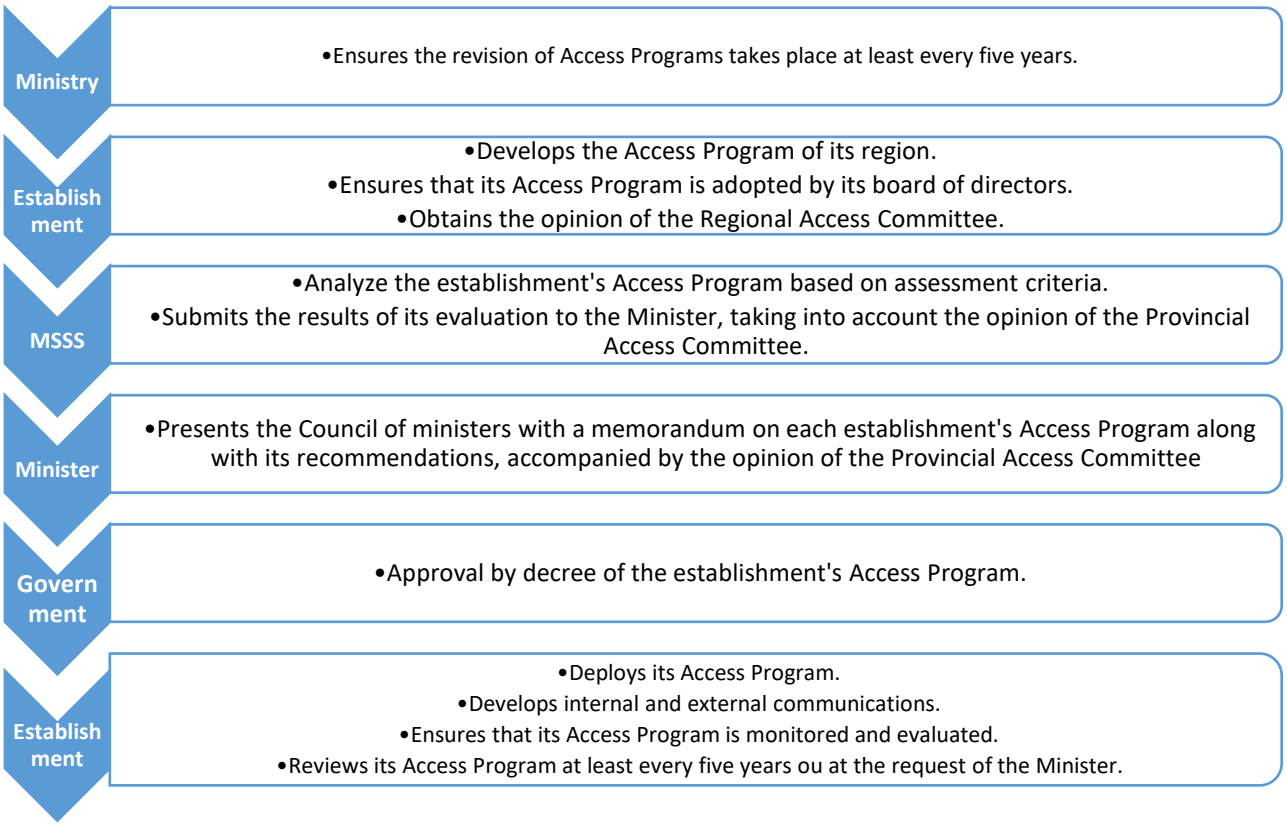

Figure 5 - Creation and Approval Process of Access Programs [Source: MSSS; translated by author]

Types of Access to Health and Social Services in English

When drafting their Access Programs, health care institutions may choose different ways to provide a service in English. They may simply list the service as being provided directly. In this case, an indicated institution may decide that a particular service will always be available (i.e., all staff members may provide it in English) or that a service will be available during specific times (i.e., they may only have certain staff members available to provide the service).[156] As for designated institutions, all services should always be accessible in both French and English.

Another option to provide access to a service in English is for the institution to contract with another institution, whether public or private, for the provision of said service.[157] In this case, the service agreement between the parties must establish which type of services will be offered, their target population, and the required human, material, and financial resources to effectuate the

[154] See *Guide*, *supra* note 11 at 16.
[155] See *ibid* at 30.
[156] See *Guide*, *supra* note 11 at 22.
[157] See *AHSSS*, *supra* note 1, s 108.

service in question.[158] The partner institution may either provide the service directly on its own premises or allow for their staff members to provide the service in another location. Where a service corridor already exists and is specifically geared towards English-speakers, the agreement to that effect must be annexed to the Access Program.[159]

Health care institutions may also provide services in English through the use of language interpreters. In these cases, the institution must provide guidance to its staff to decide when to call upon translation services and whether to provide formal (professional) or informal translation services. Institutions may choose to hire translators in their region or use technology like Jérôme+, a government online initiative meant to provide remote translation services through the Banque interrégionale d'interprètes de Montréal.[160]

Finally, institutions may collaborate with third parties, notably community organizations belonging to the Networking and Partnership Initiative (see page 48 for more information) and volunteers, to provide certain services in English.[161] The MSSS *Guide* encourages creative partnerships to provide services in English.[162]

Seniors and Services

According to the Government of Quebec, seniors, whether autonomous or not, need to access an array of services that may or may not be catered to them. These services are outlined in the government's 2022 guide *Programs and Services for Seniors*.[163] Some of the services include:

- **Health and social services** – medical records, complaints, flu vaccinations, hearing aids, prescription drug insurance plan, RAMQ coverage;
- **Home help** – financial assistance, meals on wheels;
- **Housing** – leases, discrimination complaints in rental, low-rental housing, residential adaptation, shelter allowance;
- **Transportation** – ambulance transport, driving ability and mandatory medical examinations, disabled parking permits;
- **Justice** – complaints and investigations of charter violations, power of attorney, wills, protection mandate, prearranged funeral services;
- **Taxes** – tax credits and assistance; and
- **Others** – pension from another country, Quebec pension plan.

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[158] See *Guide*, *supra* note 11 at 22.
[159] See *ibid* at 23.
[160] See "Présentation de Jérôme+" (last updated 18 October 2022), online: *Santé Montréal* <santemontreal.qc.ca/en/professionnels/services-et-outils/banque-regionale-dinterpretes/presentation-de-jerome/>.
[161] See *Guide*, *supra* note 11 at 23.
[162] See *ibid*.
[163] See Quebec, *Programs and Services for Seniors – 2023 Edition* (2023), online (pdf): *Gouvernement du Québec* < https://cdn-contenu.quebec.ca/cdn-contenu/services_quebec/Guide_Seniors_EN_2023.pdf> [*Programs and Services for Seniors*].

The SAPA Program

Management of the SAPA Program

The two major components of SAPA (*Soutien à l'autonomie des personnes âgées*) services are designed to: (1) support seniors living in their own homes; and (2) support seniors with alternative living arrangements outside of the home when they can no longer live autonomously at home. For the most part, SAPA services are delivered by the 22 CI(U)SSSs which are present in 16 of Quebec's 18 regions. The remaining two regions have Inuit or Cree populations with their own government-funded institutions and services.

In addition, there may be some limited SAPA services delivered to a small number of seniors by Quebec's seven specialized university hospitals and institutes when seniors are their patients for a period.

Seniors generally have access to SAPA programs upon request, following an assessment by a local CLSC. Placement services are provided on a regional basis via a regional admissions system. Moreover, both in-home and out-of-home seniors services are managed by the CISSS and CIUSSS.

Classification

The SAPA program follows a classification method based on the indicator Iso-SMAF (système de mesure de l'autonomie fonctionnelle), which relates to the level of autonomy of an identifiable and homogeneous group of persons with similar needs at similar costs considering their environment.[164] There are 14 Iso-SMAF profiles, in chronological order from full autonomy to limited or lack of autonomy. The Centre d'expertise en santé de Sherbrooke regroups the profiles in four categories:

- **Category 1** (Iso-SMAF profiles 1,2 and 3): Predominant Loss in Instrumental Activities of Daily Life
- **Category 2** (Iso-SMAF profiles 4,6 and 9): Predominant Loss in Mobility Functions
- **Category 3** (Iso-SMAF profiles 5,7, 8 and 10): Predominant Loss in Cognitive Functions
- **Category 4** (Iso-SMAF Profiles 11, 12, 13 and 14): Serious Mixed Alterations[165]

Within the SAPA program, seniors with any Iso-SMAF profile can receive at-home care. As shown in Figure 6 below, seniors with profiles ranging from 6 to 14 can be placed in intermediary resources (RIs) or family-type resources (RTFs), and CHSLDs are available to seniors with profiles from 10 to 14.[166]

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[164] See Quebec, *Planification de l'hébergement public de longue durée pour les aînés en grande perte d'autonomie : Audit de performance* (Québec: Ministry of Health and Social Services, 2022) at 40-44, online (pdf): Vérificateur général du Québec <www.vgq.qc.ca/Fichiers/Publications/rapport-annuel/183/vgq_Ch05_mai2022_web.pdf> [*Audit*].

[165] See "Iso-SMAF Profiles" (last accessed 8 October 2022), online: *SMAF Procedure* <www.demarchesmaf.com/en/tools/iso_smaf_profiles/>.

[166] See *Audit*, *supra* note 161.

Présentation du programme SAPA

	Soutien à domicile	Hébergement de longue durée	
Principale localisation des services offerts	▪ Maison ▪ Logement ▪ RPA	▪ RI ▪ RTF ▪ CHSLD public ▪ CHSLD privé conventionné ▪ Places publiques en CHSLD privé non conventionné	
Clientèle	▪ Personnes en perte d'autonomie liée au vieillissement (troubles cognitifs, limitations fonctionnelles, maladies chroniques, etc.) ▪ 65 ans ou plus pour la majorité de la clientèle		
	Soutien à domicile	**RI-RTF**	**CHSLD**
Profil ISO-SMAF de la clientèle	De 1 à 14	De 6 à 12	De 10 à 14
Objectifs	▪ Maintenir les aînés dans leur domicile le plus longtemps possible ▪ Soutenir les personnes proches aidantes ▪ Éviter les hospitalisations ou en réduire la durée ▪ Faciliter le retour à la maison	▪ Offrir un milieu de vie adapté aux personnes qui ne peuvent plus rester à domicile ▪ Favoriser le maintien ou l'intégration dans la communauté	Offrir un milieu de vie substitut adapté aux besoins des personnes qui ne peuvent plus rester à domicile
Services principaux	Services de longue durée : ▪ services professionnels (soins infirmiers, services de nutrition, physiothérapie, etc.) ▪ aide à domicile (préparation des repas, hygiène, aide domestique, etc.)	▪ Services professionnels (soins infirmiers, services de nutrition, physiothérapie, etc.) rendus par des intervenants du soutien à domicile ▪ Services de soutien et d'assistance 24 h/24	▪ Services professionnels (soins infirmiers, services de nutrition, physiothérapie, etc.) ▪ Services de soutien et d'assistance 24 h/24 ▪ Surveillance
Prestataires des services principaux	▪ Personnel du CISSS ou du CIUSSS ▪ Personnel d'une RPA ▪ Personnel d'un organisme d'aide à domicile, notamment d'une entreprise d'économie sociale en aide à domicile ▪ Travailleur engagé de gré à gré dans le cadre de l'allocation directe/chèque emploi-service	▪ Personnel du CISSS ou du CIUSSS ▪ Personnel d'une RI-RTF	Personnel du CHSLD

Figure 6 - SAPA Program [source: Report of the Auditor General of Québec to the National Assembly for 2021-2022, May 2022]

Services to Seniors within the SAPA Program

Services within the SAPA program can be broadly divided in two categories: at-home care services and long-term care placement services. According to the MSSS At-Home Care Policy (*La politique de soutien à domicile*),[167] governmental priority is to keep seniors living in their homes or current living arrangements rather than to place them. This priority is reflected in section 1 of the *AHSSS* which aims to "maintain and improve the physical, mental and **social capacity of persons to act in their community** and to carry out the roles they intend to assume **in a manner which is acceptable to themselves and to the groups to which they belong**" [emphasis added].

SAPA services for seniors living in their own homes are delivered from the local CLSC according to the At-Home Care Policy. They include:

- Medical care;
- Nursing care;
- Nutrition services;
- General readaptation services (physiotherapy, occupational therapy, speech therapy and audiology);
- Inhalation therapy;
- Psychosocial services;
- Consultations (psychogeriatrics, geriatrics psychiatry and pediatrics);
- Specialized readaptation services;
- Personal assistance services (hygiene care, assistance with feeding, mobilization, transfers, etc.);
- Domestic help (housekeeping, meal preparation, shopping and other errands, clothing care, laundry, etc.);
- Community activities (budget administration, administrative forms, social interactions); and
- Learning assistance (training, simulation activities, personal and domestic activities, rehabilitation.

When at-home care is no longer possible due to the low level of autonomy of the senior person or as a personal choice of the senior person or their caregivers, seniors may be placed in different institutions. The Residential and Long-Term Care Policy of the Government of Quebec describes the guiding principles in the placement of an individual:

- Respect the dignity of the individual;
- Allow the exercise of the person's rights and support their self-determination;
- Implement the partnership approach between the user, family members, and the actors of the health and social services system;
- Aim for the well-being of the resident;

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[167] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Chez soi : Le premier choix – La politique de soutien à domicile* (Québec: Ministry of Health and Social Services, 2003) at 5, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2002/02-704-01.pdf> [*Politique soutien à domicile*]; and *Audit*, *supra* note 161 at 7.

- Personalize care, services, and the living environment; and
- Promote and implement proper treatment.

Publicly funded outside-of-home living arrangement services for seniors are accessible in various levels of care, each with their own physical facilities.[168]

1. CHSLDs

Long-term care facilities, or CHSLDs, are designed to provide housing and care to seniors with important loss in autonomy. Their mission[169] is defined as follows:

> **83.** The mission of a residential and long-term care centre is to offer, on a temporary or permanent basis, an alternative environment, lodging, assistance, support and supervision services as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services to adults who, by reason of loss of functional or psychosocial autonomy can no longer live in their natural environment, despite the support of their families and friends.
>
> To that end, every institution which operates such a centre shall receive, on referral, the persons who require such services, ensure that their needs are periodically assessed and that the required services are offered within its facilities.
>
> The mission of such a centre may include the operation of a day centre or day hospital.

No institution can operate as a CHSLD unless it has been granted a permit to do so by the MSSS.[170] As such, CHSLDs are not all necessarily public, as private long-term homes under an agreement with a CI(U)SSS and private long-term homes without any agreement may still be granted a permit to operate a CHSLD. Moreover, in certain cases, a CHSLD can lease a space in a private residence when it is at maximum capacity.[171] The governance structure of CHSLDs is dictated by the *AHSSS*; and each CHSLD must have a board of directors.[172]

While private residences for seniors exist and are termed *Résidences privées pour aînés* (RPAs)[173], they usually do not provide professional health care services and are rather made for autonomous seniors.[174] Certain RPAs that have been accredited by the MSSS may apply for public funding under certain limited conditions.[175]

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[168] See Politique d'hébergement, supra note 57.
[169] See *AHSSS*, *supra* note 1, s 83.
[170] See *ibid*, ss 437-38.
[171] See *ibid*, s 454. See also "CHSLD : Conditions d'accès, d'utilisation et mise en garde" (last accessed 18 October 2022), online (pdf): *Vos droits de santé* <www.vosdroitsensante.com/15/le-centre-d-hebergement-et-de-soins-de-longue-duree-chsld> [CHSLD : Conditions d'accès].
[172] See *AHSSS*, *supra* note 1, s 119.
[173] See "RPAs : Conditions d'accès, d'utilisation et mise en garde" (last accessed 18 October 2022), online (pdf): *Vos droits de santé* <www.vosdroitsensante.com/132/les-residences-privees-pour-aines-rpa>.
[174] See CHSLD : Conditions d'accès, *supra* note 168.
[175] See *AHSSS*, *supra* note 1, s 454.

2. Intermediate Resources

Intermediate resources (RIs) are used by CI(U)SSSs to carry out part of their mandate. They may be operated by a natural person, a legal person, or a partnership that is recognized by the CI(U)SSS.[176] RIs may have different formats such as a group home, supervised apartments, or a rooming house.[177] Rents in RIs are set by the public health insurer, the Régie de l'assurance maladie du Québec (RAMQ), according to the person's income.

In accordance with the Act respecting the representation of family-type resources and certain intermediate resources and the negotiation process for their group agreements,[178] RIs are represented by the Association des ressources intermédiaires d'hébergement au Québec. They offer services to a variety of people, including seniors with loss of autonomy and persons living with a mental health concern, an intellectual disability, or an addiction. As of October 2022, there are over 17,000 people currently placed in an RI in Quebec.[179]

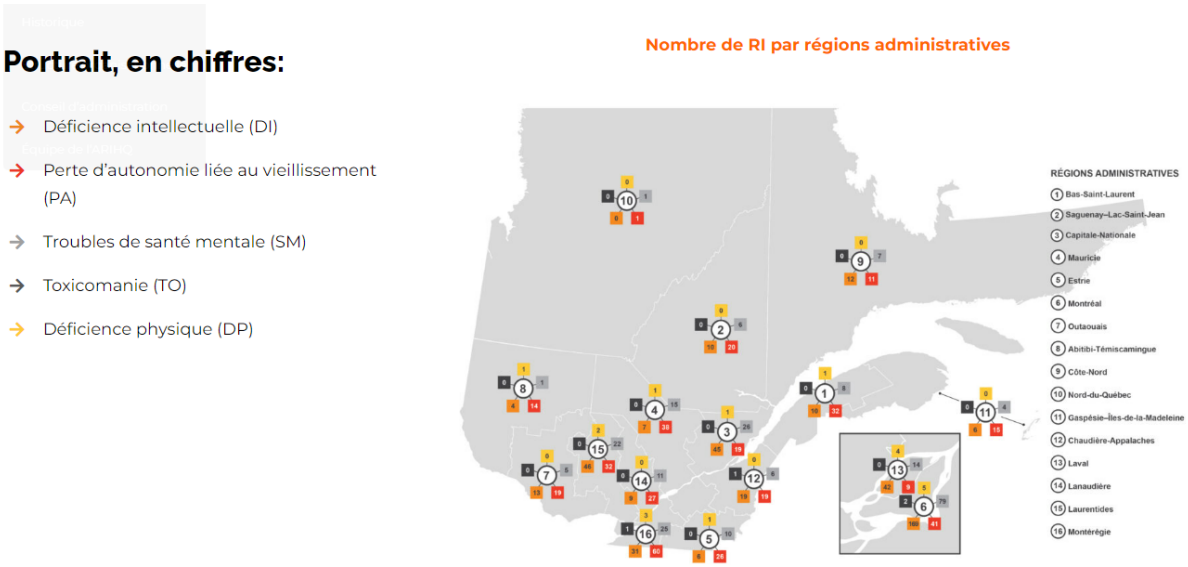

Figure 7 - RIs in Quebec [Source: arihq.com]

3. Family-Type Resources

Family-type resources (RTFs) are comprised of foster families and foster homes recognized by a public institution for the placement of adults and/or seniors.[180] Activities and services provided within these facilities cannot be commercial in nature and must be not-for-profit.[181] Like RIs, they

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[176] See *ibid*, s 302; and Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Cadre de référence : Les ressources intermédiaires et les ressources de type familial* (Québec: Ministry of Health and Social Services, 2016) at 22, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2015/15-801-01W.pdf > [*RIs et RTFs*].

[177] See Regulation respecting the classification of services offered by an intermediate resource and a family-type resource, S-4.2, r 3.1, Schedule.

[178] See CQLR c R-24.0.2, s 3.

[179] See "Portrait au Québec" (last accessed 18 October 2022), ARIHQ <www.arihq.com/portrait-au-quebec/>.

[180] See *AHSSS*, *supra* note 1, ss 310-11; and *RIs et RTFs*, *supra* note 173.

[181] See *AHSSS*, *supra* note 1, s 313.

can be represented by an organization or association.[182] Although no single group represents all RTFs in the province, the Regroupement professionnel des Ressources familiales et certaines ressources de type intermédiaire, which is comprised of the ADREQ (Association démocratique des ressources à l'enfance du Québec) and the ADRAQ (Association démocratique des ressources à l'adulte du Québec) represents RTFs from many regions of Quebec. The ADRAQ notably regroups resources in the Laurentians, Lanaudière, Montreal, Montérégie and Gaspésie regions.[183] Similarly, many members of the Fédération de la santé et des services sociaux are RTFs as well as RIs.[184]

Services that may be offered in both RIs and RTFs are determined by regulation.[185] The CI(U)SSS that uses the services of an RI or a family-type resource has the obligation to oversee the services rendered to users and assess the quality of these services.[186]

4. Seniors' Houses and Alternative Houses

These are relatively new arrangements introduced by the Coalition Avenir Québec government in 2018. Although there are currently no residents living in these arrangements, the government had promised 2,600 places would be available before the 2022 elections. However, the Société Québécoise des infrastructures, tasked with building these facilities, suggests that about 40 per cent of that target, or 1,080 places, would be available by the end of September 2022.[187] The philosophy behind these new living arrangements for seniors is to provide a space that "normalizes" their living arrangement (i.e., remains as close as possible to their experiences in their own homes) and that allows residents to be part of the decision-making process regarding their space and environment.[188] They contribute to the CHSLD mission as defined in section 83 of the *AHSSS*.

The Policy on Senior and Alternative Homes (Maison des aînés et alternatives) notably points out that the cultural and identity expression of the residents must be respected:
Any person accommodated, regardless of age or profile, has the right to a quality living environment. Consequently, the living environment must respect the identity, values, culture and language of this person, in addition to their dignity, self-determination and privacy.[189]

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[182] See Act respecting the representation of family-type resources and certain intermediate resources and the negotiation process for their group agreements, CQLR c R-24.0.2, s 3 [RTFs & RIs Act].

[183] See "Les ressources de type familial et certaines ressources intermédiaires" (last accessed 18 October 2022), online : *CDQ* <www.csd.qc.ca/regroupements-professionnels/ressources-familiales-et-certaines-ressources-de-type-intermediaire/qui-sommes-nous/>.

[184] See "Fédération de la santé et des services sociaux" (last accessed 18 October 2022), online: *FSSS* <fsss.qc.ca/propos/>.

[185] See Regulation respecting the classification of services offered by an intermediate resource and a family-type resource, S-4.2, r 3.1.

[186] See *AHSSS*, *supra* note 1, ss 5, 100-01; *RTFs & RIs Act*, *supra* note 178, s 63(4); and "Ressources intermédiaires et de type familial" (last updated 5 April 2018), online: *MSSS* <www.msss.gouv.qc.ca/professionnels/ressources/ri-rtf/controle-de-la-qualite/>.

[187] See Jocelyne Richer, "Maisons des aînés : seulement 40% des places promises prêtes avant l'élection", *La nouvelle union* (15 June 2022), online: <www.lanouvelle.net/nouvelles-nationales/maisons-des-aines-seulement-40-des-places-promises-pretes-avant-lelection/>.

[188] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, *Maisons des aînés et alternatives* (Québec: Ministry of Health and Social Services, 2020) at 5, online (pdf): *MSSS* <publications.msss.gouv.qc.ca/msss/fichiers/2020/20-863-03W.pdf>.

[189] See *ibid* ("Toute personne hébergée, peu importe son âge et son profil, a droit à un milieu de vie de qualité. En conséquence, le milieu de vie doit respecter l'identité, les valeurs, la culture, la langue de cette personne, en plus de sa dignité, son autodétermination et son intimité.").

Seniors' houses (Maisons des aînés – MDAs) will have the objective of housing seniors with a loss of autonomy, while Alternative houses (Maisons alternatives – MAs) will welcome adults living with a disability due to a physical or intellectual impairment, an autism disorder, or a mental disorder.[190]

Community Organizations Supporting English-Speaking Seniors

The Community Health and Social Services Network (CHSSN) has created a network of community organizations that can help English speakers navigate the health and social services network. Particularly, they put in place the Networking and Partnership Initiative (NPI), which is a project that "supports the development and mobilization of health and social service networks for English-speaking communities throughout the province of Quebec".[191] This network is mentioned in the 2018 *Guide* as a resource to find community organizations to collaborate with in order to provide services in English.[192] Figure 8 showcases the various organizations, many offering services to seniors, associated with the NPI:

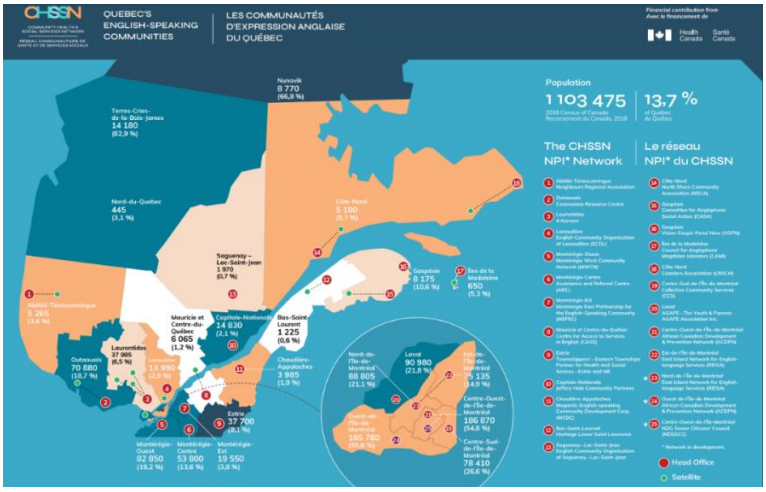

Figure 8 - CHSSN NPI Map [Source: CHSSN]

Likewise, CHSSN has developed a network of services for the well-being of seniors across the province called Senior Wellness Centres (SWC). The map at Figure 9 shows the various SWCs associated with this network:

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[190] See *Politique d'hébergement*, *supra* note 57 at 3. See also "Maisons des aînés et maisons alternatives" (last updated 22 June 2022), online: *Gouvernement du Québec* <www.quebec.ca/sante/systeme-et-services-de-sante/organisation-des-services/maisons-aines-et-maisons-alternatives>; and "Maisons des aînés et maisons alternatives : information aux futures équipes" (last updated 24 February 2022), online: *MSSS* <www.msss.gouv.qc.ca/professionnels/ressources/maisons-des-aines-et-maisons-alternatives-information-aux-futures-equipes/>.

[191] See "Networking and Partnership Initiative (NPI)" (last accessed 17 October 2022), online: CHSSN <chssn.org/projects/npi/>.

[192] See *Guide*, *supra* note 11 at 23.

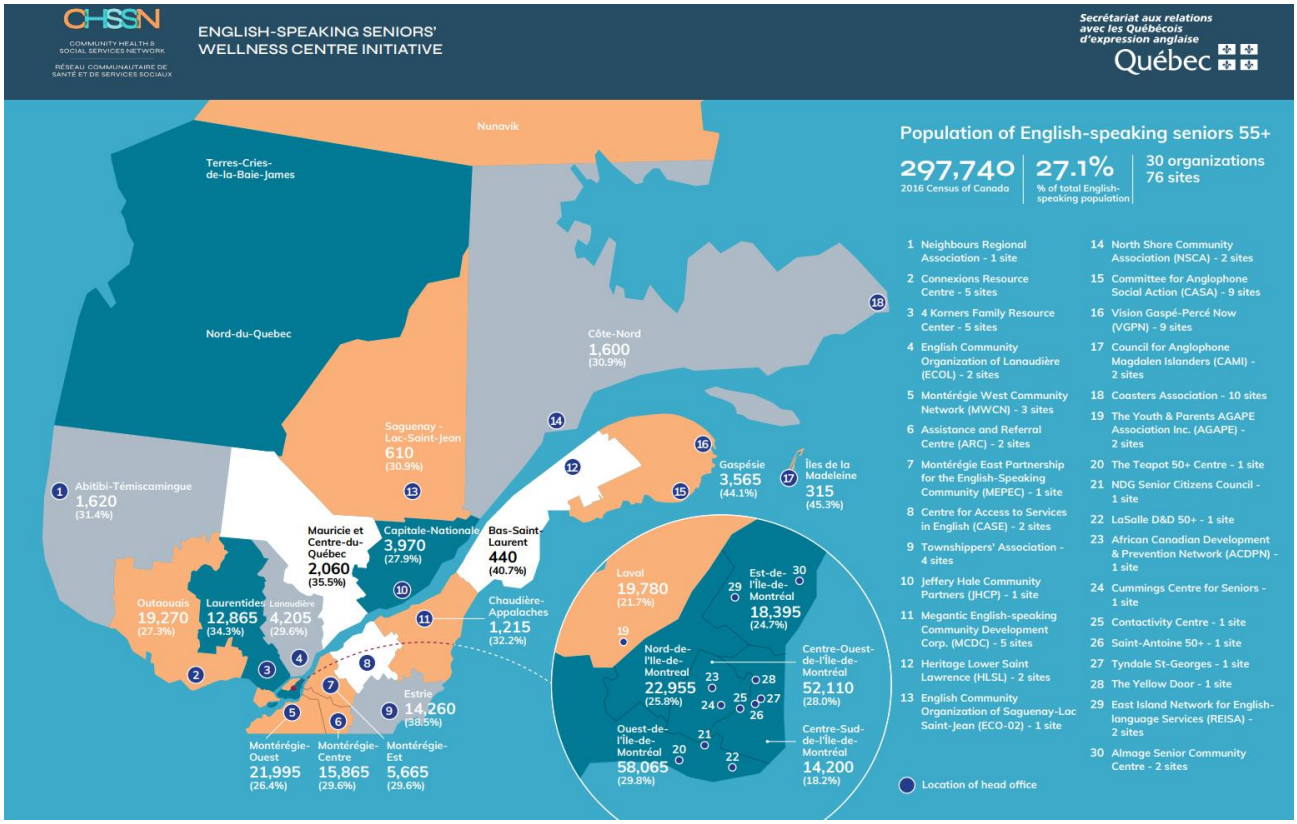

Figure 9 - CHSSN SWC Network Map [Source: CHSSN]

Other community organizations supporting ESSs are listed or documented through various regional or local networks. For example, REISA lists services offered to ESSs on the island of Montreal.[193] Likewise, Seniors Action Quebec created a map of all services offered to ESSs in Quebec.[194] Finally, the 211 Information and Referral database can be used to identify organizations that offer services to seniors across the province.

[193] See "Resources" (last accessed 17 October 2022), online: *REISA* <reisa.ca/document-center/resources/?_sft_resource-category=senior-services>.

[194] See "MapSearch Quebec for Seniors" (last accessed 17 October 2022), online: Seniors Action Quebec <map.seniorsactionquebec.ca/>.

Key Insights

- Institutions operating within a CI(U)SSS have the responsibility to provide quality health and social services that are accessible, ongoing, safe and respectful of individual rights. Their responsibilities also include subsidizing community organizations and allocating funding to required private resources.

- Access Programs list the services and facilities accessible in English within a specific CI(U)SSS. Complaints may be made if a listed service is not offered in English.

- Providing a service in English within the scope of an Access Program can be done in different ways: The institution may either provide the service directly, contract with another institution (public or private), use language interpreters, or collaborate with third parties – notably community organizations belonging to the Networking and Partnership Initiative (NPI) and volunteers.

- Care services for seniors are provided through the SAPA program. Seniors generally have access to SAPA programs upon request, following an assessment by a local CLSC. Placement services are provided on a regional basis via a regional admissions system.

- Services within the SAPA program can be broadly divided in two categories: at-home care services and long-term care placement services. Ggovernmental priority is to keep seniors living in their homes or current living arrangements rather than to place them.

- The initial assessment places the senior on an Iso-SMAF indicator scale, which rates their level of autonomy and needs. Seniors with any Iso-SMAF profile can receive at-home care. Those with profiles ranging from 6 to 14 can be placed in intermediary resources (RIs) or family-type resources (RTFs), and CHSLDs are available to seniors with profiles from 10 to 14.

- The Community Health and Social Services Network (CHSSN) has created a network of community organizations that can help English speakers navigate the health and social services network. This includes the Networking and Partnership Initiative (NPI), which is a project that “supports the development and mobilization of health and social service networks for English-speaking communities throughout the province of Quebec”

System Navigation

Introduction

Seniors and their caregivers can navigate Quebec's senior care system through the SAPA program in different ways, depending on what type of care services they wish to access. Recognizing that the system is complex and that information on how to navigate it can be difficult to obtain or understand, this section aims to provide a clear overview of how seniors or their caregivers can access two types of care services through the SAPA program: at-home care services administered through a local community health centre (CLSC), or placement in a CHSLD or RI.

Navigating the Quebec health care system in English

Quebec's Ministry of Health and Social Services recognizes that the health care system has a responsibility to help English-speaking Quebecers navigate its services. Indeed, the 2018 edition of the MSSS *Guide for developing Access Programs for health services and social services in English* points out that English speakers should not be left to navigate the services offered by themselves, but should rather be guided through these services by the health care network:

> It is important to remember that at all times, it is not up to the English-speaking user to navigate the system, but rather to the system to direct the user to appropriate service in their language.[195]

As it stands, however, there are several shortcomings embedded within Quebec's health care network that impair the ability of Quebecers in general, and English-speaking seniors (ESS) and their caregivers in particular, to both navigate and be guided through this system. How ESSs will access different care services in the SAPA program largely depends on the state of their health, the services they need at the time they seek access to the program, and their awareness of what services are available to them. The way in which they request and obtain these services will also depend on the ease with which these services can be procured in English in the RTS in which the seniors live.

[195] See *Guide*, *supra* note 11 at 23 ("Il est important de se rappeler qu'en tout temps, il n'incombe pas à l'usager d'expression anglaise de naviguer dans le système, mais plutôt au système d'orienter l'usager vers le service adéquat dans sa langue.").

Navigation of SAPA Program Services

At-Home Care Services of CLSCs

Quebec's local community service centres (*centres locaux de services communautaires*, or CLSCs) play a pivotal role in meeting the routine health care needs of the communities they serve. Among these services are medical examinations and diagnostic evaluations, physiotherapy and occupational therapy services, and respite services for caregivers, to name but a few.

Under the SAPA program, CLSCs offer a suite of services for seniors (for a complete list of SAPA services offered by CLSCs, see page 26 of this report).[196] These services are provided for seniors usually living with a handicap, recovering from an illness or a medical procedure, losing their autonomy due to their advanced age, or living with an illness.[197] They are moreover usually reserved for seniors who may need assistance with their day-to-day activities (such as eating, bathing, and dressing), but who do not yet necessarily require round-the-clock care (like the care provided in CHSLDs).[198] The goal of these at-home care services is to keep seniors in their homes for as long as reasonably possible, one of the core policy objectives of the MSSS.[199]

The procedure for an ESS or their caregiver to request at-home assistance is rather linear in its trajectory. A series of steps must be completed before any SAPA services can be administered to the senior (see Figure 10 below).

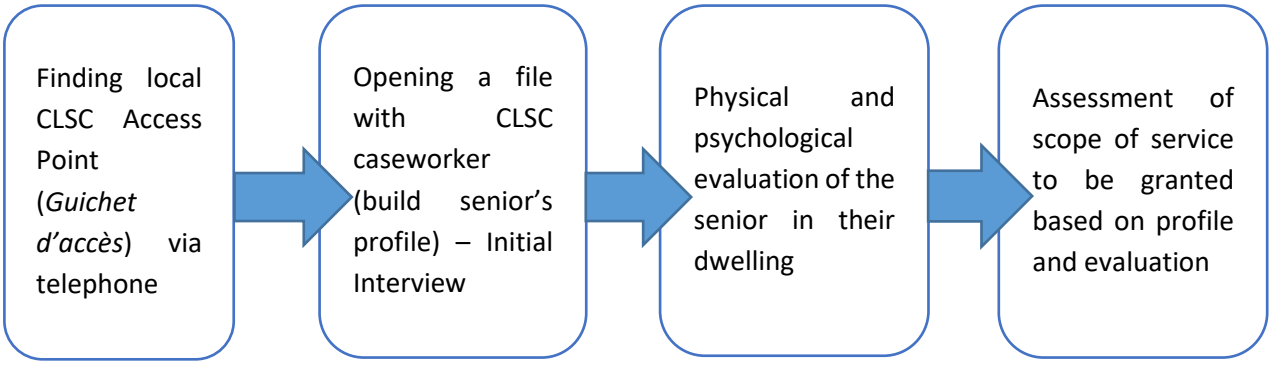

Figure 10 – Pathway to Requesting and Obtaining At-Home Care Services through a CLSC

The first step for any senior to obtain at-home care services is to open a case file with their closest CLSC. The procedure for opening a file will differ depending on which CI(U)SSS jurisdiction the senior resides. For instance, **most administrative regions in Quebec require that a case file be opened via telephone** through each territory's *Guichet d'accès* (Access Point).[200] For most regions, this entry-point can be found on the CI(U)SSS websites.

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[196] See *ibid* at 70–71.
[197] See Politique soutien à domicile, supra note 164 at 1-2.
[198] See *ibid*.
[199] See Personnes âgées en perte d'autonomie, supra note 115 at 21.
[200] See Politique soutien à domicile, supra note 164 at 13.

The table below explains how to navigate each of the twenty-two CI(U)SSS websites to locate the webpages with the relevant information on at-home care services. To navigate to this information, click on each of the section headings listed, in order. Where telephone numbers are available, these have been listed below. Please note that this information is not always available in English, but the pathway in English has been provided where applicable.

CI(U)SSS Website	Roadmap to Locate the Webpages for At-Home Care CLSC Services (as of October 2022)
CISSS Bas-Saint-Laurent	Soins et services › Personnes aînées et en perte d'autonomie › Services à domicile ○ 1-833-422-2267 (Accès à un service – AAOR) [201]
CIUSSS Saguenay–Lac-Saint-Jean	Soins et services › Soutien à domicile et centres de jour › Pour obtenir un service ○ No CLSC or support telephone numbers available on webpage[202]
CIUSSS Capitale Nationale	Services › Aînés › Vivre chez soi – soutien à domicile › Soins de santé et d'assistance à domicile ○ 418-651-3888 (l'équipe Accès)[203]
CIUSSS Mauricie et Centre du Québec	Soins et services › Soutien à l'autonomie › Services à domicile › Pour obtenir les services ○ List of telephone numbers provided for each municipality at bottom of webpage[204]
CIUSSS Estrie – Centre hospitalier universitaire de Sherbrooke	Soins et services › Soutien à domicile › Appelez votre CLSC pour demander des services ○ List of telephone numbers provided for each municipality at bottom of webpage[205]
CIUSSS Est de l'Île de Montréal	Soins et services › Personnes âgées › Soutien à domicile › Obtenir les services ○ 514-255-2490 (Guichet d'accès pour les personnes en perte d'autonomie)[206]
CIUSSS Ouest de l'Île de Montréal*	Care and Services › Services for Seniors and People with Decreasing Independence › Home Support Services ○ Telephone numbers are listed for CLSC At-Home Care Services and Housekeeping Services[207]

[201] See "Services à domicile" (last accessed 14 October 2022), online: *CISSS Bas-Saint-Laurent* <www.cisss-bsl.gouv.qc.ca/soins-services/personnes-ainees-en-perte-d-autonomie/services-a-domicile>.
[202] See "Soutien à domicile et centres de jour" (last accessed 14 October 2022), online: *CIUSSS Saguenay–Lac-Saint-Jean* <santesaglac.gouv.qc.ca/soins-et-services/soutien-a-domicile-et-centres-de-jour/>.
[203] See "Soins de santé et d'assistance à domicile" (last accessed 14 October 2022), online: *CIUSSS Capitale-Nationale* <www.ciusss-capitalenationale.gouv.qc.ca/services/aines/soutien-domicile/assistance-domicile>.
[204] See "Soutien à domicile" (last accessed 14 October 2022), online: *CIUSSS Mauricie-et-du-Centre-du-Québec* <ciusssmcq.ca/soins-et-services/soins-et-services-offerts/soutien-a-l-autonomie/services-a-domicile/>.
[205] See "Soutien à domicile" (last accessed 14 October 2022), online: *Santé Estrie* <www.santeestrie.qc.ca/soins-services/pour-tous/soutien-a-domicile>.
[206] See "Soutien à domicile pour personnes en perte d'autonomie" (last accessed 14 October 2022), online: *CIUSSS Est-de-l'Île-de-Montréal* <ciusss-estmtl.gouv.qc.ca/soins-et-services/services-domicile-pour-personnes-en-perte-dautonomie>.
[207] See "Home Support Services" (last accessed 14 October 2022), online: *CIUSSS Ouest-de-l'Île-de-Montréal* <ciusss-ouestmtl.gouv.qc.ca/en/care-services/west-island-territory/services-for-seniors-and-people-with-decreasing-independence/home-support-services/>.

CIUSSS Centre Ouest de l'Île de Montréal*	Programs and Services › Support Program for the Autonomy of Seniors (SAPA) › Home Care ○ Hyperlinks to the contact information for the CLSCs in the territory that provide at-home care services[208]
CIUSSS Centre Sud de l'Île de Montréal	Soins et services › Personnes âgées › Soutien à domicile › Accès aux services ○ Telephone numbers listed for at-home care services[209]
CIUSSS Nord de l'Île de Montréal	Soins et services › Adultes et personnes âgées › Soutien à domicile › Accès aux services ○ List of telephone numbers provided for each municipal CLSC at bottom of webpage[210]
CISSS Outaouais	Obtenir un service › Vivre avec une perte d'autonomie et services aux personnes âgées › Services de soutien à domicile › Comment y accéder? ○ Senior or caregiver must contact 811, option 2 (Info-Social) to open a case file for at-home care services[211]
CISSS Abitibi-Témiscamingue	Soins et services › Aînés › Soins à domicile › Guichet d'accès ○ List of telephone numbers provided for each municipal CLSC at bottom of webpage[212]
CISSS Côte-Nord*	Care and Services › Seniors › Home Support › Service Access Points ○ Telephone numbers for each access point for at-home care services listed on webpage[213]
CISSS Gaspésie	Soins et services › Personnes aînées et en perte d'autonomie › Services et soutien à domicile ○ Telephone numbers provided for each access point for at-home care services listed on webpage[214]
CISSS Îles-de-la-Madeleine	Programmes et services › Soutien à l'autonomie des personnes âgées (SAPA) et hébergement ○ 418-986-2572 (number to contact to ask to open a case file)[215]

[208] See "Support Program for the Autonomy of Seniors (SAPA)" (last accessed 14 October 2022), online: *CIUSSS Centre-Ouest-de-l'Île-de-Montréal* <www.ciussswestcentral.ca/programs-and-services/support-program-for-the-autonomy-of-seniors-sapa/support-program-for-the-autonomy-of-seniors-sapa/>.

[209] See "Soutien à domicile" (last accessed 14 October 2022), online: *CIUSSS Centre-Sud-de-l'Île-de-Montréal* <www.ciusss-centresudmtl.gouv.qc.ca/soins-et-services/soutien-domicile>.

[210] See "Soutien à domicile" (last accessed 14 October 2022), online: *CIUSSS Nord-de-l'Île-de-Montréal* <www.ciusssnordmtl.ca/soins-et-services/adultes-et-personnes-agees/soutien-a-domicile/>.

[211] See "Services de soutien à domicile" (last accessed 14 October 2022), online: *CISSS Outaouais* <cisss-outaouais.gouv.qc.ca/obtenir-un-service/vivre-avec-une-perte-dautonomie-et-services-aux-personnes-agees/services-a-domicile/>.

[212] See "Soins à domicile" (last accessed 14 October 2022), online: *CISSS Abitibi Témiscamingue* <www.cisss-at.gouv.qc.ca/soins-a-domicile>.

[213] See "Home Support" (last accessed 14 October 2022), online: CISSS Côte-Nord <www.cisss-at.gouv.qc.ca/soins-a-domicile>.

[214] See "Services de soutien à domicile" (last accessed 14 October 2022), online: *CISSS Gaspésie* <www.cisss-gaspesie.gouv.qc.ca/soins-et-services/personnes-ainees-et-en-perte-dautonomie/services-et-soutien-a-domicile/>.

[215] See "Soutien à l'autonomie des personnes âgées (SAPA) et hébergement" (last accessed 14 October 2022), online: *CISSS des Îles* <www.cisssdesiles.com/csss-des-iles-programmes-et-services-personnes-en-perte-dautonomie-liee-au-vieillissement-ppavl/>.

CISSS Chaudière-Appalaches	Soins et services › Soutien à l'autonomie › Soutien à domicile › Services offerts ○ Highlighted in blue is a hyperlink to the contact information of all the CLSCs in the territory that provide at-home care services[216]
CISSS Laval	Soins et services › Liste des soins et services › Soutien à domicile › Services offerts ○ Senior or caregiver must contact 811, option 2 (Info-Social) to open a case file for at-home care services[217]
CISSS Lanaudière	Liste des soins et services › Soutien à domicile › Services offerts ○ 1-866-757-2572 (access point for at-home care services)[218]
CISSS Laurentides	Soins et services › Soutien à domicile › Modalités d'accès au soutien à domicile ○ 1-866-757-2572 (access point for at-home care services)[219]
CISSS Montérégie-Centre	Soins et services › Personne en perte d'autonomie › Soutien à domicile ○ Telephone numbers for each access point for at-home care services listed on webpage[220]
CISSS Montérégie-Est	Soins et services › Personne en perte d'autonomie › Soutien à domicile ○ Telephone numbers for each access point for at-home care services listed on webpage[221]
CISSS Montérégie-Ouest	Soins et services › Personne en perte d'autonomie › Soutien à domicile ○ Telephone numbers for each access point for at-home care services listed on webpage[222]

NOTE: The asterisk (*) indicates any CISSS or CIUSSS website which has a *Soutien à domicile* (Home Support) webpage available in English as of October 2022.

Except for the Outaouais and Laval regions, this table illustrates that the navigation process for finding CLSC contact information online is conceptually similar across most CI(U)SSS jurisdictions and their websites. However, the different titles of webpages can trigger certain problems for web-users with limited or little digital literacy, be they seniors or their caregivers. Furthermore, given

[216] See "Soutien à domicile" (last accessed 14 October 2022), online: *CISSS de Chaudière-Appalaches* <www.cisssca.com/soins-et-services/soutien-a-lautonomie/soutien-a-domicile>; and "CLSC (Cordonnées des points de service)" (last accessed 14 October 2022), online: CISSS de Chaudière-Appalaches <www.cisssca.com/nous-joindre/coordonnees-des-points-de-service/clsc/>.
[217] See "Soutien à domicile" (last accessed 14 October 2022), online: *Laval en santé* <www.lavalensante.com/sad/>.
[218] See "Soutien à domicile" (last accessed 14 October 2022), online: *CISSS Lanaudière* <www.cisss-lanaudiere.gouv.qc.ca/liste-de-soins-et-services/liste-par-clientele/personnes-agees/soutien-a-domicile/>.
[219] See "Soutien à domicile" (last accessed 14 October 2022), online: *Santé Laurentides* <www.santelaurentides.gouv.qc.ca/soins-et-services/soutien-a-domicile>.
[220] See "Soutien à domicile" (last accessed 14 October 2022), online: *Portail Santé Montérégie* <santemonteregie.qc.ca/services/soutien-domicile>.
[221] See *ibid*.
[222] See *ibid*.

that this contact information is primarily available online, its access requires a certain level of digital literacy which seniors or their caregivers may not possess. It would therefore, in such cases, be encouraged for caregivers to ask the senior's doctor, health care provider, or another community resource for assistance to obtain the needed CLSC contact information.

Through this contact information, the senior or their caregiver can request that a case file be opened. During this conversation and subsequent evaluation, the senior or their caregiver may be asked a series of questions to get a sense the senior's health profile, in order for CI(U)SSS professionals to assess which health care services the senior may need. The caller will also be given the opportunity to explain the senior's particular health care problems and consequential needs.[223] However, according to MSSS policy, **any at-home care services declared necessary in a senior's situation can be provided only if all the following conditions are satisfied:**

1) The need for at-home care services is supported by evidence gathered through a professional assessment, based on the needs expressed by the senior and their caregiver(s);
2) The senior and their caregiver(s) agree to participate in the entire process and accept the CI(U)SSS' decision and the services it declares required (in certain situations, consent here need only be provided by either the senior or their caregiver(s));
3) The senior remains confined in their home due to their health condition, or it is more clinically suitable to provide the needed health care services in the home;
4) The senior's home is deemed adequate and safe following the in-person professional assessment; and
5) It is more efficient for the regional CI(U)SSS to offer the senior the needed health care services at home rather than in an institution (such as a hospital or CHSLD) or on an outpatient basis. [224]

To best comply with these policy conditions, it is important for the senior or their caregiver to openly divulge the reality of the senior's health with the agent opening the file during the initial telephone exchange.[225] It is also possible that the senior or caregiver may be asked to speak with a caseworker who may later be assigned to them, or who may relay important information to another caseworker who may be assigned the file.[226]

Since at-home care services are in high demand across the province, it is important for the senior or caregiver to clearly state, if possible, the specific at-home services the senior would need and the health- or autonomy-related reasons for this needed service.[227] For example, on the initial call, a caregiver may explain the need for hygienic services (such as assistance with bathing, dressing,

[223] See Politique soutien à domicile, supra note 164 at 12–13.
[224] See *ibid* at 17.
[225] See "Les services de soutien à domicile de votre CLSC" (last accessed 30 September 2022), online: *Index Santé* <www.indexsante.ca/chroniques/255/services-de-soutien-a-domicile-clsc.php>.
[226] See *ibid*.
[227] See *ibid*.

haircare, or nailcare) for a senior with advancing Alzheimer's and consequential decline in mobility and dexterity.

Once the initial call is completed and the case file for the senior has been opened, a health care professional from the regional CI(U)SSS will thereafter be sent to the senior's home to assess the condition of the household and the physical and psychological health of the senior in question.[228] Alongside the information gathered from the senior or caregiver during the casefile opening telephone call, the professional will draw up an assessment of the senior's health status. Based on all the information gathered during this intake process, the professional will then recommend the services they believe are needed and those that can be provided considering the human, material, and financial resources available to the senior's CLSC.[229]

If a specific service requested by the senior or caregiver is not available, or simply does not exist, the CLSC is tasked with the duty to best accommodate the needs of the senior. If the service provided is unsatisfactory, the senior or caregiver has the option, as a last resort, to file a grievance with the regional Commissioner of Complaints.

Placement Care Services of CHSLDs and RIs

Quebec's long-term care facilities (known as *centres d'hébergement de soins de longue durée*, or CHSLDs) are hospice residences devoted to patients with chronically debilitating health issues. With the majority of their facilities being populated by seniors with advanced illnesses, the need for a greater number and quality of CHSLDs will grow alongside Quebec's aging population.[230]

Among the services provided in these facilities are temporary care and accommodation following hospitalization, rehabilitation services, physiotherapy and occupational therapy services, recreational and communal activities, and palliative care services, to name but a few (for a complete list of SAPA services offered by CHSLDs, see page 26 of this report).[231]

Intermediary resources (RIs, or *ressources intermédiaires*), by contrast, provide an "intermediary" residence to seniors with enough autonomy that they need not live in a CHSLD (they can clean, cook, run errands, visit family and friends, or bathe themselves to varying degrees, for example), but who may still require more medical supervision than at-home care services from a CLSC can permit.[232]

Much like at-home care, the breadth of services offered by the staff of an RI will be customized to the particular needs of the residents, only within a semi-controlled setting with more medical and nursing attention on the premises. Note that RIs are not designated or indicated facilities, since they do not possess the legal status of a health care institution. As such, RIs are exempt from any

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[228] See *ibid*.
[229] See *ibid*.
[230] See Politique d'hébergement, supra note 57 at 9-12.
[231] See *Guide*, *supra* note 11 at 70-71.
[232] See *RIs et RTFs*, *supra* note 173 at 26.

obligation to provide services in English – though some will have agreements in place with local CI(U)SSS to provide certain services in English.

The procedure for requesting placement for a senior within a CHSLD or RI will differ depending on their health status at the time the request is initially made. For seniors who are in generally fair health and living at home but are afflicted with declining autonomy (a decrease in physical or mental faculties, such as progressing neurodegenerative or muscular diseases), they or their caregivers can file a pre-emptive request to have the senior placed in a CHSLD or RI, as outlined in Figure 11, below.

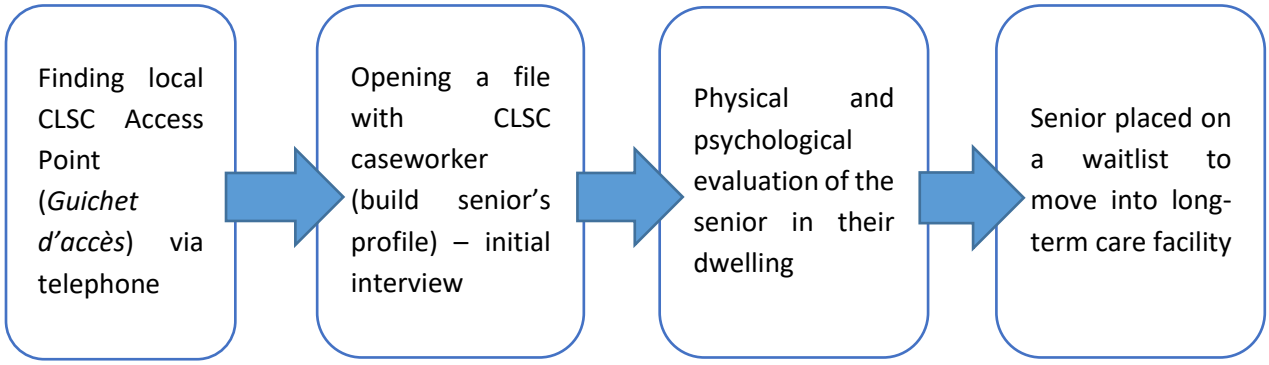

Figure 11 – Pathway to Requesting and Obtaining Placement in a CHSLD or RI for a Non-Hospitalized Senior

The first point of contact in this case will be the senior's *Guichet d'accès* (access point). As with at-home care, the senior or their caregiver will have to contact the local CLSC via telephone to open a file (see table on pages 54-56 to find contact information for CLSCs). During this first phone call with the CLSC caseworker, the senior or their caregiver should disclose all information necessary to help the caseworker develop a thorough profile of the senior's health status, including mention of any ongoing medical issues or diseases.

Following this exchange, the CLSC will send a health care professional to the senior's place of residence to examine their level of self-sufficiency, or rather, their reliance on a caregiver for everyday functioning and support.

After then getting in touch with the senior's physician (if they have one) to review their medical history, all this information is assessed by the CLSC alongside the administrations of the CHSLD or RI to determine how much time will pass before the senior in question will need permanent placement in a long-term care facility.

Seniors will then be placed on a waiting list until a space becomes available. For RIs, wait times for these lists largely depend on the availability of dwellings near the senior's place of residence. For CHSLDs, the senior's position on said list can advance if their health unexpectedly deteriorates due to a medical emergency or an unforeseen complication with their illness.

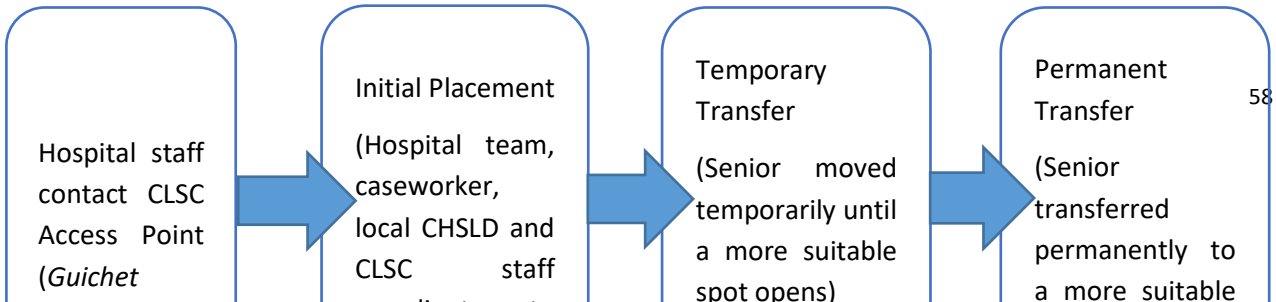

Figure 12 – Pathway to Requesting and Obtaining Placement in a CHSLD for a Hospitalized, Permanently Debilitated Senior

To that end, seniors also often face unplanned hospitalizations that may require extended medical attention and prolonged sojourns in hospice. Hospitals cannot care for seniors indefinitely in cases where their health status is poor but not necessarily worsening. In situations where a senior cannot be discharged from hospital without a need for constant care, the hospital staff (including the senior's doctor, nurses, and caseworker) will undertake the process to arrange for placement.

This stay in long-term care may be deemed temporary, until the senior regains enough health that they may return home. The stay can also be made permanent where the senior has no reasonable chance of regaining enough of their health to live semi-autonomously.

If placement in long-term care is urgently needed, then arrangements will often be made at a CHSLD when an availability open. While proximity to the senior's family members and place of residence are factored into their relocation into such a facility, the priority for health care professionals is to get the senior in long-term care as quickly as possible. Should a place subsequently open in a CHSLD closer to their family or original residence after the senior has been placed in a facility further away, the senior's caseworkers can request their relocation.

Access Barrier: Low Awareness of Procedure to Request Services

The Government of Quebec's booklet titled *Programs and Services for Seniors* is published annually and outlines the general procedure, in English, for requesting at-home care services or long-term placement through a senior's local CLSC.[233] Resources such as this booklet can be one way for seniors and their caregivers to navigate their entry into the SAPA care program.

[233] See Programs and Services for Seniors, supra note 160 at 8.

However, awareness of the booklet is very low: the population survey conducted for this report found that just 3% of seniors and 8% of caregivers are aware of it (for more on the survey, see the Population Experience section, page 62).

Further, the booklet only offers telephone numbers to contact Services Québec as a starting point "to find out how to contact the [nearest] CLSC". This guideline does not consider the difficulties that English-speaking seniors or their caregivers may experience when trying to navigate the complex voice-automated options menu. As further evidenced by the survey, one in four seniors (24%) and four in ten caregivers (39%) who requested home care services through their local CLSC found the process difficult – suggesting a need for broader and more straightforward access to services in English.

To simpify, the table below lists the options for navigating Services Québec's automated telephone menu in English. Following the options will connect the caller with a Services Québec representative within the Primary Care Access Point division.

Services Québec telephone menu navigation **(accurate as of November 2022)**	
Telephone Button to Press (Descending Sequence Order)	**Name of Option being Selected**
9	Services in English
1	Services for Citizens and Businesses
1	Services for Citizens
1	Primary Care Access Point
2	Speak to a Services Québec representative (usually English-speaking)

Key Insights

- Most administrative regions in Quebec require that a case file be opened via telephone. For both at-home care services and placement in a CHSLD or RI, the preliminary assessment is done by contacting the senior's local CLSC.
- Once the initial call is completed and a case opened, a health care professional from the regional CI(U)SSS will be sent to the senior's home to assess the condition of the household and the physical and psychological health of the senior.
- At-home care services can be provided only if certain conditions are met: evidence gathered through a professional assessment, consent from the senior and their caregiver, the senior remaining confined at home due to their health, the home being deemed adequate and safe, and home care being deemed more efficient than care in an institutional or outpatient setting.
- If a specific service requested by the senior or caregiver is not available, the CLSC must attempt to accommodate the needs of the senior.
- If any SAPA service provided is unsatisfactory, the senior or caregiver has the option, as a last resort, to file a grievance with the regional Commissioner of Complaints.

Population Experience

Introduction

This section of the report analyzes the experiences of English-speaking seniors aged 60 and over accessing SAPA care services in Quebec, as well as the experiences of caregivers to seniors aged 60 and over. Quantitative research commissioned for this report suggests that in addition to the delays and resource shortages faced by all Quebec seniors seeking care services through the public system, English-speaking seniors can face difficulties and delays accessing care services as a direct result of language barriers. These findings are then placed within a broader analysis of the barriers to accessing senior care services in English through the SAPA program, with insights drawn from qualitative interviews with community and health care stakeholders. Finally, this section offers a brief overview of the demographics of Quebec's English-speaking senior population in relation to available senior care services in English by administrative jurisdiction.

Quantitative Research Findings

Though much has been written on Quebec's health care system and the services offered to seniors, comparatively few studies have examined the provision of these services through a language lens, focusing on Quebec's English-speaking community. In the hopes of beginning to bridge this gap in the literature, the Access to Justice project commissioned Léger to conduct a study of some N=923 English-speaking seniors aged 60 and over (n=633) and caregivers to seniors (n=290). To qualify as a caregiver, respondents needed to be aged 35 or over, and currently providing care to a senior family member or friend aged 60 or more. All respondents indicated they were more comfortable accessing health care services in English.

With Quebec's senior care services already overstretched, the Léger survey of seniors and caregivers confirms existing studies that suggest demand is only set to grow in the short to medium term. A majority of English-speaking caregivers (70%) think it likely that the senior they provide care for will request care services in their home within the next five years. While this makes them significantly more likely than seniors themselves to predict this need in the near term, three in ten English-speaking seniors aged 60 and over (29%) also think they are likely to request home care services within the next five years.

The survey reveals the following insights about home care services for seniors:

Low Awareness of Resources for Seniors

Despite the "Programs and Services for Seniors" booklet being designed as an information resource for all Quebec seniors, awareness of it is extremely low among English-speaking Quebecers. Only 3% of seniors and 8% of caregivers polled had seen or read the booklet.

There is also a lack of awareness as to the range of care services seniors may request from their local CLSC. Asked to identify the different types of care services provided at home by the CLSC, many seniors and caregivers were unaware of the full range of what is available to them. There

are currently 13 care services offered to seniors in their homes through the CLSC. On average, seniors could identify four services on the list, while caregivers could only pick out 3.3 services. This underlines the necessity of better global access to information about home care services for seniors, both in French and in English.

The survey further found evidence to suggest that when awareness of care services is low, seniors are less likely to access the services available to them. More than four in ten English-speaking seniors (43%) say they don't plan to request home care services in the next five years. Within this group, some say they won't ask because they don't know what services are available nearby (12%), or they think there aren't any services available in English (11%).

Poor Perceptions of Senior Care Services

While most English-speaking seniors (85%) and caregivers (91%) have at least a reasonable idea of what care services and supports are available for seniors in their community, **very few rate their home care services as being easily available or of good quality**. When it comes to care services offered in English, perceptions are even worse.

Positive Perceptions of Home Care Services in the Community (Excellent/Very Good) Base: Total Sample (N=923)		
	Seniors	**Caregivers**
Availability overall	19%	26%
Availability of services in English	18%	24%
Quality overall	23%	34%
Quality of services in English	20%	27%

These perceptions improve somewhat among those who are already accessing home care services through a CLSC. Nonetheless, **only half of English-speaking seniors (and less than half of caregivers) receiving home care services rate them highly on availability or quality**.

Positive Perceptions of Home Care Services in the Community (Excellent/Very Good) Base: Currently accessing home care services through CLSC (N=171)		
	Seniors	**Caregivers**
Availability overall	45%	34%
Availability of services in English	50%	37%
Quality overall	50%	45%
Quality of services in English	52%	40%

The perception that senior care services are rarely available in English can lead to some **seniors and caregivers putting off requesting care services for longer than they should** – potentially only starting the process once the need becomes acute. Among the 43% of English-speaking seniors and 14% of caregivers who say they are not likely to request senior care services in the next five years, 11% of seniors and 17% of caregivers say their reason for not doing so is because "there are no available services in English nearby."

Delays and Language Barriers Mar Experience of CLSC Home Care Services

While perceptions of home care services for seniors in the community broadly negative, those currently receiving these services through a local CLSC tend express at least some satisfaction with the care they receive. Asked to think about their own experience in receiving care services through the CLSC, 76% of seniors receiving these services indicate they are at least somewhat satisfied (45% very/31% somewhat). Caregivers are more likely to express satisfaction with these services overall (86% are satisfied with the CLSC home care services received by the senior they provide care for), but more likely to be only “somewhat” satisfied (58%).

Given the broader context of overstretched senior care resources across Quebec, satisfaction may simply be a proxy for thankfulness to be receiving any care at all. Indeed, when probed further, seniors and caregivers reveal **several areas in which language can be a barrier to receiving a satisfactory level of care**.

While most (about six in ten) of those who have requested home care services through their local CLSC found the process easy, an important number of seniors (24%) and caregivers (39%) found the process difficult – suggesting a need for broader access to English services.

Delays are a fact of life for all Quebec seniors trying to access care services at home through their local CLSC. Indeed, one representative from a Montreal-area CIUSSS users’ committee told the Access to Justice project, “In our territory, there aren’t any seniors who receive services in line with their needs. Twenty per cent of them needs to wait more than three months [to receive care].” In the population survey, caregivers are more likely to report longer wait times after first making the request. Three in ten seniors (29%) and one in three caregivers (33%) report having to wait a month or more before gaining access to any care services, while roughly one in ten had to wait more than three months.

These delays can often be language-based. When communicating with the CLSC or another public health care service on behalf of an English-speaking senior, three in ten caregivers (32%) have experienced a delay or a complication to the senior’s services because of a language barrier.

A majority of survey respondents say it is not always possible to receive care services in their language of choice. An important majority of seniors receiving home care services through their local CLSC – seven in ten (69%) – report having received care services in French when they would

have preferred those services to be in English. Further, about a quarter of seniors (24%) and caregivers (27%) saying this happens frequently. This raises questions as to continuity of care and the facility with which seniors and caregivers are able to accurately able to relay health care needs to visiting care providers.

Caregiver Experience

Caregivers remain reluctant to access services and supports available to them, despite most claiming to know what services exist. While language does not appear to be a barrier for most caregivers who do access support services for themselves, a majority say they struggle to navigate the health care system in French, and many encountering language-based delays.

Only half (56%) of English-speaking caregivers feel comfortable navigating the health care system in French on behalf of the senior they're caring for. While this rises to 66% among caregivers to a senior already receiving home care services through a CLSC, it leaves many caregivers who are uncomfortable navigating the system in French despite the fact that the senior they care for must rely on them for organizing their health care needs and translating where necessary.

Three in ten caregivers (32%) say that a language barrier has caused them to experience a delay or a complication to obtaining services for the senior they care for.

Most caregivers (82%) claim to be aware of the services and supports available to them as a caregiver to a senior. However, only 21% have actually accessed them – rising to 40% among those caring for a senior receiving home care services through a CLSC. Overall, 85% of caregivers who have accessed a form of support say they were able to do so in English, leaving 15% who were unable to do so.

Qualitative Insights: Barriers to accessing SAPA care services in English

Findings from the survey data serve to supplement and strengthen insights from qualitative research conducted for this report. The conclusions drawn in this section have been surmised in part from qualitative evidence gathered through a series of structured in-depth interviews conducted by the Quebec Community Groups Network with community and health care stakeholders. Among some of the routine questions asked were the following:

1. What have been the major problems for English-speaking seniors in your region trying to access at-home care services through their local CLSCs?
2. What have been the major problems for English-speaking seniors in your region trying to access placement services in CHSLDs or RIs?
3. Have you heard of instances of English-speaking seniors who have avoiding seeking health care services due to a fear or difficulty in trying to access these services in English?
4. What is the situation regarding the availability of bilingual personnel (such as doctors, nurses, orderlies, social workers, caseworkers, or administrative staff) available to English-speaking seniors in your region?
5. How simple or difficult is it for English-speaking seniors in Quebec to request and receive a government-subsidized interpreter in health care institutions?

6. How often do you receive or hear of complaints filed behalf of English-speaking seniors with regards to a lack of sufficient services in English?
7. What would you consider to be the top health care priorities for English-speaking seniors with declining autonomy?

Between August and November 2022, 11 community organizations, four users' committees, and one private care provider from across the province were interviewed. Interviews were conducted in English or French, depending on the preference of the participant(s). The geographical span of the interviews included many of the nine RTSs with higher proportions of English-speaking seniors within the local English-speaking community. Among the RTSs represented in these interviews are those of the Greater Montreal Area, the Montérégie-Centre (the South Shore), Estrie (Eastern Townships), Laurentides (Laurentians), the Outaouais, the Gaspé Peninsula, and the Côte-Nord (Lower North Shore).

Effective communication between English-speaking seniors, their caregivers, and health care providers is vital to ensure the well-being of the seniors in question. However, as outlined below, there are several challenges facing English-speaking seniors in being able to effectively communicate about their care needs in English that can diminish their experience of Quebec's health care system on an additional level to the existing challenges of access and navigability that already face all seniors in Quebec, regardless of language.[234] These additional hurdles can also compromise the health of seniors by putting them at unnecessary risk of misunderstandings, misdiagnoses and erroneous treatments that could negatively impact their health.

Based on the structured interviews of these 16 organizations and users' committees, four distinct barriers were identified that exist across nearly all regions of Quebec. These testimonies paint a vivid picture of the unique or exacerbated hardships that English-speaking seniors must endure to try, and oftentimes fail, to obtain adequate SAPA care services in English.

Barrier 1: Lack of Health Care Information in English

One of the most universally declared obstacles for English-speaking seniors and their caregivers is an overwhelming absence of information about where, when, and how to access SAPA services in English, ,be it at-home or placement care.[235] Several community organizations conveyed the challenges for English-speaking seniors, especially those without an immediate caregiver, with limited textual or digital literacy. For instance, community representatives from the Côte-Nord region—which comprises several geographically isolated towns inhabited predominantly by English-speaking seniors, many of whom are Indigenous—explained how many seniors do not possess the reading and technical skills necessary to inform themselves of health care services, let alone those available in English.

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[234] See Duncan Sanderson, "Language Related Difficulties Experienced by Caregivers of English-Speaking Seniors in Quebec" (2020) 10:3 SAGE Open 1, online (pdf): *Sage Journals* <journals.sagepub.com/doi/pdf/10.1177/2158244020951261>.

[235] See RecreoTherapy, Understanding the Experience of English-Speaking Seniors in Quebec: Accessing and Interacting with Health and Social Services and the Effect of Health Outcomes (Montreal: One Voice Coalition, 2021), s 3.4, online (pdf): CHSSN <1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/07/One-Voice-Report-July-30.pdf> [Understanding the Experience of English-Speaking Seniors in Quebec].

While much of this information exists, it is increasingly available only online, buried deep in the interfaces of CI(U)SSS websites. Seniors without an understanding of how to navigate the internet are forced to rely on immediate family or community volunteers to help them understand what services they may need.

Forms and documents essential to the SAPA application process are often difficult to access, and more so in English. In the Laurentians, local organizations reported that while literacy rates and Internet skills are generally higher for seniors in their region compared to the general population of Quebecers over the age of 65, accessing the information in English can often prove overly difficult.

Written information on the variety of health care information on SAPA services is hard to find in French and is even less available in English. Several pamphlets, brochures, booklets are sometimes only available online in French. Printed copies of these documents may sometimes be available in CLSCs, private clinics, hospitals, or other senior care organizations, but they are not readily or widely distributed to either French- or English-speaking seniors.

What is more, many documents and forms that need to be filled in by an English-speaking senior or their caregiver may only be available in French. This could prove strenuous for seniors (or their caregivers) who do not have the French-language skills required to understand the information required in the forms, or the procedure of how and to whom the form(s) must be filled out.[236] This lack of documentation available in English creates extra hurdles that could lead to complications and delays for English-speaking seniors trying to access SAPA services. A lack of documents in English explaining how to access SAPA services perpetuates the lack of knowledge of the services available to seniors if they or their caregivers cannot understand information solely provided in French. It is hence a core problem in several RTSs across the province.

In efforts to help remedy the situation, several community organizations collaborate with the regional CI(U)SSS to translate relevant documents into English, with the resulting English versions then uploaded onto the CI(U)SSS website.

While this solution is both welcome and helpful, it does not completely solve some of the underlying issues creating an unavailability of health care information in English in the first place. For one, it relies upon the goodwill of non-governmental organizations to take it upon themselves to translate these documents for their regional CI(U)SSS. Some of these organizations may not possess the resources to translate these documents, which could project to availability of these documents solely in French. Certain informal channels exist to request these documents be translated directly through the regional CI(U)SSS, but the resultant translation delays could deter English-speaking seniors from contacting their regional health care authority.

The Quebec government annually publishes a booklet titled *Programs and Services for Seniors*, which outlines the general procedure, in English, for requesting at-home care services or long-

[236] See Sanderson, *supra* note 233 at 8.

term placement through the senior's local CLSC[237] . The booklet is written in plain language and is clearly designed for a general public audience. However, when asked whether they or the English-speaking seniors they serve were aware of the booklet's existence, most community organizations had not seen it before, and many agreed that it is not readily available to anyone without Internet access. Moreover, while the booklet provides a helpful starting point for accessing SAPA services, it does not provide a written outline for accessing these services from beginning to end, and what ESSs or their caregivers may expect (and for which they may wish to prepare) throughout the process. Attempts by the Access to Justice Project to identify and speak to the Ministry responsible for producing the booklet were unsuccessful.

Barrier 2: Lack of Interpreters and English-speaking Health Care Personnel

MSSS policy provides that translation services should be available in all of Quebec's health care institutions 24 hours a day, seven days a week, across all RTSs in the province.[238] The government is further responsible for ensuring health care users are made aware of translation services. However, the language of the policy itself severely restricts this recommendation. The need for translation services must be assessed on a case-by-case basis, taking into account the resources of each particular health care institution.[239]

The loose language and conditions of this policy have ensured that government-subsidized interpreters in health care institutions are no more than an unrealized theory across Quebec. Every community organization and users' committee interviewed for this report admitted that for the health care facilities in their region, no translators were available to translate French-language communications for English-speaking patients. Instead of formal translation staff, much of the translation efforts for English-speaking patients depend entirely on the highly variable English-language skills of health care professionals (such as doctors, nurses, orderlies, social workers, case workers, or administrative staff) or the caregiver of the ESS in question.

Further, there is evidence that regional CISSS and CIUSSS administrators are reading the policy to mean that interpretation services should only be made available to patients who do not speak French or English, effectively excluding English-speaking Quebecers from the opportunity to receive the services of an interpreter if needed. One CIUSSS users' committee confirmed as much to the project in an interview. While not a facility for providing services to seniors, the Montreal Children's Hospital website also makes it clear that interpretation services are for those who do not speak French or English.[240] However, the MSSS policy on interpreters specifically mentions English-speaking Quebecers, recognizes that they are a group to whom language barriers are more likely to apply, and reiterates Article 15 of the AHSSS.[241]

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[237] See *Programs and Services for Seniors*, *supra* note 160 at 8, 12 (page 8 contains general information on how to request at-home care services, while page 12 has information on the procedure to applying for placement in long-term care like in a CHSLD).

[238] See Orientations de l'interprétariat, supra note 83 at 11.

[239] See *ibid* at 11-12.

[240] See "Service d'interprétation" (last accessed 13 February 2023), Montreal Children's Hospital <https://www.hopitalpourenfants.com/patients-et-familles/services-hospitaliers/service-dinterpretation>.

[241] See Quebec, La direction des communications du ministère de la Santé et des Services sociaux, Orientations ministérielles concernant la pratique de l'interprétariat dans les services de santé et les services sociaux au Québec (Québec: Ministry of Health and Social Services, 2018) at 7, online (pdf): MSSS <publications.msss.gouv.qc.ca/msss/fichiers/2018/18-406-03W.pdf>.

In 2016, the CHSSN published a report on the state of interpretation services in English to help Quebec's English-speaking community have better access to health and social services in their language. The report found that formal interpretation services were rarely used for health and social services in English, and that "use of formal interpreters is mostly limited to contested cases."[242] Further, the report found that among the four banks of interpreters in Quebec had only a very small proportion of interpreters able to work in English, and that all reported a very low number of requests for English interpretation services.[243] With few English-speaking seniors and caregivers aware of their right to such services, demand remains low, which ultimately provides justification for not investing in more interpretation resources. Based on research conducted by the Access to Justice project, it would appear that access to these services has not progressed in the past six years.

Representatives of several community organizations interviewed for the present report also explained how for English-speaking seniors without a caregiver (or without a caregiver with adequate French-language skills), it can be difficult to find a health care worker on shift in a given institution with the necessary English-language skills to adequately understand the accent, phrasings and tone of the seniors. This is a problem especially in CI(U)SSSs other than those of Montreal's West End and West Island regions.

In addition to language, a lack of cultural competency can be a particular issue for English-speaking racialized and immigrant communities. For instance, one community organization reported that seniors within Montreal's English-speaking Black community who have accessed at-home care services through a CLSC often end up requesting that care providers stop visiting them, after efforts to communicate fall through. This may be due to difficulties in understanding a senior's dialect or simply not treating them with cultural sensitivity during interventions such as help with bathing or administering medication. Separately, a CIUSSS Users' Committee spoke to the project about a lack of trust in the public health care system among African and Caribbean communities, and the challenges this can present when attempting to build relationships with caregivers – particularly in a high-turnover environment.

A distinct but related potential barrier appaears to be emerging in the wake of the heightened political climate around Bill 96 (*An Act respecting French, the official and common language of Québec*). Several community stakeholders interviewed conveyed instances of health care professionals unwilling to attempt to speak in English to patients or caregivers, specifically citing the rights provided in the *Charter of the French Language* further strengthened by the recent passing of Bill 96.

As most organizations and users' committees emphasized in their interviews, an inability to understand medical instructions in their first language can cause several stresses and problems for

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[242] See "Les services d'interprétariat en langue anglaise pour améliorer l'accès des personnes issues des communautés d'expression anglaise du Québec aux services de santé et aux services sociaux dans leur langue » (CHSSN : Mylène Kossein, 2016) at 7, online (pdf) <https://chssn.wpenginepowered.com/wp-content/uploads/2021/08/Rapport_Interpretation_mars_2016_FRA_FNL.pdf>.
[243] See *ibid* at 18.

seniors and their caregivers if neither can successfully act as their own interpreter. It can create unnecessary problems for seniors or their caregivers in a variety of scenarios.[244]

Firstly, if an English-speaking senior or their caregiver calls a local CLSC to request at-home assistance for a senior with declining autonomy, the full scale of the senior's health profile may not be able to be properly ascertained if the CLSC cannot provide a caseworker on-duty who is able to communicate in English.

Secondly, an English-speaking senior who may need to be placed into a CHSLD immediately after hospitalization will need this transition explained to them, which can be difficult and overwhelming if not properly communicated in a language they can understand.

Thirdly, information as simple as appointment times, locations or directions within a health care facility, can be misunderstood by an English-speaking senior or their caregiver if the administrative personnel with whom they interact can or will only speak to them in French.

Fourthly, with respect to at-home care services, there is a high turnover of nurses and other personnel who help seniors in their homes. Aside from the inability of many seniors to therefore build a rapport or relationship of trust and respect with a single, continuous at-home health care worker, the turnover means that English-speaking may have a home care provider who can speak English one week, and then not the next. This lack of continuity means that English-speaking seniors and their caregivers are either beholden to the goodwill of bilingual health care professionals, or at worst, left to their own devices.

Barrier 3: Reluctance of English-speaking Seniors to Seek Out Health Care Services

In certain CI(U)SSS territories where there is a sizeable English-speaking community but no bilingual institutions, the availability of SAPA services in English are wholly contingent on the local will to enforce and uphold each regional institution's Access Program. According to many of the community organizations based in these territories, this can create an uneven level of service for English-speaking seniors and their caregivers based simply on where they live.

Some of these organizations relayed examples of English-speaking and their families that have been forced to contemplate moving to different regions where there are more English-speakers and SAPA services are more readily available in English. This is not always feasible in practice: many English-speaking seniors live close to the poverty line, and many of their families cannot afford to relocate to an area of the province that may better service their elderly family members.[245] This is

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[244] See Understanding the Experience of English-Speaking Seniors in Quebec, supra note 234, s 3.4.

[245] See Poverty and Social Exclusion in Quebec: Quebec's English-speaking Communities – A Brief submitted by the Community Health and Social Services Network (CHSSN) in contribution to the development of the third Action Plan to combat poverty and social exclusion by the Government of Quebec (Montreal: Community Health and Social Services Network, 2016) at 4, online (pdf): CHSSN <chssn.wpenginepowered.com/wp-content/uploads/2021/08/Poverty-and-Social-Exclusion-Brief.pdf>. See also Claire Loewen, "Quebec Allophones, Anglophones more likely than Francophones to Live Below Poverty Line, Study Finds", CBC Montreal (2 January 2018), online: <https://www.cbc.ca/news/canada/montreal/quebec-allophones-anglophones-more-likely-than-

one reason why English-speaking seniors with declining autonomy often remain reluctant to seek out assistance. According to several community stakeholders, this reluctance can stem from pride and the desire to maintain a vision of self-reliance, as well as a reluctance to attempt to navigate the convoluted channels necessary to obtain SAPA services that will likely be limited in scope.

These qualitative findings are further reflected by data from the population survey: more than four in ten (43%) English-speaking seniors aged 60 and over say they are unlikely to request care services in their home – a view shared by 14% of caregivers to a senior. Asked why they won't request these services, most seniors (76%) say they won't need them, while others point to the fact that they already get help from friends or family (27%).

Yet even in cases where English-speaking seniors have family members who are willing to pay for the senior to move to another region to obtain better services there, many refuse out of fear of being isolated from their loved ones. This has resulted in instances where seniors in need of at-home care have prolonged requesting these services for far too long. With caregivers unable to devote themselves full-time to the care of the senior, the risk is that seniors will eventually suffer a serious injury that could have been avoided. When this happens, these seniors are hospitalized and oftentimes forced in the next available spot in long-term care, oftentimes in facilities with limited or no English-language personnel or services, simply through lack of available resources.

For many of the stakeholders interviewed, this climate of worry plays out as a self-fulfilling prophecy, in which English-speaking seniors are forced into facilities where they do not speak the language, as an indirect result of their resistance to access services for fear of not attaining them in English.

Barrier 4: Hesitation over Filing Complaints or Raising Awareness of Lack of Services in English

Many community stakeholders across Quebec pointed to a fear among English-speaking seniors or their caregivers to file complaints related to care services received under the SAPA program.

This reluctance inadvertently exacerbates a lack of basic data surrounding the program, and particularly language-based data. One of the major obstacles in conducting research into the lived experience of English-speaking seniors and their caregivers accessing Quebec's senior care system is the minimal levels of government-collected quantitative data to corroborate qualitative findings.[246]

Declaring formal grievances would enable the Commissioner of Complaints or the Ombudsman's office to collect data on instances where English-speaking seniors have experienced inequitable

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francophones-to-live-below-poverty-line-study-finds-1.4470365#:~:text=It%20found%20that%20across%20all%20regions%20of%20Quebec%2C,line%20than%20anglophones%20in%20the%20same%20age%20group. >; citing Jack Jedwab, "Low Income in Quebec, No Matter How you Slice it, Anglophones Far Worse than Francophones" (Association of Canadian Studies, PowerPoint, December 2017).

[246] See Clarke & Martin, *supra* note 13 at 4-5.

health care services on the basis of language, be it from lack of bilingual personnel, a lack of information, or hostility or discrimination based on the senior's first spoken language.[247]

Even within but especially beyond the CIUSSSs of Montreal's West End and West Island, many community organizations and users' committees agreed that there is a genuine fear amongst English-speaking seniors and their caregivers to "rock the boat" or "make waves". This is arguably driven by the overstretched nature of senior care services in general.

There is consensus amongstakeholders interviewed that SAPA services are stretched very thin among the regional populations overall, irrespective of language. Examples include:

- For seniors needing at-home care, nurses are only able to visit at most a few days a week, leaving caregivers to perform the large remainder of duties for the senior they care for.
- Waitlists for placement in long-term care facilities average two years for seniors with declining autonomy who may need permanent, full-time care, leaving the extra burden to fall on caregivers who may not be equipped (materially, financially, or physically) to take on these extra responsibilities.
- In some regions, such as the Côte-Nord, there is both a small pool and a high turnover of medical and nursing staff, which results in towns sometimes having no locally based doctor or nurses for extended periods of time.

A decentralized provincial health care system where resources are allocated to and managed by the respective CI(U)SSSs, combined with an ageing population[248], means that many CI(U)SSSs lack the financial resources needed to guarantee a continuous, satisfactory stream of SAPA services being delivered to seniors. The priority for these health care institutions, according to many of the stakeholders interviewed, is to best provide the service itself. As an unfortunate and possibly inadvertent consequence, linguistic considerations and cultural sensitivity often fall by the wayside.

Even in situations where services in English should have been provided based on the regional or institutional Access Program, many English-speaking seniors and caregivers are hesitant to demand service in English, or to complain if they do not receive it. As many users' committees and community organizations interviewed affirmed, most seniors and caregivers are "simply grateful" to be receiving services at all in Quebec's underfunded and understaffed health care network.

The concern for many English-speaking seniors and their caregivers is drawing attention to their inability to receive services in English may result in negative consequences. Stakeholder interviews yielded several examples based on communications with senior clientele. For instance, seniors worrying that if they demand an English-speaking nurse for their at-home care, the senior may be subject to hostile behaviour by a health care professional that could harm the senior's health or dignity. Alternatively, many caregivers with seniors in long-term care fear raising language-related

[247] See Commissaire aux plaintes, supra note 52 at 15; and Lignes directives relatives au comité de vigilance, supra note 55 at 4-5.
[248] See Institut de la statistique du Québec, supra.

concerns to the administrative staff or health care personnel of the facility out of fear that their senior may be mistreated by workers there, or may be refused care services in future. Whether or not these worries are justified by data, the fear is real amongst English-speaking seniors and their caregivers, who can sometimes feel reluctant to insist on services in English where they may very well be entitled to them.

Bilingual institution designations and demographics by language

Of Quebec's 22 CI(U)SSS jurisdictions, only two (CIUSSS Centre-Ouest-de-l'Île-de-Montréal and CIUSSS Ouest-de-l'Île-de-Montréal) house health care institutions designated bilingual by the provincial government to offer all their services in both French and English. While this means that English-speaking seniors attempting to access SAPA care services through other CI(U)SS jurisdictions may have a harder time doing so in English, a lack of resources across all health care jurisdictions in Quebec means that accessing these services can be challenging everywhere, regardless of language.

The Quebec government may designate an institution as bilingual if the majority of the population it serves speaks English, in accordance with subsection 29.1(3) of the *Charter of the French Language* (see page 11 for more information).[249] This "majority"-based criterion, however, fails to account for or respond to the differing rates of aging amongst English- and French-speaking seniors.

For instance, based on demographic research conducted by Dr. Joanne Pocock, in nine of Quebec's 22 RTSs (*réseaux territoriaux de services*, or Regional Services Networks) as of 2016, the proportion of English-speaking seniors within the total English-speaking population is greater than the proportion of French-speaking seniors within the total French-speaking population in the same region (see Annex for the original tables and the raw demographic numbers in each RTS from the Pocock Provincial Profile).[250]

Of these nine RTSs, only one (Centre-Ouest-de-l'Île-de-Montréal) has bilingual health care institutions recognized by the Quebec government.

Proportion of English- and French-speaking Seniors Living at Home by RTS, 2016 (RTS with higher proportion of English-speaking seniors indicated in bold)		
RTS – CI(U)SSS	Proportion of English-speakers aged 65 or over (%)	Proportion of French-speakers aged 65 or over (%)
Bas-Saint-Laurent	24.5	21.4
Saguenay–Lac-Saint-Jean	18.7	19.2

[249] See *CFL*, *supra* note 2, s 29.1. For a complete list of all healthcare institutions designated as bilingual by the Quebec government, see also *Order in Council respecting institutions designated under section 508 of the Act respecting health services and social services*, CQLR c S-4.2, r 9.

[250] See Joanne Pocock, *Socio-Demographic Profile of the Population Aged 65 and Over: Province of Quebec (Based on the 2016 Census of Canada)* (Montreal: Community Health and Social Services Network, 2021) at 6-7, online (pdf): *CHSSN* <https://chssn.wpenginepowered.com/wp-content/uploads/2021/08/Seniors-Profile-Quebec.pdf> .

Capitale-Nationale	15.2	18.4
Mauricie-et-du-Centre-du-Québec	19.8	20.0
Estrie – CHU de Sherbrooke	23.0	18.8
Ouest-de-l'Île-de-Montréal*	15.7	16.9
Centre-Ouest-de-l'Île-de-Montréal*	16.9	13.9
Centre-Sud-de-l'Île-de-Montréal	9.0	12.2
Nord-de-l'Île-de-Montréal	14.0	13.9
Est-de-l'Île-de-Montréal	11.5	16.1
Outaouais	13.4	14.4
Abitibi-Témiscamingue	13.4	16.2
Côte-Nord	17.1	16.5
Gaspésie	26.9	23.7
Îles-de-la-Madeleine	25.2	22.9
Chaudière-Appalaches	16.9	18.3
Laval	10.8	15.7
Lanaudière	14.4	15.9
Laurentides	19.1	16.1
Montérégie-Centre	16.7	16.2
Montérégie-Est	15.8	17.2
Montérégie-Ouest	13.4	15.2

NOTE: The asterisk (*) denotes CI(U)SSSs designated to offer all health care services in French and English.

It should be noted that seniors make up a larger proportion of the French-speaking population than do seniors within the local English-speaking population in the CIUSSS territory of Montreal's West Island (Ouest-de-l'Île-de-Montréal) – one of the two CIUSSSs designated to provide all services in both English and French. However, this CIUSSS territory holds bilingual institutions that can service them entirely in French, while the same cannot be guaranteed in the CI(U)SSS territories where English-speaking seniors proportionally outweigh French-speaking seniors.

While demographic data by RTA or CI(U)SSS region from the 2021 census is not yet available, and while data in the table above accounts only for seniors living at home (excluding those placed in long-term care facilities), the fact remains that Quebec populations population is ageing, and is expected to continue to do so. According to population projections by the Institut de la statistique du Québec, seniors aged 65 and over could go from 20% of the population in 2020 to 27% by 2066.[251] This suggests that English-speaking seniors – like their French-speaking neighbours – will increasingly expect health care services through the SAPA program in the years to follow.[252]

[251] See "Towards a population of 10 million people in Québec by 2066" (last accessed 12 February 2023), online: Institut de la statistique du Québec <https://statistique.quebec.ca/en/communique/towards-a-population-of-10-million-people-in-quebec-by-2066>.

[252] See Joanne Pocock, *Access to English-language Health and Social Services in Quebec: Provincial Profile (Baseline Data report 2019-2020)* (Montreal: Community Health and Social Services Network, 2021), online (pdf): *CHSSN* <https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/CHSSN-CROP-Times-Series-Provincial-Profile.pdf> [Pocock, *Provincial Profile*].

As it stands, however, SAPA services offered in English in regions across the province are lacking in several respects.[253] Many seniors and their caregivers face unique obstacles in accessing SAPA services in English not otherwise experience by the French-speaking community seeking SAPA services in their language. Between 2005 and 2019, the proportion of English-speaking seniors able to be served in English at their local CLSC dropped from 81.7 to 70.3 per cent.[254] Moreover, within the same 14-year period, the proportion of English-speaking seniors able to be served in English during an overnight stay in hospital declined from an already low 25.5 to 20.4 per cent.[255]

Key Insights

While most seniors and caregivers claim to know what services are available to them locally, very few can prove their knowledge of specifics.

- Seniors and caregivers can only identify a handful of home care services available through their local CLSC.
- Fewer than 10% have seen or read the government booklet published annually the details the programs and services available to seniors in Quebec, suggesting information is not being adequately disseminated to Quebec's English-speaking seniors and their families.
- Of the 43% of seniors who are unlikely to request these services in the next five years, one in ten (12%) say it's because they don't know what services are available nearby.

Despite section 15 of the *AHSSS* establishing the right for English-speaking persons in Quebec to access public health care services in English, there are numerous instances of this right not being accessible for English-speaking seniors and their caregivers.

- A majority (69%) of seniors receiving home care services through their local CLSC report having received care services in French when they would have preferred those services to be in English – a frequent occurrence for one in four.
- With only half (56%) of English-speaking caregivers saying they can comfortably navigate the Quebec health care system in French, it is unsurprising that one in three who care for a senior receiving care services through the CLSC have experienced a delay or complication to the senior's services because of a language barrier.
- These barriers exist against a backdrop of a health care system that is complex to navigate in any language. Many seniors (24%) and caregivers (39%) who have requested home care services through their local CLSC found the process difficult – underscoring the need for broader access to English services and information.

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[253] Some improvements have been made in regions across the province, yet wide discrepancies of services still ensure that many ESSs cannot get the services they need in English. See Joanne Pocock, *The Community Liaison Model: Improving Access to Health and Social Services for Quebec's English-speaking Communities* (Montreal: Community Health and Social Services Network, 2022) at 12-19, online (pdf): *CHSSN* <1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2022/04/2022-03-25-CHSSN-Liaison-Report-EN.pdf>.

[254] See Pocock*, Provincial Profile*, *supra* note 229 at 26-27.

[255] See *ibid* at 42-43.

English-speaking Quebec seniors and their caregivers tend to view home care services for seniors unfavourably in terms of availability and quality, particularly when it comes to receiving these services in English.

- These perceptions are contributing to some seniors' decision to avoid or postpone requesting CLSC care services: one in ten (11%) seniors who are unlikely to request these services in the next five years say it's because "there are no available services in English nearby."

Conclusion

Health care services for seniors in Quebec are experiencing a period of unprecedented demand due to a confluence of factors, from an ageing population to the unique challenges of the COVID-19 pandemic. Demand is felt even more acutely in the more remote regions of Quebec, where resources are so limited that there may be only one doctor or nurse available to provide services for seniors across a vast geographical terrain.

Under these circumstances, third-party providers have become increasingly relied upon to share the burden of service provision. From the perspective of seniors receiving care services in their home or in an institutional setting, this often translates to a lack of continuity in terms of who provides them with care. For the most vulnerable seniors in particular, the prospect of a revolving door of care providers tasked with helping them bathe, eat and receive their required treatments can be a daunting experience, both for their sense of dignity and personal safety. These are concerns that apply to all Quebec seniors, regardless of language, gender, culture or creed.

This report argues that when seniors's first language is something other than French, access to these services can become even more challenging.

We have focused on English-speaking seniors because the English-speaking community has a right, enshrined in section 15 of the Act Respecting Health Services and Social Services, to receive health care services in English. That this right is framed within the "organizational structure" and "human, material and financial resources" of the health care institutions in which it is to be exercised, means that under the current period of systemic stress and high demand for health care services, English-speaking seniors less likely than ever to be able to exercise this right.

Ministerial health policy recognizes that language should be a consideration for the equitable delivery of services to users. However, with respect to the English-speaking community of Quebec, a recommendation has thus far not translated into substantive equity in access to health care services in English. The lack of a mechanism to monitor when and where these language barriers arise make it all the more difficult to assess where these problems exist and how to best correct them.

This report offers new data based on a representative survey of English-speaking seniors and caregivers, which indicate barriers to accessing senior care services in English through the SAPA program in four overarching areas: a lack of available and widely disseminated health care information in English, a lack of English-speaking health care personnel and interpreters, challenges related to the reluctance of English-speaking seniors to seek out the care services they need, and hesitation over filing complaints when care services in English are sub-standard or unavailable.

We argue that government measures to integrate non-Francophone seniors into Quebec's predominantly Francophone health care network should be sensitive to the unique challenges faced by English-speaking seniors, as well as immigrant populations. This is particularly important in cases where bilingual seniors are in cognitive decline: even though many of these seniors may

well have learned French well enough to communicate with health care workers at points in their life, research has shown that regressing to use of their first language (in this case, a language other than French) can often be an early sign of cognitive impairment or development of dementia.

While relationships between the CI(U)SSS network and community groups working on behalf of the English-speaking community may have weakened since the 2015 restructuring of the health care system, we remind the Ministry of Health of its own advice, as stated in the *Guide pour l'élaboration du programme d'accès aux services de santé et aux services sociaux en langue anglaise*, to encourage creative partnerships between the health network and community organizations belonging to the Networking and Partnership Initiative and volunteers, to ensure the provision of certain services in English.

Quebec Premier Lucien Bouchard once sought to reassure English-speaking Quebecers that their right to receive health care services in their language was not under threat, famously saying in 1996 that "when you go to the hospital and you're in pain, you may need a blood test, but you certainly don't need a language test." Nearly thirty years later, this axiom is no longer as watertight as it once was.

Annex

Population by Language and Age Group (Table - Percentages)

Age Groups as a Proportion of the Total Population, Among English and French Speakers Québec and its RTS Territories, 2016										
Geography	English Speakers					French Speakers				
	55 to 64 years	65 years and over	65 to 74 years	75 to 84 years	85 years and over	55 to 64 years	65 years and over	65 to 74 years	75 to 84 years	85 years and over
Québec	12.6%	14.5%	8.5%	4.4%	1.6%	15.3%	17.0%	10.8%	4.8%	1.3%
RTS du Bas-Saint-Laurent	16.2%	24.5%	19.0%	4.6%	-	18.9%	21.4%	13.9%	5.9%	1.6%
RTS du Saguenay – Lac-Saint-Jean	12.2%	18.7%	11.4%	6.1%	1.3%	18.0%	19.2%	12.2%	5.6%	1.4%
RTS de la Capitale-Nationale	12.7%	15.2%	8.8%	4.6%	1.8%	15.4%	18.4%	11.7%	5.3%	1.5%
RTS de la Mauricie-et-du-Centre-du-Québec	15.7%	19.8%	12.8%	5.6%	1.5%	17.2%	20.0%	12.9%	5.6%	1.6%
RTS de l'Estrie – CHU de Sherbrooke	15.6%	23.0%	13.2%	7.1%	2.6%	16.3%	18.8%	12.4%	5.1%	1.3%
RTS de l'Ouest-de-l'Île-de-Montréal	14.1%	15.7%	9.3%	4.8%	1.5%	14.9%	16.9%	10.1%	5.2%	1.5%
RTS du Centre-Ouest-de-l'Île-de-Montréal	11.1%	16.9%	9.0%	5.4%	2.5%	10.3%	13.9%	8.1%	4.2%	1.6%
RTS du Centre-Sud-de-l'Île-de-Montréal	9.2%	9.0%	5.7%	2.5%	0.9%	12.4%	12.2%	7.8%	3.4%	1.0%
RTS du Nord-de-l'Île-de-Montréal	11.8%	14.0%	7.6%	4.7%	1.7%	11.3%	13.9%	7.7%	4.4%	1.8%
RTS de l'Est-de-l'Île-de-Montréal	13.2%	11.5%	6.6%	3.6%	1.3%	13.1%	16.1%	9.1%	5.3%	1.7%
RTS de l'Outaouais	13.9%	13.4%	8.7%	3.7%	1.0%	15.2%	14.4%	9.6%	3.8%	1.0%
RTS de l'Abitibi-Témiscamingue	18.0%	13.4%	9.2%	2.8%	1.4%	16.7%	16.2%	10.5%	4.5%	1.1%
RTS de la Côte-Nord	13.8%	17.1%	10.5%	5.4%	1.2%	16.6%	16.5%	10.4%	4.9%	1.2%
RTS de la Gaspésie	17.1%	26.9%	15.5%	8.5%	3.0%	20.6%	23.7%	14.8%	7.0%	1.9%
RTS des Îles	20.1%	25.2%	15.1%	6.5%	3.6%	20.1%	22.9%	14.9%	6.7%	1.4%
RTS de Chaudière-Appalaches	15.4%	16.9%	11.6%	4.8%	-	16.2%	18.3%	12.0%	5.0%	1.3%
RTS de Laval	10.9%	10.8%	6.3%	3.5%	1.0%	14.4%	15.7%	9.3%	5.0%	1.4%
RTS de Lanaudière	15.2%	14.4%	9.7%	3.6%	1.1%	15.6%	15.9%	10.7%	4.3%	0.9%
RTS des Laurentides	15.2%	19.1%	11.8%	5.6%	1.7%	15.9%	16.1%	10.8%	4.3%	1.0%
RTS de la Montérégie-Centre	12.9%	16.7%	10.3%	4.8%	1.6%	14.7%	16.2%	10.6%	4.5%	1.1%
RTS de la Montérégie-Est	13.9%	15.8%	9.5%	4.7%	1.6%	15.4%	17.2%	11.2%	4.9%	1.1%
RTS de la Montérégie-Ouest	13.0%	13.4%	8.3%	4.0%	1.1%	14.7%	15.2%	10.0%	4.2%	1.0%

Source: JPocock Research Consulting, 2016 Census, Statistics Canada. Population in private households - 25% sample. The linguistic concept is First Official Language Spoken with multiple responses distributed equally.

Source: Pocock, Joanne, *Socio-Demographic Profile of the Population Aged 65 and Over: Province of Quebec (Based on the 2016 Census of Canada)* (Montreal: Community Health and Social Services Network, 2021) at 6-7, online (pdf): *CHSSN* <https://chssn.wpenginepowered.com/wp-content/uploads/2021/08/Seniors-Profile-Quebec.pdf>.