"BUILDING ON THE FOUNDATIONS – WORKING TOWARD BETTER HEALTH OUTCOMES AND IMPROVED VITALITY OF QUEBEC'S ENGLISH-SPEAKING COMMUNITIES"

REPORT TO THE FEDERAL MINISTER OF HEALTH

SUBMITTED BY THE CONSULTATIVE COMMITTEE FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

AUGUST 2007

REPORT TO THE FEDERAL
MINISTER OF HEALTH

Prepared by the Consultative Committee
For English-Speaking Minority Communities

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The Honourable Tony Clement
Minister of Health
House of Commons
Ottawa, Ontario K1A 0A6

Honourable Minister:

As Co-Chairs of the Consultative Committee for English-Speaking Minority Communities, we are pleased to submit the present report for your consideration.

The first report of the Consultative Committee was presented in July 2002 and provided an overview of the situation of the one million Anglophones in Quebec with respect to their demographic characteristics and their access to health and social services. It also provided recommendations to improve access to health services in English in Quebec, most of which were funded and implemented over the 2003-04 to 2007-08 period.

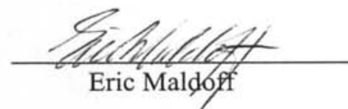
This second report takes stock of changes in English-speaking minority communities since the first report, outlines the evolution of the Quebec health and social services system, and summarizes the results of initiatives taken to improve access to health services in English across Quebec over the last five years. The report also assesses the current health needs and priorities of English-speaking minority communities and provides a series of recommendations to build on progress to date and achieve better health outcomes for Anglophone minorities in Quebec.

This report is the product of collaboration among community members and organizations as well as health professionals and institutions. The engagement of these diverse stakeholders demonstrates their ongoing commitment to improving both the health outcomes and the vitality of English-speaking minority communities in Quebec.

We would be pleased to meet with you to present our report and discuss future steps to support English-speaking minority communities in the health sector.

Yours sincerely,

Marcel Nouvet



Eric Maldoff

Co-Chairs

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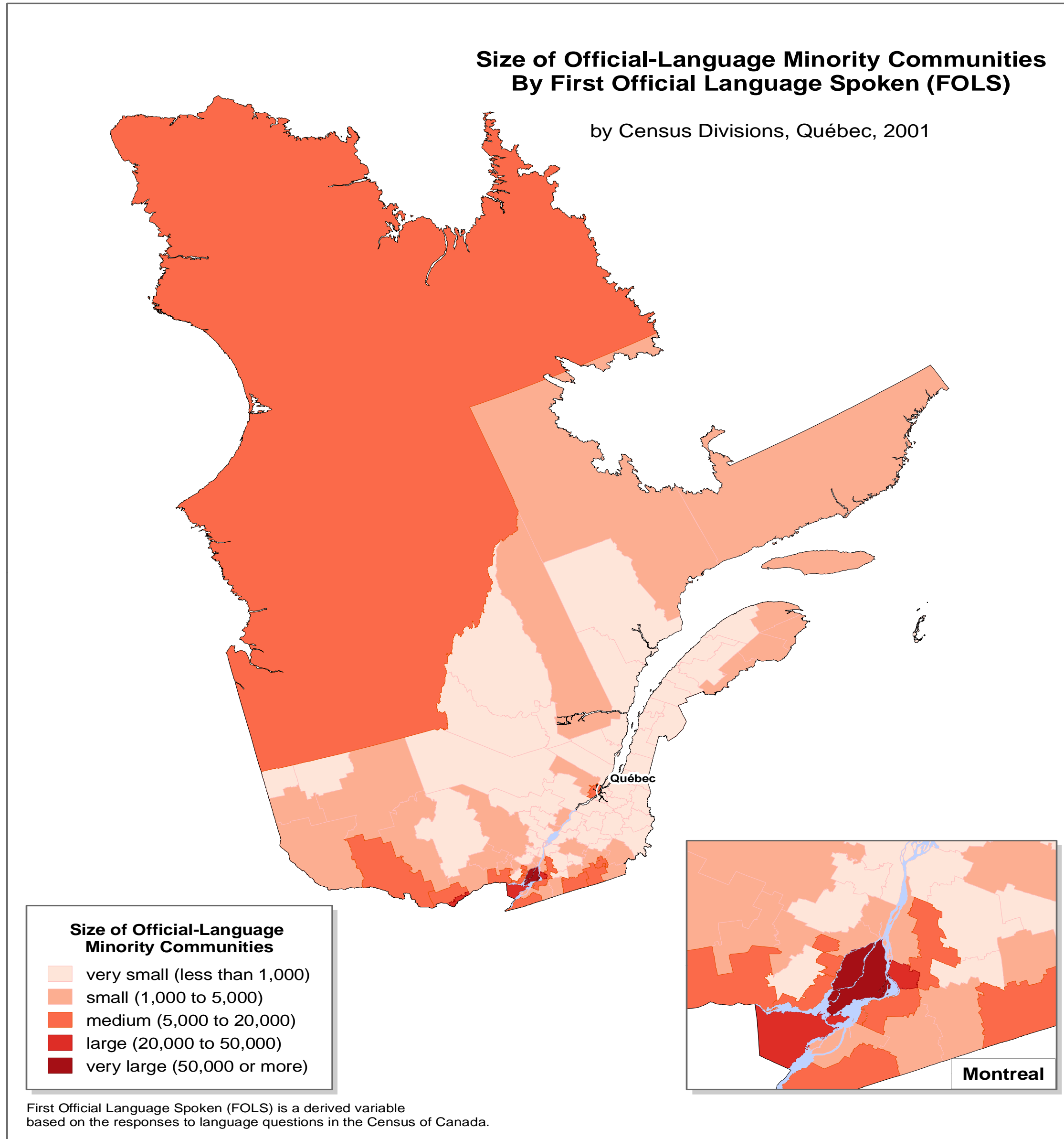
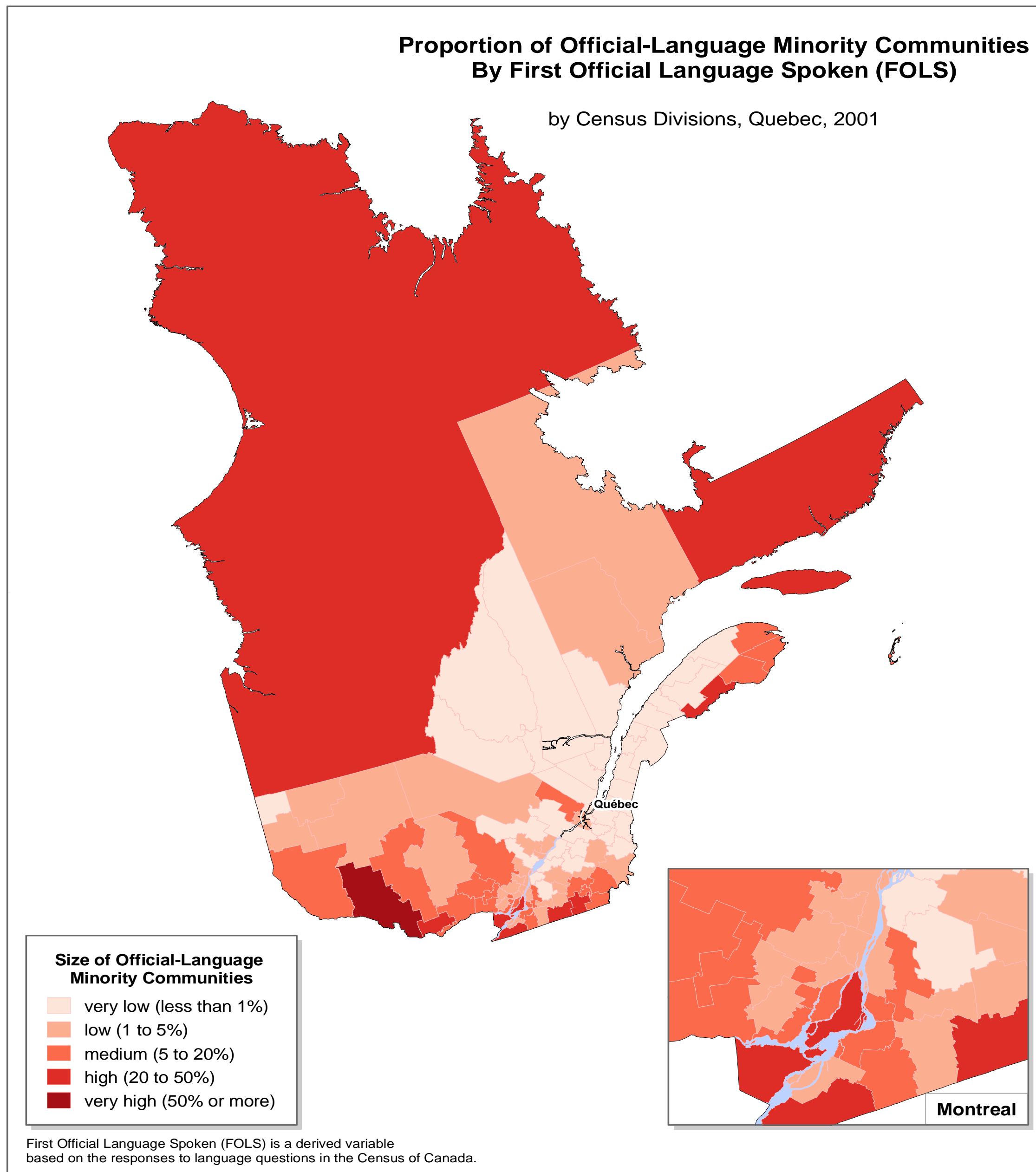
THE SIZE OF QUEBEC'S ENGLISH-SPEAKING COMMUNITIES[1]



Map produced by: Research Team, Official Languages Support Programs, Canadian Heritage, October 2006

[1] The large red region in the upper left-hand side includes the Cree and Inuit populations.

QUEBEC'S ENGLISH-SPEAKING COMMUNITIES AS A PROPORTION OF THE POPULATION OF ITS REGIONS[2]



Map produced by: Research Team, Official Languages Support Programs, Canadian Heritage, October 2006.

[2] The large red region in the upper left-hand side includes the Cree and Inuit populations.

QUEBEC'S ENGLISH-SPEAKING POPULATION BY ADMINISTRATIVE HEALTH REGION, 2001[3]

Quebec Administrative Health Region		English-speaking people (First Official Language spoken)
Region 01	Bas-Saint-Laurent	820
Region 02	Saguenay-Lac-Saint-Jean	1,765
Region 03	Québec	11,065
Region 04	Mauricie et Centre-du-Québec	4,885
Region 05	Estrie	23,390
Region 06	Montréal	563,940
Region 07	Outaouais	53,945
Region 08	Abitibi-Témiscamingue	5,315
Region 09	Côte-Nord	5,740
Region 10	Nord-du-Québec	310
Region 11	Gaspésie-Îles-de-la-Madeleine	9,740
Region 12	Chaudière-Appalaches	2,685
Region 13	Laval	53,385
Region 14	Lanaudière	8,215
Region 15	Laurentides	30,565
Region 16	Montérégie	129,125
Region 17[4]	Nunavik	5,225
Region 18[5]	Terres-Cries-de-la-Baie-James	8,850
TOTAL		918,965

[3] According to First Official Language spoken. J W COMM for the Community Health and Social Services Network, 2001 Census of Canada.
[4] Primarily Inuit population.
[5] Primarily Cree population.

SUMMARY

MEETING THE NEW PRIORITIES OF CANADA'S GOVERNMENT

The Report affirms the identity of Quebec's English-speaking communities in the context of Prime Minister Stephen Harper's declaration of the government's commitment to Official Language Minority Communities at Embrun, Ontario, in March 2007. The Report sets out a blueprint for new federal action reflecting the Minister of Health's key priority of improving the health of specific population groups.

Strategic points of entry are identified in Quebec's health and social services system through which new federal investments aiming to improve health outcomes of particular groups such as children, youth and seniors can contribute to key intervention programs serving local populations in new community-based services. The additional hurdles for a vulnerable English-speaking clientele are identified. The Report states that the Quebec community-based model is a framework for new federal action supporting areas such as mental health and substance addiction.

Timely access to specialized medical care for distant English-speaking minority communities is cited as a priority. New federal resources would help support Quebec's initiative to create 'corridors' of access to specialized medical services to ensure equitable access to treatment for the whole population, including English-speaking Quebecers.

The Report states that English-speaking Quebecers work as partners within Quebec's health and social services system to improve health outcomes and the vitality of their communities. The intent is not to create a parallel system, but to ensure services for English-speaking people are fully integrated into the new context of Quebec's health and social services network.

UPDATING THE 2002 STRATEGY

In July 2002, the Consultative Committee for English-Speaking Minority Communities (CCESMC) submitted its first Report to the federal Minister of Health. Five levers were identified, three of which were funded by the federal *Action Plan for Official Languages*: community-institutional networking, adaptation of service delivery models (primary health care), and training and human resources development. In 2006, the Committee approved a Strategic Planning Framework to identify long-term actions to advance the recommendations of the first Report and define the priorities for federal action in the period ahead. The present Report to the Minister updates the portrait of English-speaking minority communities and describes the new context of Quebec's health and social services system. The Report reviews the results of the federal Action Plan measures, noting implementation challenges, and reports on the results of other actions not included in the Plan. A blueprint for action is presented as a framework for proposing six levers grouping 20 recommendations of an Intervention Plan. The Plan addresses new challenges with respect to ensuring the health and well-being of English-speaking minority communities.

COMMUNITY CONTEXT

Demographic and health determinant characteristics

The Report reinforces the importance of health and social services in English, citing the role of language and culture in the range of factors affecting the health status of English-speaking minority communities. A summary of the impact of demographic trends as well identified barriers to access reinforce the view of service providers and community organizations that access for English-speaking people must be a high priority of the public system.

An evidence base is presented as a basis for identification of community needs and priorities for action. The portrait of the vitality of English-speaking minority communities describes the most recent information on demographic and health determinant characteristics. The portrait shows a general demographic decline of communities in most regions, with dramatic decline in certain areas. The phenomenon of aging communities and loss of adult-aged members traditionally providing social support is identified. The importance of income as a health determinant is underscored with a presentation of vulnerable groups living with low income. The portrait of low income is generalized across the regions and points to the relative disadvantage of many English-speaking minority communities when compared to the French-speaking majority. A link is also made between low educational attainment and geographic isolation.

English-speaking minority communities generally experience higher unemployment rates than the Francophone communities of their regions. The employment gap is dramatic in about half of the administrative regions. In the national context, English-speaking minority communities are second after New Brunswick with respect to high jobless rates relative to adjacent majority communities.

The Report identifies the vulnerability of English-speaking minority communities with respect to social environments and social support networks. The evidence points to a weaker sense of belonging to local communities, when compared to other groups. The belief that the future of English-speaking minority communities is threatened is prevalent, and indications of youth out-migration are identified. The phenomenon of significant recourse to family and friends in the case of illness is described; along with the dramatic rates of unpaid care of seniors in English-speaking minority communities, when compared to other groups.

A revealing national portrait of use of health services by official language minorities and majority groups is presented. The study reveals that English-speaking minority communities scored lower than all other groups with respect to having a regular doctor, use of hospital services and difficulty getting care from a specialist. The study also noted significant differences with regard to rating of quality and satisfaction with health care and community-based services.

The extent of access to the range of health and social services in English is described, noting regional disparities. The portrait defines for the first time the degree of access to services in the eastern sector of Montreal. The phenomenon of underrepresentation of English-speaking professionals in the Quebec health and social services system is identified.

Evolution of Quebec's health and social services system

The impact of system reforms on institutions serving English-speaking people is presented. Changes to the mandates of historical institutions serving the community are described, along with the reality of obtaining services in English from Francophone institutions in regions outside Montreal. The problems of access to English-language services in eastern Montreal are highlighted. While the challenge of community mobilization to address persistent gaps in access remains, new orientations of Quebec's system, along with the federal investments through the Action Plan, are developments creating conditions to improve access to the range of services.

The major features of the Quebec reforms are presented and include the creation of 95 local services networks, along with integrated university health networks to facilitate access to ultra-specialized medical services and coordinate teaching, research and training.[6] The new public health strategy is also cited as a feature of reform. The important role of clinical and organizational projects as a complementary feature of approved access programs for services in English is highlighted. The timing of reform of Quebec's health and social services system with the federal Action Plan investments presents an opportunity to develop long-term formal relationships between English-speaking minority communities and service providers. Continued cooperation between the two levels of government and recognition of English-speaking minority communities as full partners are other conditions identified in order to successfully address future challenges.

BUILDING FOUNDATIONS: RESULTS OF THE 2002 STRATEGY

Networking and cooperation

The Report describes the 11 formal networks bringing together English-speaking minority communities and service providers. The outcomes of network activity include production of a knowledge base for each network; more community participation in the health and social services system; identification of the needs and priorities of English-speaking minority communities; better coordination of various actors involved in adapting services; recruitment and coordination of volunteers, development of information and referral mechanisms; and stage-setting for longer term structural reorganization and development of new services.

Three challenges for ensuring ongoing viability of networks are noted. Sustainability of networks is dependent on the ongoing commitment of public partners and the ability of communities to secure their capacity to maintain the community coordination role. Community governance is at the heart of each network. It must function in a manner not to duplicate institutional governance structures or transfer the community agenda to public structures that risk marginalizing interests of English-speaking minority communities. Vulnerable communities pose a third challenge, as current networks cover only 21% of the English-speaking population. Some of these communities do not have the capacity to mobilize to participate in a networking initiative.

[6] An "integrated university health network" is known in Quebec as a "RUIS", or "réseau universitaire integré de santé".

Primary health care

Service providers and community organizations involved in 37 projects affirm that conditions of access to health and social services for English-speaking minority communities improved leading to an increased demand for services. Projects are strengthening the capacity of public institutions to serve English-speaking minority communities. There is an increase in personnel capable of providing services in English; services are better adapted to respond to need; and there is increased knowledge of community needs. English-speaking people are becoming more informed of services and there are strengthened ties between community organizations and service providers.

The challenges include the need for strategies to sustain the results of investments through the clinical and organizational projects; which are at the heart of the new populational approach to providing services. Given the complexity of service reorganization and structural change, a new strategy for investment needs to take into account the multi-year, multi-step reform of Quebec's health and social services system.

Training and human resources development

The Report describes the importance of the role of McGill University as the organization responsible for the measure, as it is the only English-language educational institution offering the complete range of professional degree programs in the health and social services fields. The university adds the important dimension of research to the different initiatives of training and human resources development working within Quebec's health and social services system. Five areas of project activity carried out in 2005-2006 are presented which include English second language training for over 1,400 Francophone professionals; the 22 pilot internship partnerships to retain professionals in the regions; the provision of public health programs by Telehealth to 11 isolated communities; the development of a distance professional support program; and the establishment of an inter-university research team.

The challenges include the integration of language training into the human resources development priorities of Quebec's health and social services system, as well as adaptation of internship practices to ensure public institutions continue to recruit English-speaking professionals. It is also important that these professionals have adequate French-language skills.

Youth out-migration and underemployment of English-speaking people in Quebec's health and social services system are cited as priorities for targeted action to bolster the capacity of English-language professional degree programs in the health and social services fields to recruit English-speaking youth at the high school and community college levels into their programs.

An organizational challenge for Telehealth serving English-speaking minority communities relates to the stretched capacity of the current telecommunications system to serve as a platform for distance service delivery. A second challenge is ensuring that designated 'corridors' of service provided by the integrated university health networks do not impede access to Telehealth programs for English-speaking minority communities.

Other areas of activity not funded by the federal Action Plan

The Report describes activities in the area of research and strategic information. Initiatives of strategic knowledge development led by community organizations are presented, as well as a community partnership with McGill University to develop research orientations with respect to English-speaking minority communities. There is a key challenge of mobilization of key actors in a domain not recognized as a priority field of research.

With respect to application of technology to improve access to services, the Report notes that the Telehealth initiative involving the Community Health and Social Services Network, McGill University and the McGill University Health Centre requires a sustainability plan to introduce the model as a cost-effective way to deliver public health programs to distant English-speaking minority communities. Similarly, the Community Learning Centre pilot projects (using schools as service delivery points) require validation as a means to receive distance community support programs before investment can be increased to extend the model to other communities.

Community health promotion strategies supported by the Public Health Agency of Canada have strengthened the capacity of target communities to map health determinants to improve collaboration between communities, planning authorities and service providers. New knowledge on English-speaking minority communities was created, the social economy was tested as a model to develop services and a provincial forum brought together stakeholders involved in initiatives to improve access to health and social services for English-speaking minority communities. The challenge is positioning the communities for future investments aligned with the new Quebec Public Health Plan and an emerging national public health strategy.

BLUEPRINT FOR ACTION: STRATEGIES FOR RESULTS

The Report presents four linked strategies to serve as the foundation of the proposed Intervention Plan, which aims to improve health outcomes and the vitality of English-speaking minority communities in the period ahead.

Strategy One: Consolidation of new networks of communities and public partners

Formal networks are a key to sustaining improvements in access and effecting the organizational changes in the system to meet long-term goals. Engagement of the community's historical institutions is an element of sustainability. The openness of the health and social services system to addressing the needs of English-speaking people is evident in the willingness of public partners to enter into functional relationships with communities. The provincial network is a key actor linking different actors and developing collaborative relationships with government and institutional stakeholders, such as McGill University.

Strategy Two: Five strategic entry points for action to improve health outcomes

The current stage of reform of the Quebec health and social services system presents new opportunities to introduce measures of improvement of health outcomes for English-speaking communities. Targeting points of entry is seen as an effective way to ensure actions achieve organizational change. Incubation of new service models is one entry point that favours development of service models in innovative organizations with a view to introducing them (or adaptations of them) into the health and social services system.

A second entry point is broad system intervention that promotes system-wide changes having a structural or long-term impact on access to English-language services. Examples are the Info-Santé program (health information line) and client tracking systems. Another entry point is the adaptation of clinical and organizational projects which develop services reflecting the characteristics and needs of the population of a given territory. This is a key entry point, as it provides the local program framework for federal investments in the new priority areas that would contribute to the initiatives of Quebec's community-based service network. The fourth entry point is the adaptation of service 'corridors' of the integrated university health networks to ensure English-speaking patients can move from one tier of medical services to another and be served in English. New federal resources in this area would contribute to Quebec's efforts to ensure timely access to specialized medical services for the whole population, including English-speaking communities. And lastly, adaptation of prevention and promotion activities aims to ensure that English-speaking minority communities receive public health programs in English at the provincial, regional and local levels.

Strategy Three: Informing public policy and influencing government actions

Demonstrating the impact of investments meets accountability requirements and helps shape public policy that will have a long-term impact on the health status of English-speaking minority communities. The strategy accepts that governments and their agencies are important stakeholders in the implementation of strategies to improve services.

Strategy Four: Strategic knowledge development

Developing strategic knowledge is crucial for mobilizing stakeholders engaged in initiatives to improve access to English-language services. One principal area of activity is knowledge development and dissemination as demonstrated by the provincial network. A second area is promotion of research partnerships to support inter-university research programs, create community-university research alliances, create strategic clusters of researchers and develop applied research addressing the realities of institutional and community environments.

PRIORITIES AND RECOMMENDATIONS

The Report proposes an Intervention Plan that sets out the actions required to improve health outcomes and the vitality of Quebec's English-speaking communities.

INTERVENTION PLAN

MAINTAINING AND BUILDING NETWORKS OF COMMUNITIES AND PUBLIC PARTNERS

Recommendations:

It is proposed that:

1. Based on an evaluation of the results achieved, the 11 networks currently funded receive ongoing stable funding beyond 2007-2008;

2. Vulnerable communities in another 24 regions, comprising up to 30% of Quebec's English-speaking population, receive support for the development of networks; and

3. Vulnerable communities unable to mobilize resources to participate in calls for network proposals receive special funding to assist them in accessing a network development program.

STRATEGIC LONG-TERM INVESTMENT IN NEW MODELS OF SERVICE ORGANIZATION TO IMPROVE HEALTH OUTCOMES FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

Recommendations:

It is proposed that:

4. Designated portions of federal funding to improve the health of Canadians and, in particular, to support Quebec's initiatives to reform its health and social services system, be directed to the development of new models of service delivery for English-speaking communities in a manner consistent with Quebec's multi-year reform plan; and

5. A multi-year federal contribution be accorded for the development of new models of service delivery for English-speaking minority communities in accordance with five strategic areas of intervention to ensure lasting effects of measures to improve access to health and social services in English. They are:

    - Support for institutions acting as incubators of new models for eventual integration into the system;

    - Broad system interventions that maximize the impact of improvement measures in the health and social services network, such as Info-Santé and Info-Social, and client information systems;

    - Adaptation of clinical and organizational projects;

    - Adaptation of service corridors and integrated university health networks; and

- Adaptation of prevention and promotion programs.

MAINTAINING AND EXPANDING TRAINING AND DEVELOPMENT OF HUMAN RESOURCES

Recommendations:

It is proposed that:

6. A multi-year federal contribution be accorded for the training and development of human resources of Quebec's health and social services system to support their capacity to serve English-speaking people in their language;

7. A second phase of language training place priority on development of a model to document and evaluate the impact of different variables related language training and their effect on the offer of services in English;

8. A second phase of language training place a priority on: (a) the development of measures to support maintenance of second language skills that include professionals, training organizations and other stakeholders; (b) the integration into the workplace of the language skills acquired by professionals participating in language-training programs;

9. A second phase of internships and retention initiatives place priority on development of tested models of internship and retention of professionals in the regions;

10. A second phase of internships and retention initiatives place priority on targeted action to increase the capacity of English-language professional degree programs in the health and social services fields to recruit English-speaking youth into their programs;

11. A second phase of distance community support be extended to increase capacity to provide public health programs to isolated or underserved English-speaking minority communities. A priority should be placed on an evaluation of best practices and the impact of the measure on the offer of services in English;

12. A second phase of distance professional support be funded in order to extend capacity in accordance with the development of corridors of access to specialized and ultra-specialized health services to each integrated university health network;

13. A new investment in training and human resources development encourage knowledge-building, new evaluation approaches and support a research promotion program; and

14. A new investment in training and human resources development promote information technologies as a means of supporting professional development through networking between health and social services

professionals serving distant or isolated English-speaking minority communities, and other professionals serving English-speaking people.

PROMOTING RESEARCH AND STRATEGIC INFORMATION

Recommendations:

It is proposed that:

15. A federal action plan with dedicated funding for research on Official Language Minority Communities be implemented;

16. A federal action plan include the following elements:

    - Coordinated departmental commitments to fund research;
    - A national policy to promote Official Language Minority Communities as a research field in order to orient research funding bodies to open competitions;
    - Creation of university chairs and training programs to recruit young researchers;
    - Creation of joint research funding programs involving federal departments and the research bodies;
    - Promotion of data access protocols with Statistics Canada;
    - Implementation of a funding program to promote community capacity to generate knowledge and research and participate in research partnerships;
    - A strategy to link research between Official Language Minority Communities and with Quebec universities and funding bodies; and
    - A funding program to support knowledge transfer through partnerships between learning institutions and English-speaking minority communities in order to promote the widest application of new knowledge.

PROMOTING TECHNOLOGY TO BETTER SERVE ENGLISH-SPEAKING MINORITY COMMUNITIES

Recommendations:

It is proposed that:

17. Envelopes to develop services to English-speaking minority communities be earmarked in major infrastructure programs such Canada Health Infoway, the Canadian Foundation for Innovation and other federal contribution programs supporting Quebec's Telehealth development; and

18. Federal interdepartmental partnerships with the English-speaking official language communities support expansion of the role of new Community Learning Centres in the delivery of health and social services in English. Specifically, funding would increase community capacity to coordinate distance community support programs in the area of public health using new videoconferencing networks.

PROMOTING POPULATION AND PUBLIC HEALTH STRATEGIES FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

Recommendations:

It is proposed that:

19. A federal contribution be provided to Quebec's English-speaking communities in order to support their participation in Quebec's Public Health Plan establishing new public health initiatives at the provincial, regional and local levels; and

20. The Public Health Agency of Canada actively promote English-speaking minority communities as stakeholders in the development of a new national public health strategy.

INTRODUCTION

MEETING THE NEW PRIORITIES OF CANADA'S GOVERNMENT

This Report to the federal Minister of Health is an affirmation of the identity of Quebec's English-speaking communities in Prime Minister Stephen Harper's declaration at Embrun, Ontario, on March 24, 2007: "Canada's success as a country lies in the strength of its founding values and the fundamental decency of its citizens". With this declaration, the Government affirmed its commitment to supporting bilingualism, and to supporting the minority language communities across the country.[7]

Health is one of the Government's key priorities. Improving the health outcomes of all Canadians means addressing the particular health status inequalities that affect Quebec's English-speaking population as one of Canada's two Official Language Minority Communities. This Report identifies the evidence base of demographic factors and health determinants that are influencing health outcomes in English-speaking minority communities. With the foundations established to support new initiatives, the Report set outs a blueprint for new federal action.

Improving the health of specific population groups is a key priority of the federal Minister of Health. Initiatives will be implemented to improve health outcomes for specific groups such as children and youth, and seniors. These groups face particular challenges compared to other Canadians. In Quebec's English-speaking communities, this vulnerable clientele faces additional hurdles due to language, geographic isolation, rapidly aging communities, and the high incidence of economic vulnerability of families and youth.

Quebec's health and social services system is shifting toward community-based services. The Government has recognized the link between the living conditions of all Quebec citizens and their health. Mental health and substance addiction are two of the eight key intervention programs in Quebec's new community-based services. The Quebec model is the framework for new federal action contributing to provincial initiatives to address these priorities. The Report outlines the strategic points of entry of new federal investments in Quebec's reformed system that would address the needs of English-speaking people. These needs also include timely access to specialized medical services, particularly for English-speaking patients from distant or isolated communities. Quebec's intent to create corridors of access to specialized health services is a major step toward reducing wait times for specialized medical intervention and ensuring equitable access to treatment for all Quebecers. The Report proposes how a federal contribution to Quebec's initiative will help ensure that the needs of English-speaking people are taken into account in the reorganization of the system.

English-speaking Quebecers are working as partners within Quebec's health and social services system to improve health outcomes and the vitality of their communities. The goal is not to create a parallel network of services, but to work with service providers and government to ensure that measures to improve access for English-speaking communities are fully integrated into a modern system serving all Quebecers.

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[7] Speech of Prime Minister Stephen Harper to the Prescott and Russell 9th Banquet de la Francophonie, March 24, 2007, Embrun, Ontario.

Mandate of the Consultative Committee for English-Speaking Minority Communities (CCESMC)

In August 1994, the Government of Canada approved the establishment of an accountability framework for the implementation of sections 41 and 42 of the *Official Languages Act.* These provisions commit the federal government to enhancing the vitality of Official Language Minority Communities and ensuring the participation of key federal departments and agencies in their development. The Act was reinforced on November 25, 2005 with the adoption of the *Act to Amend the Official Languages Act (promotion of English and French)*, aimed at ensuring that all federal institutions take positive measures to meet their obligations and making Part VII of the Act enforceable.

To support the Government of Canada's commitment to Official Language Minority Communities, the federal Minister of Health created the Consultative Committee for English-Speaking Minority Communities in October 2000.

The Committee's mandate is to:

- Provide advice to the Minister of Health on ways of enhancing the vitality of English-speaking minority communities in Quebec and to support their development;
- Provide advice to the Minister of Health, the Public Health Agency of Canada and the Health Canada on matters of coordination of federal initiatives pertaining to health;
- Provide its perspective on proposed initiatives in various stages of development and implementation with a view to ensuring an optimal impact on English-speaking minority communities in Quebec;
- Provide a forum to help update the multi-year Action Plan in order to assist the Health Canada in meeting its obligations under Section 41 of the *Official Languages Act;*
- Provide advice to the Minister of Health, the Public Health Agency of Canada and Health Canada on the implementation of the federal *Action Plan for Official Languages; and*
- Liaise with English-speaking minority communities in Quebec so as to facilitate information sharing; and liaise with the Consultative Committee for French-Speaking Minority Communities outside Quebec with a view to enhancing the vitality of Official Language Minority Communities.

The Consultative Committee is made up of the following persons:

- Two co-chairs, one representing the English-speaking minority community and one representing the Government of Canada;
- Eight members representing English-speaking minority communities;
- Senior officials of Health Canada and the Public Agency of Canada;
- The Health Canada National Coordinator, Section 41, Part VII and the Quebec regional coordinator;
- A Quebec regional representative of the Department of Canadian Heritage; and
- Two co-secretaries, one representing the English- speaking minority community and one representing Health Canada.

THE COMMITTEE'S 2002 REPORT

In July 2002, the Committee submitted a Report to the federal Minister of Health proposing a multi-year plan based on five levers aimed at improving access to health and social services in English for Quebec's English-speaking communities. To meet this goal, a comprehensive strategy proposed measures to support community-institutional networking, strategic information, use of technology, adaptation of service delivery models and training and human resources development.

The Report served as a guide for the federal *Action Plan for Official Languages* launched in March 2003. The Plan supported three levers proposed by the CCESMC: community-institutional networking, adaptation of service delivery models (primary health care), and training and human resources development. Funding was committed for the period 2003 to 2008 for community-institutional networking and training and human resources development. The primary health care transition initiative is supported until March 2007. By March 2008, the federal commitment to improving access to services for Quebec's English-speaking communities will have been $30.1 million.

After submission of its Report to the Minister, the CCESMC played a central role in implementing the Action Plan by designating the three organizations mandated to carry out the three measures. The Committee continues to be the key body for Health Canada with respect to identifying the priorities for future action, naming of future contribution program beneficiaries and monitoring the implementation of current Action Plan measures. To support this mandate, the Committee developed a strategic planning framework which served as the basis for updating the 2002 strategy.

UPDATING THE 2002 STRATEGY

In 2005, the Consultative Committee for English-Speaking Minority Communities undertook a review of the Committee's mandate. In the context of these discussions, it was agreed that a strategic planning exercise would be carried out to produce a framework to guide medium and long-term activities of the Committee. The result was a Strategic Planning Framework, which was approved in May 2006. The immediate priorities were to identify the short-term and medium-term actions needed to fulfil the requirements of the *Action Plan for Official Languages* and to address the gap following the end of the Primary Health Care Transition Fund in March 2007. At the same time, the Planning Framework identified long-term actions and activities that would advance the five levers recommended in the Committee's 2001 Report to the Minister. With this orientation, the CCESMC set the basis for preparation of the present Report outlining the priorities for federal action in the period ahead.

This Report will describe progress achieved with the current Action Plan measures as well as propose an Intervention Plan for initiatives beyond 2008. The Intervention Plan is consistent with a sustainability strategy presently guiding actions to ensure integration of results of current and future investments into Quebec's health and social services system. Through the strategic planning process, the Committee has sought to ensure that its priorities are anchored in validated needs of English-speaking minority communities, as well as the orientations, policies and programs of government partners. This balanced and proactive orientation is felt to best ensure conditions for success of efforts to improve health outcomes and enhance vitality of English-speaking communities in Quebec.

COMMUNITY CONTEXT

THE IMPORTANCE OF HEALTH AND SOCIAL SERVICES IN ENGLISH

In its 2002 Report to the Minister, the CCESMC noted that language is a key factor in the successful delivery of health and social services. A Health Canada Report states, "There is compelling evidence that language barriers have an adverse effect on access to health services".[8] There is a broad range of factors affecting the health status of communities including language and culture. Viewed from a population health perspective, communities may face additional health risks in an environment where access to linguistically and culturally appropriate services is limited due to minority status.[9]

When a range of health determinants and demographic indicators are combined to give a relative measure of community vitality, there are at least ten of sixteen administrative regions in Quebec where English-speaking communities are linguistically and culturally at risk.[10] The trend shows increased vulnerability, as English-speaking minority communities declined in size in a majority of administrative regions between 1996 and 2001.[11]

Other studies have confirmed that language barriers affect access and quality of care for linguistic minority communities. Obstacles to communication can reduce recourse to preventative services; increase consultation time including the number of tests and the possibility of diagnostic and treatment errors; affect the quality of services requiring effective communication such as social services; reduce the probability of treatment compliance and reduce users' satisfaction with the services received.[12]

For English-speaking minority communities, barriers to access remain a major preoccupation of certain key health and social services institutions serving them. An overwhelming majority of service providers and community organizations involved in primary health care transition measures of the federal Action Plan placed high importance on access as a priority of the public system. English-speaking people face particular barriers to access that include: a shortage of human resources capable of offering services in English; lack of a sufficient volume of service requests in English in regions of low population density to justify a service offer; difficulty in planning services given a lack of information on needs; patterns of use of services by English-speaking people whereby recourse to public services more often occurs in dire situations; ambiguity concerning the legal framework governing the language of work (French) and the legislative guarantees of services in English; and finally, the low capacity of communities to act in regions where they are demographically weak and lack community infrastructure.[13]

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[8] Sarah Bowen, *Language Barriers in Access to Health Care,* Health Canada, 2001.
[9] James Carter, *A Community Guide to the Population Health Approach,* Community Health and Social Services Network (CHSSN), March 2003, p. 18.
[10] CCESMC, *Report to the Federal Minister of Health,* Health Canada, 2002, p. 10.
[11] Joanne Pocock, *Baseline Data Report 2005-2006,* CHSSN, February 2006, p. 14.
[12] FCFA, *Pour un meilleur accès à des services de santé en français,* 2001.
[13] ENAP, *Final Report: Evaluation of the Implementation and Initial Impact of the Primary Health Care Transition Project of the CHSSN,* October 2006, p. 11.

Access to health and social services in English remains a high priority for English-speaking communities across Quebec. Regardless of whether English-speaking people go to a doctor's office, use a health information line, a local community services centre or a hospital, an overwhelming majority of them (over 80%) affirm that it is very important to receive their service in English.[14]

PORTRAIT OF THE VITALITY OF ENGLISH-SPEAKING MINORITY COMMUNITIES

Since the presentation of the portrait of vitality of English-speaking minority communities in the 2002 Report to the Minister, new knowledge on the demographic and health status of English-speaking minority communities has been developed. A compendium of this information is contained in a companion document prepared to complement this Report.[15] The following is a summary of evidence highlighting vulnerability of English-speaking minority communities. The factors described are elements that influence the health status of the communities. This evidence base is key in the identification of needs and priorities for action to improve the vitality of English-speaking minority communities.

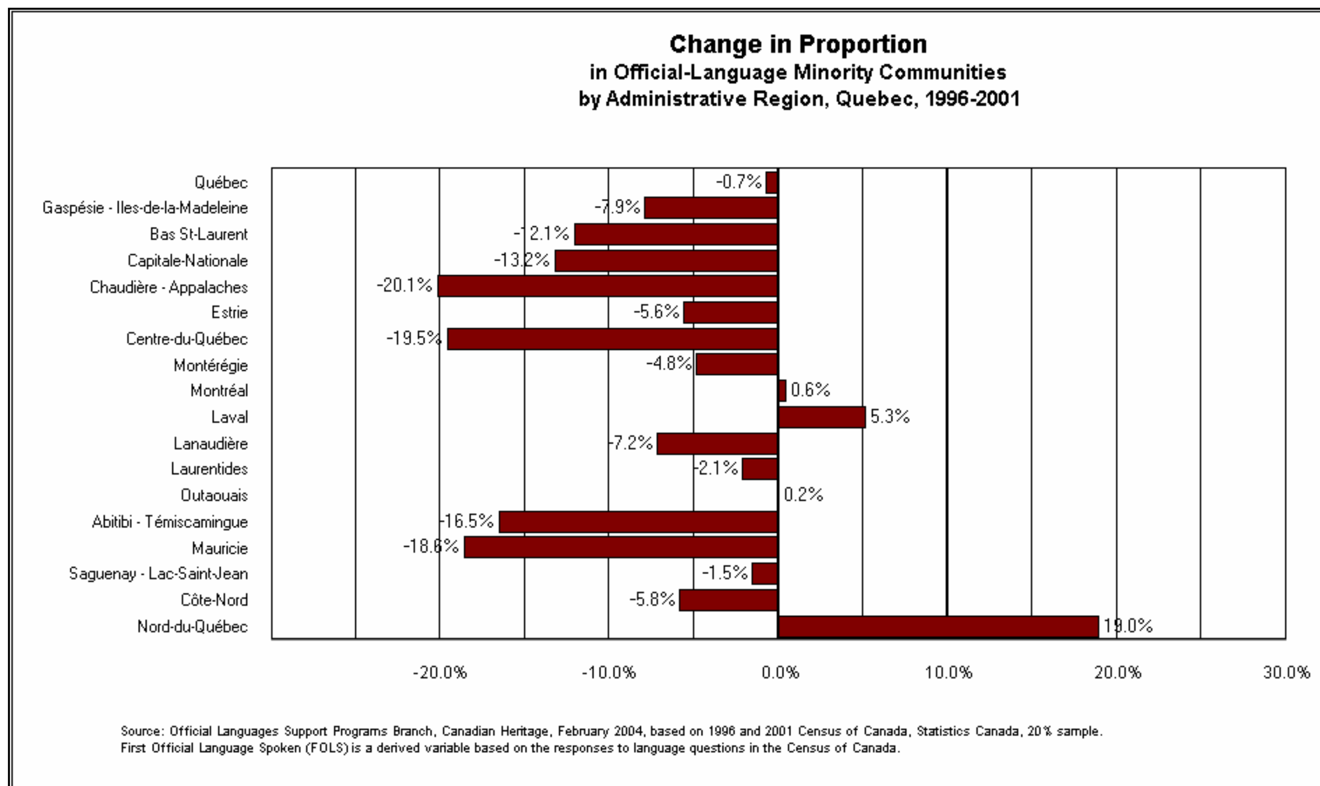
DEMOGRAPHIC VITALITY

Demographic decline

Between 1996 and 2001, English-speaking minority communities experienced the largest decline in absolute numbers (6,873 persons) of any of the other official language minority communities in Canada.[16] The English-speaking population of Quebec in 2001 stood at 918,965 persons, as defined by first official language spoken. Within Quebec, English-speaking minority communities declined in 14 of 17 administrative regions.[17] Dramatic declines occurred in five regions, where English-speaking minority communities dropped by over 13% in a five-year period.[18]

[14] Results of the CHSSN-CROP Community Vitality Survey contained in the *Baseline Data Report 2005-2006,* Joanne Pocock, CHSSN, February 2006, p. 69-74.
[15] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, 2007. The document is available on the website of the Community Health and Social Services Network (CHSSN), http://www.chssn.org .
[16] Ibid., Table: *Change in size, Official-Language Minorities, Canada, 1996-2001*, p. 18.
[17] Ibid., Table: *Change in size, Official-Language Minorities, Quebec, 1996-2001*, p. 19.
[18] Ibid., Table: *Change in Proportion, Official-Language Minorities, Quebec, 1996-2001*, p. 21. Capitale-Nationale (Québec) dropped by 13.2%, Chaudière-Appalaches by 20.1%, Centre-du-Québec by 19.5%, Abitibi-Témiscamingue by 16.5%, and Mauricie by 18.6%.

DEMOGRAPHIC CHANGES IN QUEBEC'S ENGLISH-SPEAKING COMMUNITIES 1996-2001

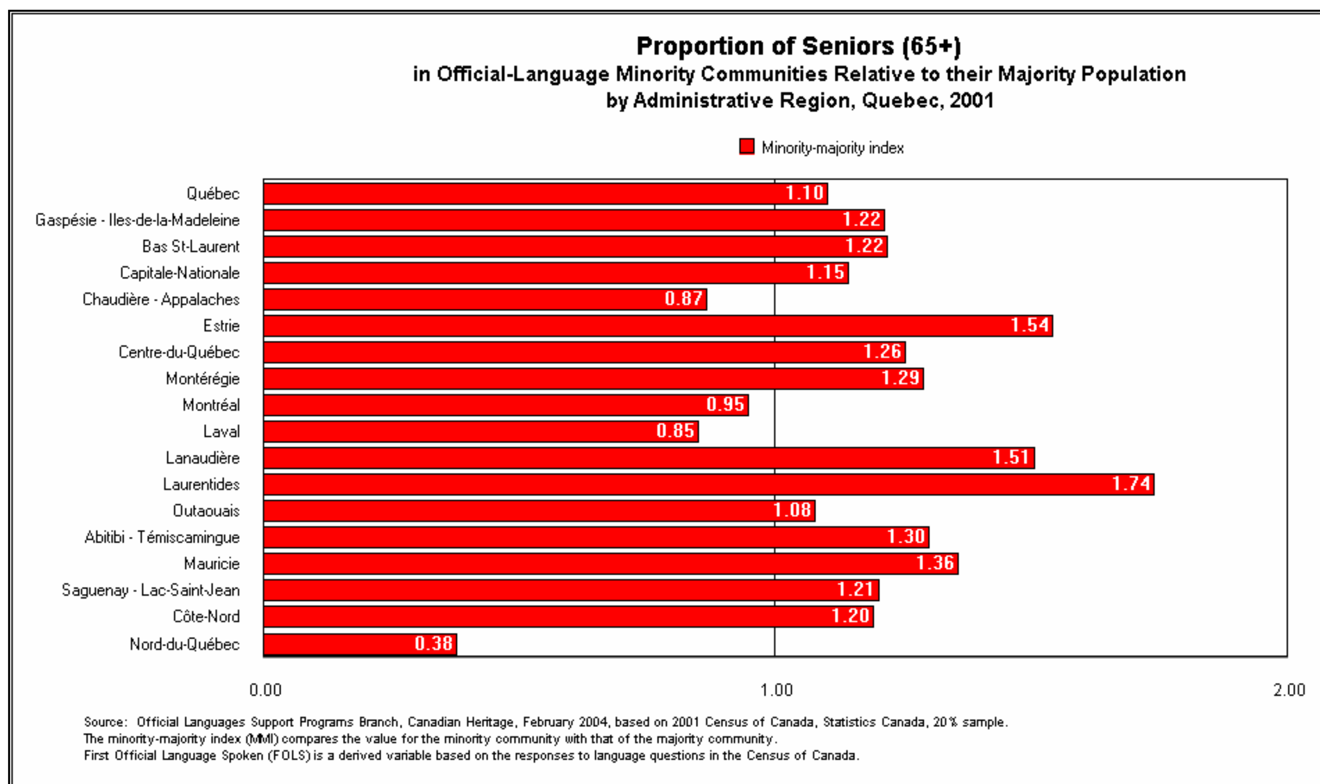


Aging communities

English-speaking minority communities are aging at a faster rate than the French-speaking majority communities in 13 of 17 administrative regions.[19] In eleven regions, the proportion of seniors aged 65 and older relative to the whole English-speaking minority community was over 20% higher than that of Francophone seniors in the majority communities.[20] English-speaking minority communities have smaller proportions of youth (aged 5 to 19 years), and the adult generation (aged 40 to 59) in relation to their total population, compared to Francophone communities.[21] This latter adult age group is called the 'caregiver' generation and represents a missing middle group from many English-speaking minority communities, reflective of out-migration that occurred between 1976 and 1986.

[19] Ibid., Table: *Seniors in Official-Language Minorities (MMI), Quebec 2001,* p. 54.
[20] Ibid.
[21] Ibid., Table: *Age Structure (MMI), Quebec's Official-Language Minorities, 2001,* p. 44.

Quebec's aging English-speaking communities compared to the French-speaking majority



The table above compares the proportion of seniors in the English-speaking minority population of each region with that of the French-speaking majority. The values greater than 1.00 are percentages that indicate the extent to which the proportion of seniors in English-speaking minority communities is greater than the proportion of seniors in the French-speaking majority communities.

Determinants of health status

It is recognized that a broad range of individual and collective factors are connected with health status. Key among these are income and education, employment, social environments, social support networks and access to the health and social services system.

Low income

Income and social status are considered to be the most important determinants of health. Less than half of Canadians in the lowest income bracket rate their health as very good or excellent. They are more likely to die

earlier and suffer more illnesses.[22] In Quebec, poor and very poor income levels are linked to factors such as higher incidence of drug use, average to poor eating habits, food insecurity, lack of recreational physical activity, excessive weight, long-term health problems, and high levels of psychological stress, among other impacts.[23]

English-speaking Quebecers are 26% more likely than the Francophone majority to have incomes below the Statistics Canada low-income cut off.[24] The rate of low income in English-speaking minority communities is greater than that in Francophone communities in 15 of 17 administrative regions. The low income gap between English and French-speaking communities is 20% or greater in 7 of 17 regions. Certain groups in the population are at greater risk of experiencing health problems. The rate of low-income among unattached English-speaking individuals is very high, with 42.9% of them living below the Statistics Canada low-income cut off.[25]

ENGLISH-SPEAKING PEOPLE LIVING ALONE BELOW THE STATISTICS CANADA LOW-INCOME CUT-OFF

Proportion Living Alone who are below the Low-Income Cut-off (LICO)[26]	Total %	Anglophones	Francophones	Minority-Majority Index[27]
Québec (Province)	41.8	42.8	41.4	1.03
*Bas-Saint-Laurent	41.2	34.8	41.2	0.84
*Saguenay-Lac-Saint-Jean	41.1	30.4	41.2	0.74
Québec	43.9	41.9	43.9	0.96
*Mauricie et Centre-du-Québec	43.1	38.6	43.1	0.90
Estrie	39.2	35.6	39.5	0.90
Montréal	46.3	45.3	46.1	0.98
Outaouais	36.4	35.0	36.6	0.96
Abitibi-Témiscamingue	38.3	43.2	38.1	1.13
Côte-Nord	33.2	31.3	33.3	0.94
*Nord-du-Québec	33.5	66.7	33.0	2.02
Gaspésie-Îles-de-la-Madeleine	41.5	34.8	42.4	0.82
Chaudière-Appalaches	36.5	45.5	36.5	1.25
Laval	39.5	45.1	38.7	1.16
Lanaudière	37.7	45.4	37.5	1.21
Laurentides	37.1	32.8	37.4	0.88
Montérégie	37.2	36.0	37.3	0.96

[22] Public Health Agency of Canada, *Population Health Approach,* http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants. A presentation of key determinants of health cites evidence from a number of Canadian studies.
[23] Institut de la statistique du Québec, *Enquête social et de santé 1998.*
[24] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *Population with Incomes Below the Low-income Cut-off, Quebec, 2001,* 2007, p. 76.
[25] Ibid., Table: *Persons Living Alone Who Are Below the Low-Income Cut-off (LICO), Quebec, 2001,* p. 77.
[26] JW COMM, for the Community Health and Social Services Network, Statistics Canada, 2001 Census of Canada. Interpretation of data for regions marked with an asterisk should be done with caution because of small census samples. The Nord-du-Québec region includes Cree and Inuit populations.
[27] The Minority-Majority Index compares the proportion of English-speaking people living alone below the low-income cut-off compared to the same population in the French-speaking majority. The values greater than 1.00 are percentages that indicate the extent to which the proportion of English-speaking people living alone below the low-income cut-off is greater than the proportion of this group in the French-speaking community of a region.

Single parent families are vulnerable with respect to income security. This is the case for English-speaking minority communities. While 36.5% of English-speaking lone parent families are below the Statistics Canada low-income cut off, the rate is 33.7% for Francophones. In the Montreal region, the rate of low-income in English-speaking single-parent families (41% below the low-income cut off) is higher than the low income rate in English-speaking minority communities in a majority of the administrative regions.[28]

ENGLISH-SPEAKING PEOPLE LIVING IN LONE PARENT HOUSEHOLDS BELOW THE STATISTICS CANADA LOW-INCOME CUT-OFF

Proportion Living in Lone Parent Households who are below the Low-Income Cut-off (LICO)[29]	Total %	Anglophones	Francophones	Minority-Majority Index[30]
Québec (Province)	34.1	36.5	33.7	1.08
*Bas-Saint-Laurent	30.2	59.1	30.1	1.96
*Saguenay-Lac-Saint-Jean	32.1	46.7	32.0	1.46
Québec	32.3	42.0	32.1	1.31
*Mauricie et Centre-du-Québec	32.9	35.4	33.0	1.07
Estrie	27.6	35.9	26.8	1.34
Montréal	43.5	41.0	44.3	0.93
Outaouais	31.7	29.5	32.0	0.92
Abitibi-Témiscamingue	30.6	31.5	30.5	1.03
Côte-Nord	25.5	20.3	26.4	0.77
*Nord-du-Québec	30.3	na	30.4	na
Gaspésie-Îles-de-la-Madeleine	30.1	23.8	31.1	0.76
Chaudière-Appalaches	25.1	17.4	25.2	0.69
Laval	28.8	32.8	28.4	1.15
Lanaudière	31.1	36.9	31.0	1.19
Laurentides	30.4	21.9	31.0	0.71
Montérégie	30.3	30.3	30.2	1.02

Low educational attainment

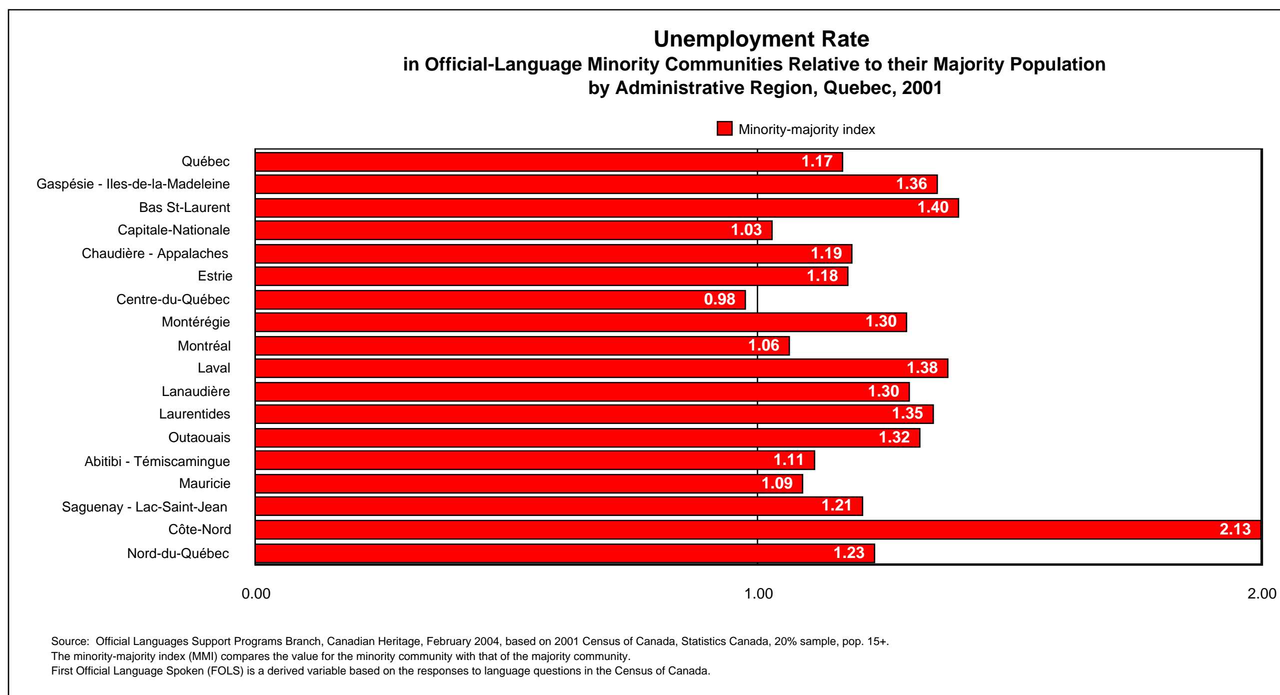
With respect to educational attainment, English-speaking minority communities in distant regions are much more likely to have higher proportions of community members without high school diplomas than in more urban

[28] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *Proportion of Those Living in Lone Parent Households Below LICO,* 2007, p. 78.
[29] JW COMM, for the Community Health and Social Services Network, Statistics Canada, 2001 Census of Canada. Interpretation of data for regions marked with an asterisk should be done with caution because of small census samples. The Nord-du-Québec region includes Cree and Inuit populations.
[30] The Minority-Majority Index compares the number of English-speaking people living in lone parent households below the low-income cut-off compared to the same population in the French-speaking majority. The values greater than 1.00 are percentages that indicate the extent to which the proportion of English-speaking people living in lone parent households below the low-income cut-off is greater than the proportion of this group in the French-speaking community of a region.

regions. [31] In six regions, the rate of non-completion of high school is greater than that in the majority communities.[32]

Unemployment

English-speaking minority communities in Quebec are second in Canada after New Brunswick with respect to having unemployment rates greater than the surrounding majority communities. While New Brunswick



Francophones have a rate 25% higher than that of New Brunswick Anglophones, English-speaking Quebecers have an unemployment rate 17% higher than that in Francophone communities.[33] English-speaking minority communities are experiencing a rate of unemployment that is significantly higher than in surrounding French-speaking communities in 8 regions; a rate that is 30% or higher than the majority.[34]

UNEMPLOYED ENGLISH-SPEAKING PEOPLE

Social environments and social cohesion

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[31] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *No High School Diploma (RGI-Prov), Quebec, 2001*, 2007, p. 61.
[32] Ibid., Table: *No High School Diploma (MMI), Quebec, 2001*, p. 59. The communities are in Gaspésie-Îles-de-la-Madeleine, Estrie, Laval, Abitibi-Témiscamingue, Côte-Nord and Nord-du-Québec.
[33] Ibid., Table: *Unemployment Rate (MMI) - Canada, 2001,* p. 67.
[34] Ibid., Table: *Unemployment Rate (MMI), Québec, 2001,* p. 68.

Social environments are a reflection of civic vitality and sense of belonging. English-speaking Quebecers had the lowest rate of strong sense of belonging to a local community (67%), when compared to the French-speakers in Quebec and the rest of Canada, as well as Anglophone Canadians.[35] This is consistent with other information confirming that over 60% of English-speaking Quebecers believe that the future of their regional English-speaking community is threatened.[36] As well, 30% of English-speaking minority youth aged 18 to 30 do not believe they will be living in the same municipality in five years.[37]

Social support networks

Social support networks contribute to an individual's sense of control over life circumstances and promote community vitality. English-speaking Quebecers overwhelmingly turn to family and friends first in the case of illness (80%) as opposed to seeking the services of a public institution (10.7%).[38] English-speaking minority communities lead all other Official Language Minority Communities in Canada by a wide margin with respect to the total of unpaid hours of assistance provided to seniors.[39] The rate of unpaid care in 9 administrative regions is 50% or greater in English-speaking minority communities than that of the majority communities.[40]

Use of health services

With respect to use of the health system by English-speaking Quebecers, a Health Canada study provides a revealing portrait. Quebec English-speakers were compared to the French-speaking majority in Quebec, French-speaking minorities outside Quebec and Anglophone Canadians, with respect to their use of health services. Quebec English-speakers scored the lowest of the groups for questions related to having a regular doctor, use of hospital services and difficulty getting care from a specialist. Also, significant difference was identified for: rating of quality health care; satisfaction with the way health care was provided; and quality and satisfaction with community-based care, while controlling for such important factors as: age: sex; urban or rural area, self-rated health: having chronic conditions: education: employment status: and income.[41]

Access to health and social services in English

Access to the range of health and social services in English depends on the type of service offered and varies greatly from region to region. Generally, a majority of English-speaking people receive services in English from a doctor in a private clinic or office. Less than of 50% English-speakers received doctor's services in English in

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[35] Ibid., Table: *Strong Sense of Belonging to Local Community,* p. 87.
[36] Jack Jedwab, *Unpacking the Diversity of Quebec Anglophones,* The Canadian Institute for Research on Linguistic Minorities, November 2006, unpublished, p. 5. This is a Report commissioned by the Community Health and Social Services Network that looks at results of the CHSSN-CROP Community Vitality Survey, 2005.
[37] Ibid., p. 9.
[38] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *Source of Support in the Case of Illness, Quebec, 2005,* 2007, p. 126.
[39] Ibid., Table: *Unpaid Care to Seniors (MMI), Canada, 2001,* p. 138.
[40] Ibid., Table: *Unpaid Care to Seniors (MMI), Quebec, 2001,* p. 139.
[41] Elena Tipenko, *Statistical analysis of health system utilization, use of diagnostic testing, and perceptions of quality and satisfaction with health care services of Official Languages Minority Communities (OLMC),working paper,* MSDAD, Health Canada, 2006.

4 administrative regions. These are regions where the community forms a very small proportion of the regional population.[42]

The rate of access to English-language services declines for other public health and social services. Two-thirds were served in English in a local community service centre, with the rate falling under 50% in 9 of 19 regions and sub-regions (including Montreal East). For Info-Santé services (health information line), the general rate drops to 63%, with 10 regions and sub-regions reporting under 50% access in English. Less than 50% of English-speakers received emergency room and out-patient clinic services in English in 10 regions and sub-regions. This was also the case in 8 of 19 regions and sub-regions for overnight stays in a hospital.[43]

Almost 1 in 5 English-speakers were uncomfortable asking for services in English in 13 of 19 regions and sub-regions (including Montreal East).[44] The reasons most often cited were concern the request would impose a burden on personnel (24.7%) or a delay in service might occur (22.3%).

Underrepresentation in the personnel of the health and social services system

As with most Official Language Minority Communities in Canada, the proportion of English-speaking Quebecers with post-secondary qualifications in the health domain is much less than that of the majority community.[45] The rate of employment of English-speaking people in Quebec's health and social services system falls significantly short of that of the French-speaking majority in every administrative region. Underrepresentation of English-speakers among personnel is considered to be linked with under use of public services by English-speakers and weak participation of communities in the governance structures of public institutions in many regions.[46]

EVOLUTION OF QUEBEC'S HEALTH AND SOCIAL SERVICES SYSTEM

IMPACT OF SYSTEM REFORMS ON INSTITUTIONS SERVING ENGLISH-SPEAKING PEOPLE

The transformation of the health and social services system in Quebec has affected community infrastructure, including the institutions historically serving English-speaking minority communities. Reform of the health and social services network over the last decade has resulted in the consolidation of many of these historical institutions. Legislative guarantees of services in English have ensured that institutions continue to have a recognized mandate to serve English-speaking people, but at the same time they must demonstrate their capacity to serve the majority French-speaking population.[47]

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[42] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *Language of Service – Private Doctor, Quebec, 2005,* 2007, p. 127.
[43] Ibid., Tables: p. 128 – 132.
[44] Ibid., Table *Comfort Level in Requesting Services in English, Quebec, 2005,* p. 133.
[45] Ibid., Table: *Post-Secondary Qualifications in the Health Domain (MMI), Canada, 2001,* p. 158.
[46] Ibid., Table: *Employed in Health Occupations (MMI), Quebec, 2001,* p. 164.
[47] In October 2006, the Government of Quebec adopted a decree designating institutions mandated to provide the full range of their services in English. A number of the institutions are those historically serving English-speaking minority communities and benefit from an exemption from certain provisions of the Charter of the French Language, thus permitting them to function as bilingual institutions. Of the 42 institutions named, 29 are in Montreal, (8 of which are long-term care

In regions other than Montreal, the few existing historical institutions serving the health and social services needs of English-speaking minority communities have been subject to reorganization, altering traditional mandates and in some instances, transferring governance to the majority community.

English-speaking people outside the Montreal region are likely to receive their services from French-language institutions. Significant challenges continue to face community members with respect to obtaining services in English and participating in the governance structures of these institutions. Under utilization of public services continues to be reality[48], as English-speaking people are more likely to turn to family and friends first before using a public institution in the case of a health issue.[49] Constant effort is required by communities to ensure transformed institutional networks are adapting services to meet the needs of English-speaking people.

Problems of access are not only a reality of communities off the island of Montreal. In the eastern sector of Montreal, the rate of satisfaction of English-speaking people with access to services is low, compared to that of English-speakers in the rest of Montreal. French-language institutions are the principal service providers for the population in this part of the region and do not necessarily have personnel capable of providing services in English.[50]

The ongoing transformation of Quebec's health and social services system has profoundly altered the institutional networks serving English-speaking communities. As a result, mobilization is a constant challenge for communities and service providers in their efforts to address persisting gaps in services in English in the areas of primary health care, social services, rehabilitation, long-term care and general and specialized medical services.[51]

The investments through the federal Action Plan, the current review of access programs of services in English[52] and new orientations that aim to bring services closer to the population are promising developments that can help create conditions necessary to improve access to a range of services for English-speaking minority communities.

The new context of Quebec's health and social services system

The Quebec government has embarked on a major reform aiming to create local integrated networks of health and social services. One of the goals is to broaden the perspective of the health and social services system beyond a focus on service delivery to include enhancement of health outcomes at the individual and population levels.

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centres or residences), 1 in Quebec, 3 in Estrie (Eastern Townships), 2 in Outaouais (western Quebec), 1 in Côte-Nord (Lower North Shore), 1 in Laval, 1 in Lanaudière, 1 in Laurentides, and 3 in Montérégie.

[48] While 26% Francophones used Info-Santé (health information line) in a 12 month period, only 15% of Anglophones did so. SOM, *Étude sur la notoriété du service Info-Santé,* Final Report presented to the CHSSN, May 2005, p. 18.

[49] Joanne Pocock, *Baseline Data Report 2005-2006,* CHSSN, February 2006, p. 36.

[50] Joanne Pocock, *Baseline Data Report 2005-2006,* CHSSN, February 2006, p. 29. While 39.4% of English-speakers in eastern Montreal are satisfied with access to services in English, the rate is 55.3% in western Montreal.

[51] CCESMC, *Report to the Federal Minister of Health,* Health Canada, 2002, p. 15.

[52] Regional agencies are currently preparing new access programs of health and social services in English, which will be approved by the Government of Quebec. The plans identify the institutions which must ensure certain identified services are accessible in English for English-speaking people.

In 2004, 95 health and social services centres (CSSS) were created by merging local community service centres (CLSC), long-term care centres (CHSLD) and, in most cases, a hospital. The number of public health establishments dropped 42% from 339 to 195. Complementarity between the public network and private general medical practice is being created by linking family medicine groups and network clinics. Integrated university health networks are being set up to facilitate access through designated 'corridors' to ultra-specialized services in order to avoid duplication of expensive medical services. These networks also coordinate the teaching and research missions of university-affiliated health institutions. They foster the maintenance of professional qualifications and oversee medical training and distribution of medical students among the institutions of the integrated university health networks. New orientations guiding Quebec's public health strategy will support development of public health plans at the provincial, regional and local levels. These changes will profoundly alter the way English-speaking people will receive health and social services in the years ahead.

A major initiative is being undertaken to decompartmentalize professional practice and promote teamwork in the health sector. Clinical and organizational plans are being developed that will profoundly alter the way in which health services will be offered to a territorially defined population.[53] The new health and social services centres, at the core of these local networks, will assess a population's needs, identify gaps and establish mechanisms and service models to ensure effective access to services. The development of clinical and organizational projects adds a complementary feature to the access programs defining the legal entitlement of English-speaking people to receive services in English.[54] The two are closely linked, as the clinical and organizational projects must take into account the particular characteristics of the population concerned, including their linguistic characteristics.

The federal Action Plan measures aimed at improving access to primary level health and social services, providing training and development of human resources and supporting networking of communities and service providers have come at an opportune time as Quebec's health and social services system is poised for its next major phase of reform. Development of long-term formal relationships between communities and public partners is seen as a key condition for the successful integration of the Action Plan measures into the new context of Quebec's health and social services system.

To address future challenges, continued cooperation is required between the two levels of government, with the recognition of English-speaking minority communities as full partners. In this manner, federal policy and resulting measures supporting Quebec's initiatives will reflect the interests of all stakeholders, reinforce current public investments and ensure long-term government commitment to the vitality of English-speaking minority communities.

[53] *Projet clinique, Cadre de reference pour les réseaux locaux de services de santé et de services sociaux,* Document principal, MSSS, October 2004.
[54] *Frame of reference for the implementation of programs of access to health and social services in the English language for English-speaking persons,* MSSS, March 2006.

BUILDING FOUNDATIONS: RESULTS OF THE 2002 STRATEGY

Formative and final evaluations of the three measures funded by the Action Plan are indicating that the investments are beginning to bear fruit. Successful implementation of the initiatives and positive assessments of early results have affirmed the commitment of all stakeholders to bring the measures to maturity and set the stage for long-term changes that will improve health outcomes for Quebec's English-speaking communities.

The investments are supporting activities that will have ranged in duration from a few months to four years. Regardless of whether activities are related to networking, primary health care transition or training and human resources development, the medium and long-term outcomes are closely linked to structural reforms in Quebec's health and social services system that will affect the whole population including English-speaking minority communities.

Federal Action Plan Investments

Measure	Action Plan commitment	Actual resources invested	Timeframe
Networking and Partnership Initiative	$ 4.7 M	$ 4.3[55]	2004-2008 (4 years)
Primary Health Care Transition Phase 1	$ 10 M	$ 10 M	January 2005 – March 2006 (15 months[56])
Primary Health Care Transition Phase 2	$ 3.4 M	$ 3.4 M	December 2006 – March 2007 (4 months[57])
Training and Human Resources Development	$ 12 M	$ 11.5 M[58]	July 2004-2008 (3 years, 8 months[59])

Stakeholders associated with the evaluations have generally agreed that the time frame of the federal investments has allowed them to achieve many short term objectives and create the conditions necessary to affect more substantive and permanent change. There is a prevailing view that more time and resources are required to achieve the longer term structural changes necessary to sustain improved access and ensure better health outcomes for English-speaking minority communities.

[55] Because of delay between announcement of the Action Plan in March 2003 and the implementation of the Contribution Program, the allocation for 2003-2004 was reduced to support program start up activities in the last quarter of the 2003-2004 fiscal year. The actual networking activity began in 2004-2005.
[56] Delays in finalizing the Contribution Agreement and completing the inter-governmental protocol reduced the project implementation period to 15 months.
[57] Delays in the release of the $3.4M reduced the project implementation period to 4 months.
[58] Delays in the launch of the Contribution Program and negotiation of the inter-governmental protocol resulted in the loss of the $.5M allocation for 2003-2004
[59] The Contribution Agreement was signed in July 2004, thus reducing the implementation period.

ACTIVITIES FUNDED BY THE FEDERAL ACTION PLAN

BUILDING THE FOUNDATIONS: NETWORKING AND COOPERATION

Eleven formal networks are bringing together English-speaking minority communities and service providers at the local, regional and provincial levels. Most of these networks are working to integrate the other two measures funded under the Action Plan: the primary health care transition projects as well as language training, retention and distance service projects. This strategy has ensured that community participants in each network have a vital minimum capacity to mobilize and create networks with public partners. The institutional stakeholders are gradually committing the resources required to ensure their own participation and contribute to the achievement of shared network objectives.

Regional and Local Partnership Networks

Organization sponsoring a network	Administrative Region	Administrative sub-regions covered by the network[60]	English-speaking population (Number[61] and % of sub-region population)	
Coasters' Association	Côte-Nord	1 territory	3,560	63%
Council for Anglophone Magdalen Islanders	Gaspésie-Îles-de-la-Madeleine	1 territory	805	5.6%
Vision Gaspé Percé Now	Gaspésie-Îles-de-la-Madeleine	1 territory 1 shared territory[62]	2,630 920	13% 5.1%
Committee for Anglophone Social Action	Gaspésie-Îles-de-la-Madeleine	1 territory 1 shared territory	5,670 (920)	17.2%
Megantic English-speaking Development Corporation	Chaudière-Appalaches	3 territories	2,215 635 545	1.5% .8% 1%
Townshippers' Association	Estrie	7 territories (entire region)	23,390	8.4%
Townshippers' Association	Montérégie	2 territories	11,140 3,560	23.2% 4.3%
Catholic Community Services	Montréal	4 territories (eastern Montreal)	13,910 30,005 19,935 22,655	8.4% 24.5% 12.6% 12.5%
Regional Association of West Quebecers	Outaouais	5 territories (entire region)	53,945	17.2%
Total	7 of 16 regions (43%)	26 territories of 95 (27%)	195,520 of 918,955 (21%)	

[60] The administrative sub-territories are geographic areas to be served by health and social services centres (CSSS). Networks may not necessary cover all English-speaking minority communities in a given sub-territory, depending on the stage of network development and the degree of involvement of public partners. As well, some networks may cover small communities in an adjacent sub-territories not assigned to them above.

[61] English-speaking people are identified by mother tongue or first official language depending on which variable provides the most accurate representation of the number of English-speakers in a territory. The statistics are drawn from *Charactéristiques démographiques et sociales de la population Anglophone de chaque région socio-sanitaire du Québec*, Jan Warnke, CHSSN, September 2006. The profiles are available at http://www.chssn.org .

[62] Both Vision Gaspé Percé Now and CASA serve the English-speaking minority communities in the territory of CSSS du Rocher Percé.

Two other networks have been established to address sector and provincial needs. The Fraser Recovery Program provides programs to prevent youth and adult substance abuse. The Community Health and Social Services Network (CHSSN) fosters projects and initiatives through partnership and network building to promote access to English-language health and social services and support the vitality of English-speaking minority communities.

Sector and Provincial Networks

Organization sponsoring a network	Programs	Network Partners
Fraser Recovery Program (sector network)	-Prevention and treatment of youth and adult substance abuse -Organization of local networks to prevent substance abuse -Development of ADAPT (Alcohol and Drug Abuse Prevention Team) -Drug and alcohol awareness campaigns	-Networks in eastern Quebec (Lower North Shore, Gaspé Coast, Magdalen Islands, Quebec, Chaudière-Appalaches) -CHSSN Telehealth Program
Community Health and Social Services Network (provincial network)	-Community development and capacity building for networks and other English-speaking minority communities -Knowledge development and partnering for research -Information resources to promote data access, online information and network communication links -Innovative models of service delivery that promote Telehealth partnerships, primary health care transition, human resource retention strategies and social economy	-64 member organizations that include: • 19 community organizations with health and social services as one aspect of their mandate • 17 community resources in the health and social services sector • 10 public health and social services institutions • 3 public organizations in the education sector • 5 foundations • 7 associate members that include institutes, associations and other networks • 3 corporate members -Partnership with the Quebec Ministry of Health and Social Services for implementation of the primary health care transition projects -Partnership with McGill University for the implementation of training and human resources development initiatives

NETWORKING OUTCOMES[63]

Creation of networks

Formal networks engaging community and public partners are operating in all the target regions. The provincial network (CHSSN) has linked all the network units. Knowledge and best practices are shared between networks

[63] ENAP, *Preliminary Evaluation Report: Health and Social Services Networking and Partnership Initiative,* Quebec Community Groups Network (QCGN), November 2006.

through stakeholders' forums such as conferences and retreats. A newsletter communicates network activities to all constituencies. In each community, the networks recruited multiple partners. These include volunteers, as well as community, municipal and health and social services organizations.

Knowledge development

The provincial network produced a knowledge base for each network. Baseline data Reports and regional and local profiles of demographic and health determinant characteristics ensure knowledge-based network development. This information has assisted networks to establish needs and priorities, support community outreach and develop communication tools. Network stakeholders have affirmed that the focus on a sound knowledge base has contributed to new information on determinants of the health and well being of English-speaking minority communities.

Community participation

Through the networks, English-speaking minority communities are building relationships with health and social services institutions. The interactions have led to community participation in committees, projects and activities. This has increased the participation of English-speaking people in the health and social services system and sensitized public partners to community needs.

Identification of needs and priorities

Priorities of access to services were identified and actions undertaken in the funded communities. Data generation helped clarify the population's needs and has led to projects and Action Plans. Public partners have stated that network activities have greatly increased public sector awareness of community needs and are leading to a common understanding of issues requiring intervention.

Coordination

The identification of partnerships is resulting in better coordination of the various actors engaged in projects to adapt services or develop new service models. More coordination is likely as projects are in the early stages of development and need time to mature. Numerous network partners have discovered new community groups with the same interests. The new contacts are fostering better collaboration. Partners that had never worked together are showing more openness to the idea of sharing organizational resources with other partners to promote implementation of health and social service projects.

Volunteer development and training

Some community organizations and public partners now have access to English-speaking volunteers to assist in service delivery. Some networks have recruited a significant number of volunteers and created a data base to coordinate them. Volunteer training has been established in some networks to support their complementary role with the health and social services institutions.

Information and referral services

Networks have developed communications tools for referring English-speaking community members to existing resources and services. Many community members are now using these information services, which ensure English-speaking people are directed to the appropriate organizations.

Reorganization and development of new services

Networks are in the early stages of development and are just approaching the substantial challenges of service reorganization. As structural changes involve many actors at different levels of the public system, creating new services is a longer term network objective, although some are moving more rapidly in this direction. Reorganization and development of services is tied to the multi-step process of: development of clinical and organizational projects in each of the 95 local serevices networks; implementation of integrated university health networks for access to specialized and superspecialized services and coordination of teaching, research and training; and implementation of new public health strategies at the provincial, regional and local levels.

CHALLENGES

Sustainability

An important element of the sustainability of current network initiatives is the ongoing commitment of public partners and other community resources to work with English-speaking minority communities. This results in joint priorities and actions that address evolving community needs, provide real benefits and reflect the new context of Quebec's health and social services system.

This new context also presents challenges, as the structural changes will take time and involve many actors at different levels. It is clear that public institutions have very little or no resources to support the communities' network coordinating role over the long haul. The community partners are challenged to develop sustainability plans to secure their capacity to coordinate the networks and exercise effective leverage as recognized players in the health and social services system.

Community governance

All eleven networks function with a model of community governance to ensure the interests of English-speaking minority communities are central to the network activities. Public partners have responded well to this model and have identified benefits in participating in coordination structures that are complementary to their own formal institutional processes. The challenge is to maintain a community network governance model that does not duplicate, but contributes effectively to the institutional coordination and consultation mechanisms public partners must use to plan services for the whole population of their territory. A transfer of the community network agenda to public partners means that the specific interests of English-speaking minority communities risk being marginalized.

Vulnerable communities

The portrait of demographic and health determinant characteristics of English-speaking minority communities highlights many vulnerable communities. The current regional and local networks reach only 27% of the 95 sub-regional administrative territories that are at the heart of the populational approach to service organization. Approximately one-fifth of the English-speaking minority population lives in territories where regional and local networks are operational. Communities in the Laurentides, Lanaudière, Saguenay, Mauricie et Centre-du-Québec, Bas-Saint-Laurent and Abitibi-Témiscamingue regions are demographically vulnerable, have weak community infrastructure and experience health status inequalities. In other regions, such as Montérégie and Chaudière-Appalaches, networks do not cover all territories with vulnerable English-speaking minority communities.

The evaluation of the implementation and early results of the networks points to differences emerging between the communities participating in networks and those who are not. Participating communities are experiencing significantly more positive impacts of knowledge development, community participation, identification of needs and priorities, coordination, and volunteer training and development.[64]

The challenge is how to engage vulnerable English-speaking minority communities in the context of major reorganization of the health and social services system, when their community capacity to develop and sustain networks is very limited or non-existent.[65]

BUILDING THE FOUNDATIONS: PRIMARY HEALTH CARE

Under the auspices of the Community Health and Social Services Network, 37 primary health care transition projects were implemented in a 15 month period ending in March 2006.[66] Projects were carried out in 14 administrative regions with the aim to improve access to primary level health and social services in English and foster links between English-speaking minority communities and service providers.[67] Three priority areas were targeted: better access to health information lines (Info-Santé); improved access to front-line community-based health and social services; and adaptation of living environments in institutions to meet cultural and linguistic needs of English-speaking people.

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[64] ENAP, *Preliminary Evaluation Report: Health and Social Services Networking and Partnership Initiative,* Quebec Community Groups Network (QCGN), November 2006, p. iii-iv.
[65] The evaluation points out that a number of communities failed to apply successfully to the networking contribution program because of insufficient capacity to mobilize and perform the application task. This suggests that weaker communities need targeted support in order to successfully bid for new resources to form networks.
[66] An additional 23 primary health care transition projects are funded for 2006-2007. The projects are built on the first phase of the primary health projects by adding targeted initiatives to improve mechanisms to monitor health status of English-speaking people; adapt services as part of developing clinical and organizational projects; and strengthen partnerships between institutional and community partners.
[67] To see the results of each project, consult the *CHSSN 2004-2006 Primary Health Care Access Initiative – Project Guide*, available on the CHSSN website: http://www.chssn.org .

Service providers and community organizations surveyed on project results affirmed that conditions of access to health and social services for English-speaking minority communities improved, and that project activities are leading to an increase in demand for services by English-speaking people. Service providers believe that the projects are strengthening the capacity of their organizations to serve English-speaking minority communities. Specifically, there is an increase in personnel capable of providing service in English, services are better adapted to respond to needs and there is increased knowledge of community needs. [68] English-speaking people are becoming more informed of services as a result of strengthened ties between community organizations and service providers. The network projects in certain regions are playing a key role in producing positive results. This is the case where primary health care projects are part of the network activities in the Gaspé, Montérégie, Estrie, Montréal (east) and the Outaouais.

Reorganization of the health information system (Info-Santé)

A series of inter-related initiatives were coordinated with the implementation of a major overhaul of the Info-Santé program by the Ministry of Health and Social Services. Four centralized English-language Info-Santé centres were established in Montréal, Laval, Estrie and Outaouais. The purpose is to ensure a critical mass of bilingual nurses in designated centres to serve English-speaking people 24 hours a day, 7 days a week. To achieve this, over 1,550 protocols used by nurses to advise callers were updated and translated into English. Inventories of community resources were also updated and translated and 97 nurses received language training.[69]

Human resources recruitment and development

Eight projects recruited a total of 64 professionals to increase availability of services in English. A number of projects recruited volunteers from English-speaking minority communities to complement services. Thirty volunteers received orientation sessions. Over half the projects offered specialized language training for 391 nursing, social work and other professionals.

Translation of documents for users and professionals

Almost half of the projects translated documents for both English-speaking usersclients and the professionals designated to serve them. This activity contributed to the improvement of the offer of services. Over 791 documents and guides for English-speaking users were translated along with 288 documents for professionals.

Cooperation and partnership activities with English-speaking minority communities

Partnership activities with community organizations were considered a main action lever for service providers. Joint activities included needs assessments that in some cases led to decisions on measures to improve access to

[68] ENAP, *Final Report: Evaluation of the Implementation and Initial Impact of the Primary Health Care Transition Project of the CHSSN,* October 2006, p. iii.
[69] *Rapport final des activités et des résultats du projet « Amélioration de l'accès aux services et aux soins de santé primaires pour les personnes d'expression anglaise du Québec,* CHSSN, May 2006, p 28.

services.[70] This cooperative approach supported the joint actions of service providers and community organizations to promote the offer of services in English-speaking minority communities.

Promotion of services

Promotion activities informed English-speaking people of services in English in order to encourage greater use by communities. Over half of the projects had promotional campaigns, which included use of brochures, published notices and articles. Over 2,900 English-speakers attended orientations, forums and workshops on health promotion and related topics.

Development of informational resources

Just under half of the projects carried out studies of community needs. In some cases, the results provided information on the quality of the services and their level of use by English-speaking people. In many cases the needs surveys led to decisions regarding improvement of access to services.

The CHSSN produced extensive demographic and socio-economic profiles on English-speaking minority communities in each administrative sub-territory. The material was transmitted to the 37 project promoters and their community partners to assist them in the planning and implementing the primary health care transition projects.

Service reorganization activities

The service reorganization initiatives aimed to change the way services are provided by introducing new models of service organization. The goal was to address the problem of insufficient demand for services in English (due to under use or dispersed populations) with a structural approach to improving the offer of services. The reorganization of the health information line (Info-Santé) to create four central facilities to serve English-speaking people is the major example of this activity.

Service reorganization projects involved both inter-organizational and intra-organizational initiatives. Inter-organizational activities targeted services within a given territory and involved several organizations. An example is the Centre de santé et de services sociaux (CSSS) Pontiac in the Outaouais region, which has developed an integrated palliative care program across its territory. An interdisciplinary team was recruited and trained. A series of complementary actions included other community resources, a community hospital and its foundation, the regional development agency and organizations in the English-speaking community. The project has led to the design of a new palliative care centre to be housed at the Pontiac Community Hospital.

An intra-organizational strategy for structural change involves reorganizing services within a single organization. An example of this is the CSSS-*Institut universitaire de gériatrie de Sherbrooke* in the Estrie region, which developed a nine-person team of recreation technicians to deliver a program of individualized

[70] ENAP, *Final Report: Evaluation of the Implementation and Initial Impact of the Primary Health Care Transition Project of the CHSSN,* October 2006, p. 23.

social and educational activities for English-speaking residents in its four long-term care pavilions. The program involved families of the residents in the development phase, which also saw the recruitment and training of community volunteers to support the project.

CHALLENGES

Sustainability of results in a context of change

The measures to improve access to primary health care and first level social services occurred over a short 15 month time frame, while the reorganization of the system is to take place over a longer period. The development of the clinical and organizational projects is a key to sustaining the results of these investments in the context of reorganization of services using a populational approach. The full implementation of Quebec's 95 local services networks still lies ahead. The challenge is to ensure that the results of the early investments to improve primary level health and social services for English-speaking people are sustained and carried forward into the next phases of restructuring Quebec's health and social services system.

Complexity of service reorganization objectives

Implementing the structural changes to the system required to ensure long-term solutions to problems of access posed challenges for project promoters because of the short project implementation period. Service reorganization requires a four-step process of studies and joint activities to establish profiles of supply and demand; proposal of service delivery models; negotiating and signing of partner agreements; and implementing decisions that affect the deployment of human resources. The strategies of project promoters to influence regional decision-making processes were often limited by the actions of other stakeholders responding to different priorities, and by the hierarchical position of the project promoters in the health and social services system. The challenge is ensuring the investments aimed at structural improvements of access to services for English-speaking communities are aligned with the multi-year, multi-step reform of the Quebec system.

BUILDING THE FOUNDATIONS: TRAINING AND HUMAN RESOURCES DEVELOPMENT

The McGill University Training and Human Resources Development Project aims to ensure that Quebec's health and social services system can maintain a sufficient complement of personnel capable of providing the range of services in the English language. The university plays a key role, as it as it is the only English-language institution offering the complete range of professional degree programs in the health and social services fields. Its leadership in research is adding an important dimension to the implementation of the measures. The Community Health and Social Services Network is the principal contracted community partner responsible for ensuring liaison between the project and English-speaking minority communities.

The initiative is contributing to an enhanced capability of the Quebec health and social services system to ensure its human resources can provide continuous quality services to English-speaking people. Project measures are

supporting improvements in the range and quality of services provided to small or dispersed English-speaking minority communities. A key feature is an innovative partnership model linking the University with the 17 regional health and social services agencies, a number of health and social services institutions, language training organizations and community organizations. Their contribution is outlined in the following table. Partnership agreements are helping to increase the number of English-speaking professionals that will work in the regions. As a result, collaboration with service providers and English-speaking minority communities is creating a new role for the English-language educational milieu in training and supporting professionals who work, or intend to work, in the regions.

An advisory committee is consulted regularly on aspects of project implementation as well evaluation and research initiatives. The consultative body is comprised of mandated representatives of constituencies considered as stakeholders in the project's activities. Members include representatives of the *Ministère de la Santé et des Services sociaux*, the professional orders of social workers and nurses, public institutions, community representatives, the *Consortium national de formation en santé*, the McGill University Health Centre and academics working on the inter-university research team associated with the Project.

Partnerships and inter-sector collaboration[71]

Measure	Partner	Contribution
Language Training Program	-Community Health and Social Services Network -*Ministère de la Santé et des Services sociaux* -Health and social services agencies -Health and social services centres and their local network partners -Community-based organizations -Training organizations	-Ensures participation of English-speaking minority communities -Ensures projects are consistent with departmental priorities -Coordinates program implementation in each region -Share in assessing staff needs and in program implementation, monitoring and evaluation -Make their needs known and share in local or regional projects -Provide training and share in the trainer exchange and support network
Retention of professionals in the regions	-Educational institutions -*Ministère de la Santé et des Services sociaux* -Health and social services centres and their local network partners -Community-based organizations	-Partners with McGill project and health and social services institutions - Ensures projects are consistent with departmental priorities -Agree to maintain or create placement sites -Support institutional placement sites
Distance professional support	-McGill University Health Centre -English and French Language Centre (McGill Faculty of Arts) -*Consortium national de formation en santé* (CNFS)	-Design of distance professional support program -Design of written French program for English-speaking students who will be working in a Francophone environment -Partnership for fieldwork supervisor training program
Distance community support	-Community Health and Social Services Network	-Coordinates program implementation, monitoring and evaluation

A range of measures are being implemented. They include language training; regional retention of graduates of professional degree programs; and distance community and professional support initiatives.

Language training

In 2005-2006, the first year of the language training program, English second language training was provided for 1,427 Francophone professionals in 15 regions.[72] The training objectives were developed by each health and social services agency in conjunction with the public institutions and the English-speaking community of each

[71] McGill Training and Human Resources Development Project, *Annual Report 2005-2006,* June 2006, p. 15.
[72] Ibid., p. 9.

region. Training priorities were selected in accordance with the needs of English-speaking communities identified as part of access programs for health and social services in English to be approved by the Quebec government.

Of the personnel involved, 56% occupied posts in reception and referral services, 24% in social services posts, and 20% in health services. Eighty-one institutions participated, which included 39 health and social services centres, 14 rehabilitation centres, 8 hospitals, 6 youth centres and 6 long-term care centres.[73] In 2006-2007, all 17 regions will be participating with an expected enrolment of 2,000 Francophones.

Recruitment and retention of human resources

The aim of this pilot measure is to encourage English-speaking professionals, including students in professional degree programs, to move to or stay in the regions. The project is funding 22 pilot internship partnerships in 14 regions.[74] Each partnership involves educational institutions with one or more service providers and the local English-speaking community. An important activity is the development of student internships in Francophone institutions that will encourage these institutions to hire graduates. Nine of the partnerships are led by health and social services institutions and 6 by community organizations. There are 5 projects led by educational institutions to support student internships in the different regions.

Over 132 confirmed offers of internship have been put forward by the partnerships. The internships will help fill gaps in nursing, occupational and physiotherapy, dietetics, social work and other professions.

A range of measures are supporting the partnerships. These include an on-line supervision course to assist those in the Francophone institutions who will be supervising English-speaking students. The course was designed by the *Consortium national de formation en santé* and marks an important collaboration between the CNFS and McGill University.

As well, French language courses are being offered to bolster French-language written and oral skills of English-speaking students in professional degree programs. This is a key initiative aimed at encouraging English-language graduates to feel comfortable working in Francophone institutions, whether in the eastern sector of Montreal or in the regions. It will also help students meet the language requirements for professional accreditation in Quebec. Other activities include the creation of a bank of internship opportunities in the regions, a summer externship program and a student support program to help students offset the costs of internships away from home.

Distance community support

The distance community support program is offering distance services through videoconferencing or Telehealth to English-speaking minority communities in distant or rural regions. The Community Health and Social Services Network coordinates the measure in partnership with the McGill University Health Centre. Access to a

[73] Ibid., p. 10.
[74] Ibid., p. 12.

range of prevention and health promotion information has improved for a number of communities. Communities have acquired an expertise and a capacity to identify needs and mobilize community participation in Telehealth sessions. Partnerships have been established between English-speaking minority communities and the institutions in their region providing health promotion and prevention programs.

In 2005-2006, Telehealth programs were delivered to 11 isolated communities reaching 28 different videoconferencing sites. Programs included information on cancer, parent-adolescent communication, palliative care, prevention of drug and alcohol abuse and bereavement.[75] In 2006-2007, the program reached new communities with professionals addressing issues of attention deficit disorders, bullying in schools, mental health, and dyslexia.

Almost 700 people have participated in the sessions.[76] The Telehealth program is filling an important gap in access to public health and prevention programs in English in communities with insufficient numbers to warrant provision of the services in English by local institutions.

Distance professional support

The McGill University Health Centre is coordinating a program using Telehealth to support professionals working with English-speaking minority communities in different regions. The objective is to provide distance professional support to isolated English-speaking professionals to encourage them to remain in the regions. Also participating are French-speaking professionals serving English-speaking people who want access to English-language resources to improve their ability to serve an English-speaking clientele.

Professional development and training are aspects of new mandates accorded the four integrated university health networks (including the McGill University Health Centre), in the new context of Quebec's health and social services system. Time was required to ensure the distance professional support measure was in conformity with the new ministerial orientation assigning a corridor of access to specialized and superspecialized health services to each integrated university health network. A flexible approach was eventually sanctioned allowing the launch of the distance professional support program in March 2007.

Research program

The McGill project has supported the creation of an inter-university research team which is working to establish an infrastructure for research into questions related to communication and language training issues affecting access to health and social services for linguistic minorities.[77] The research team also provides expertise, where appropriate, to the language training component of the McGill project. Four areas of research have been identified which will eventually contribute to new knowledge relevant to communication and the delivery of services to Official Language Minority communities.

[75] Ibid., p. 13.
[76] Evaluations of the Telehealth sessions are available on the Community Health and Social Services Network website: http://www.chssn.org.
[77] Participating researchers come from McGill University, Concordia University, Université du Québec à Montréal and Université de Montréal.

CHALLENGES[78]

Integrating language training into human resources development priorities

English-language training courses for Francophone professionals have met with great success, as they were undertaken on a voluntary basis and adapted to the service context and vocabulary of the health and social services system. Other incentives contributed to this success, including provision of staff replacement costs in some instances for institutions releasing personnel for training. With over twenty different organizations providing the language training, a challenge remains with respect to establishing standardized levels of language competence required for different types of intervention. Moving to this next stage of developing training standards will help ensure that English-speaking people receive the same quality of services in English throughout Quebec. There is also the challenge of workplace integration of the language skills acquired by the professionals completing a language training program.

Quebec's human resources in the health and social services sector are in major flux due to extensive reorganization of personnel and retirement of professionals from the system. The constant movement of personnel creates major challenges for institutions aiming to ensure continuous access to services in English. The challenge is to ensure that English second language training is integrated into the human resources development plans of the institutions and that recurring resources are provided to meet ongoing needs.

Adapting internship practices in the health and social services system

The internship pilot program being developed through the 22 partnerships is seen as a means to compensate for the lack of manpower by attracting potential new employees. For the institutions responding to the needs of their English-speaking clientele, the program is perceived as very promising. Internship programs in health and social services require, in most cases, that the institutions provide personnel to supervise students. This is often seen as extra work for professionals acting as supervisors who, themselves, are often overextended. The challenge is to establish terms of remuneration of public institutions that would encourage their ongoing participation in internship programs for English-speaking students.

Francophone institutions require that students in internship programs meet French-language competency levels in order to function in a Francophone administration. The challenge is ensuring that recurring resources are available for English-language degree programs in order that English-speaking students interning in Francophone institutions have the required French-language skills.

Youth out-migration is a factor affecting many regions. The English mother-tongue community fell from 14% to 9% of the total population in Quebec in 15 years.[79] A 1991 survey carried out in English-language high schools

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[78] The challenges identified in the implementation of the training, retention and distance service measures emerged from consultations with stakeholders held by the Provincial Committee for the dispensing of health and social services in the English language, in the preparation of its opinion to the Quebec Minister of Health and Social Services on the integration of the results of the federal Action Plan measures into the health and social services system. The opinion was submitted in December 2006.

[79] Uli Locher, *Youth and Language, Volume II, Language Use and attitudes among young people instructed in English (secondary IV through CEGEP),* Conseil de la langue française (Québec), Chapter 8, 1994.

and CEGEPs (community colleges) underscored dissatisfaction with opportunities in Quebec, with 73% of English-speaking students stating they envisioned their future outside Quebec.[80] While studies estimate an actual departure rate of over 30%, the out-migration of youth is having an affect on regions. Targeted action is required to bolster the capacity of English-language professional degree programs in the health and social services fields to recruit English-speaking youth at the high school and CEGEP levels into their programs. Such a strategy would address the issue of youth retention in the regions, as well as the problem of chronic underemployment of Anglophones in Quebec's health and social services system.[81]

Recruitment and retention of professionals in the regions is a challenge for all institutions regardless of language. It also affects regions like Montreal, which risks losing graduates through recruiting efforts of other regions or provinces. In a context of competition for human resources, and difficulty attracting professionals to the regions, drawing English-speaking professionals to intern and then work in distant regions requires extra effort from all partners concerned. In this regard, a long-term investment is required in order to encourage knowledge-building and new evaluation approaches that can contribute to the development of effective recruitment and retention strategies.

Organizational and capacity challenges for Telehealth

Videoconferencing is an effective way to serve English-speaking minority communities in distant or rural regions. These are communities that would not otherwise have access to public health programs that are available to the majority community. Quebec's telecommunications network supporting videoconferencing capacity is at its limit with respect to its ability to support a growing volume of activities. With an increasing burden on the transmission network, distance community support programs are not necessarily perceived as a service priority. The challenge is to establish protocols of access to the telecommunications system that recognize that the distance community support programs fall within the objectives of Quebec's public health strategy, and that access to the telecommunications network be assured for programs destined for English-speaking communities.

The establishment of the integrated university health networks with designated corridors has created ambiguity with respect to mandates to provide services to English-speaking minority communities located outside the designated corridor of the McGill University Health Centre. The challenge is to ensure that in the implementation of the new corridors of access to specialized and superspecialized health services, the needs of all English-speaking minority communities are taken into account; and that ministerial orientations explicitly recognize the obligation for integrated university health networks to undertake agreements between themselves to ensure full access to these services, including those delivered by Telehealth.

[80] Ibid., Chapter 10.

[81] CCESMC, *"Building on the Foundations – Working Toward Better Health Outcomes and Improved Vitality of Quebec's English-speaking Communities"*, Compendium of Demographic and Health Determinant Information on Quebec's English-speaking Communities, Table: *Employed in Health Care and Social Assistance,(MMI), Quebec, 2001,* 2007, p. 154.

ACTIVITIES NOT FUNDED BY THE FEDERAL ACTION PLAN

Two other levers proposed by the CCESMC in its 2002 Report were not identified in the federal Action Plan. Notwithstanding, a strategy was implemented to move forward in the areas of research and strategic information, and technology. As well, initiatives were supported by the Public Health Agency of Canada through the Population Health Fund that complement the Action Plan investments.

BUILDING THE FOUNDATIONS: RESEARCH AND STRATEGIC INFORMATION

Two principal factors characterized the situation of research on English-speaking minority communities at the time of the Committee's 2002 Report to the Minister. First, there was no coordinated strategy in the research community to pursue research on English-speaking minority communities in Quebec. Second, there was a general state of institutional disengagement with little incentive for researchers to pursue the community as an area of study. Research focussing on Official Language Minority Communities has not been recognized as a mainline fundable field of research.

Since 2004, the Quebec Community Groups Network (QCGN) and the Community Health and Social Services Network (CHSSN) have pursued a coordinated knowledge generation and research strategy, which is now delivering promising results. The QCGN mobilized the research community by holding a conference in 2005 that laid the groundwork for the creation of a research network, and has defined research as one of its key strategic orientations. The QCGN is pursuing concrete initiatives such as the development of an inventory of researchers, and the creation of a single-window, virtual community resource as a knowledge base for use by communities, researchers, planners and policy-makers. The QCGN is also developing its capacity to produce trend studies on the vitality of English-speaking minority communities in Quebec as part of its knowledge generation strategy.

The CHSSN focussed on knowledge development, knowledge dissemination, and research partnerships within the university milieu. It has compiled demographic data, survey information and health determinant profiles that provide comprehensive portraits of the health status and vitality of English-speaking minority communities in Quebec. Three Baseline Data Reports, a Centre *de recherché sur l'opinion publique* (CROP) survey, an interactive data model with census information and community health survey data are products of this initiative. This new information is being actively disseminated to community, institutional and government stakeholders.

The CHSSN partnership with the McGill Training and Human Resources Development Project is shaping a community-institutional research partnership and creating momentum to define thematic orientations of research on the health of English-speaking minority communities. A CHSSN research symposium in February 2006 brought together researchers and community and public partners to share information and best-practices on research, evaluation and community development initiatives. This information-sharing encouraged stakeholders, but also underscored gaps in the promotion of research, evaluation and knowledge dissemination in support of the vitality of English-speaking minority communities.

Other initiatives are helping to position stakeholders for more concerted action. The inter-university research team associated with the McGill project is actively pursuing participation in strategic research networks to

contribute to sharing, access and application of research knowledge. Eventual links between researchers in Quebec, the rest of Canada and beyond can serve as an important lever in efforts to define national objectives supporting research on Official Language Minority Communities. In this regard, joint participation of English and French-speaking representatives on the advisory committee to the Canadian Institutes of Health Research (CIHR) is an important step. CIHR has adopted a three-year strategic plan which, among other goals, aims to define a domain of research on the health of Official Language Minority Communities and establish partnerships to fund identified research themes. The work of the Statistics Canada Post-Censal Survey advisory group and the creation of the Canadian Heritage- Social Sciences and Humanities Research Council (SSHRC) research program are other examples of actions that are slowly advancing the research agenda.

Challenges

While there has been significant progress in mobilizing key actors to define a research strategy for English-speaking minority communities, there are significant challenges to achieving desired outcomes. The domain of research on Official Language Minority Communities is not recognized as a priority. Consequently, mobilization of research, particularly within large university settings, is difficult in the absence of a defined field of research.

Building the foundations: Technology

Telehealth

The Committee's 2002 Report to the Minister identified technology as a lever to extend the provision of health services to distant, dispersed or rural English-speaking communities in Quebec. The proposed measures aimed to expand the use of Telehealth and Telemedicine; support the development of multi-disciplinary intake centres for distance services; and develop enabling connectivity and technology infrastructure. A multi-year Telehealth partnership between McGill University, the McGill University Health Centre (MUHC) and the Community Health and Social Services Network has established this lever as a service delivery model for English-speaking minority communities. An evaluation by McGill of an earlier pilot project testing video technology as a service delivery model for psycho-social intervention and health promotion concluded that the technology conformed to professional standards of practice.[82]

The CHSSN and the MUHC continued the development of a Telehealth program for English-speaking minority communities with short-term project funding until the absorption of the program by the McGill Training and Human Resources Development Project. A three-year program is now underway and delivering substantial results for English-speaking minority communities. The MUHC-CHSSN Telehealth partnership has been identified in the MUHC Strategic Plan, approved by the *Ministère de la Santé et des Services sociaux*. It is in conformity with the MUHC designation as an integrated university health network, defining service access corridors with 22 local services networks in seven regions.[83]

[82] The Centre for Applied Family Studies, McGill University School of Social Work, *Evaluation Report: Patient and Community Support Network,* March 2003.
[83] Agreements between integrated university health networks to ensure English-speaking minority communities in all corridors have access to specialized and superspecialized services are pending.

Challenges

A sustainability plan is required to significantly expand Telehealth as a normal cost-effective model of delivery of English-language services, within the new context of the organization of health and social services in Quebec.

Community Learning Centres

The second technology measure proposed by the CCESMC is the development of multi-disciplinary intake centres for distance services. The CHSSN invited the *Ministère de l'Éducation, du Loisir et du Sport* (MEQ) and the Quebec English School Boards Association to test the concept as part of its community vitality survey conducted by CROP in 2005.[84] The survey results showed very strong support for the 'community school' concept, and health and social services was identified as one of the needs to be addressed. The MEQ subsequently launched a pilot program to create 15 Community Learning Centres in October 2006.

The development of Community Learning Centres offers an opportunity for community and institutional stakeholders promoting improved access to health and social services for English-speaking minority communities to participate in partnerships with schools interested in this community component.

In the development phase of the Video Collaboration Network that will link the 15 centres, the CHSSN will contribute program proposals for the delivery of health and social services to the Community Learning Centres through the CHSSN Telehealth Program, in collaboration with the McGill University Health Centre and the Jeffery Hale Hospital. The CHSSN is a member of the resource advisory group to the MEQ project and is preparing to contribute its expertise in the areas of: team consultation; information and materials on population health strategies; demographic and health determinant profiles; service delivery models; and community development strategies.

CHALLENGES

The Community Learning Centres are pilot projects that will test the feasibility of opening up schools to their communities through the development of partnerships with the public, private and community sectors. If the model is successful, resources will be required to extend the model to other communities and increase the investment in community capacity to coordinate distance community support programs in the area of public health.

BUILDING THE FOUNDATIONS: POPULATION HEALTH

In 2007, the CHSSN completed implementation of a five-point community health promotion strategy for English-speaking minority communities.[85] The three-year project was funded by the Public Health Agency of

[84] *CHSSN-CROP Community Vitality Survey,* 2005.
[85] The project built on a CHSSN initiative launched in 2003 "A Community Guide to the Population Approach". The purpose of the guide was to introduce community organizations to the population health approach to defining need, priorities and action to improve health determinants affecting English-speaking minority communities. The project "We

Canada through the Population Health Fund. It promoted participation of English-speaking communities in the development of health promotion strategies and strengthened their role in Quebec's health and social services system. Initiatives were launched to engage different sectors and bring English-speaking minority communities directly into the development of population health models in the newly created local services networks.

The project strengthened community capacity in 10 target communities to map health determinants to promote collaboration between communities, planning authorities and service providers. The CHSSN-CROP survey produced new information on the vitality of English-speaking minority communities, and a report on the status of social support networks in English-speaking minority communities was published.[86] The strategy targeted the communities of the Lower North Shore and the Gaspé coast for development of pilot social economy projects to create new resources serving health and social services needs. A provincial conference took place in February 2006, bringing together all stakeholders involved in initiatives to improve access to health and social services for Quebec's English-speaking communities.

CHALLENGES

The next project phase projected for 2007-2008, will focus on delivery of adapted public health programs to target English-speaking minority communities in collaboration with the *Institut national de santé publique* along with regional and local public health programs. An invitation to share best practices with other community networks outside of Quebec will be developed, particularly with networks serving minority French-speaking communities. As well, important new census information on English-speaking minority communities will help update demographic and health determinant profiles.

The health promotion initiatives will serve to support the participation of English-speaking communities in the implementation of Quebec's Public Health Plan establishing the framework for new public health initiatives at the provincial, regional and local levels. The CHSSN will also seek to ensure English-speaking minority communities are stakeholders in the development of a new national Public health strategy.

Can Act" moved to the next phase of implementation of a health promotion strategy in English-speaking minority communities using approaches enunciated in the guide.

[86] Joanne Pocock, *Social Support Networks in Quebec's English-speaking communities,* CHSSN, April 2006.

Blueprint for action: Strategies for results

All stakeholders involved in the implementation of the federal Action Plan have participated in efforts to ensure that results of the measures are sustained in English-speaking communities and Quebec's health and social services system. The provincial network (CHSSN) brought stakeholders together in February 2006 to review progress and identify strategies to effect long-term change. The provincial network developed a strategic orientation and sustainability plan to act as a blueprint to guide collective efforts to maximize the benefits of current investments and set the stage for future action. Four linked strategies have emerged and serve as the foundation for action to improve health outcomes and the vitality of English-speaking minority communities in the period ahead.

Strategy one: Consolidating new networks of communities and public partners

Formal networks of communities and public partners are a key to sustaining improvements in access and effecting the organizational changes in the system to meet long-term goals. The networking measure is helping to create durable partnerships between communities and the broader health and social services system, as well as reinforcing links between English-speaking minority communities, their resources and their historical institutions.

Engagement of the community's historical institutions with English-speaking minority communities is an important element of network sustainability. McGill University's role in implementing measures in communities and the health and social services system, along with supporting an inter-university research program to create new knowledge, is a major new development. The partnership of the McGill University Health Centre Telehealth Program with the CHSSN demonstrates a capacity to deliver new services to English-speaking minority communities. Other historical institutional stakeholders are actively engaged in the networking model, such as the West Montreal Readaptation Centre in the McGill internship program and Saint-Brigid's Home-Jeffery Hale Hospital in the CHSSN primary health care transition project.

The health and social services system is demonstrating new openness to addressing the needs of English-speaking people in a context of major reform. This is evident in the willingness to adopt strategies to integrate and sustain current investments and welcome new initiatives. The 11 new networks supported by the Action Plan are showing that public partners can become comfortable in functional relationships with English-speaking minority communities. Each network has developed a sustainability plan involving its public partners in order to promote the long-term viability of the network units.

The provincial network is a key actor in mobilizing efforts to sustain the new networks. Its network model links 65 community organizations, public institutions, foundations, and other stakeholders dedicated to a common purpose of promotion of projects and partnerships to improve access to health and social services for English-speaking minority communities. The *Ministère de la Santé et des Services sociaux* has become an important collaborator with the provincial network in the implementation of the primary health care transition projects. It has provided support to McGill University in the implementation of the Training and Human Resources Development Project. This new relationship with the senior-level public administration is a pivotal one, and essential to the success of strategies to integrate the current federal investments and to setting the stage for future initiatives.

STRATEGY TWO: FIVE STRATEGIC ENTRY POINTS FOR ACTION TO IMPROVE HEALTH OUTCOMES

Development of new models of service delivery is essential to adapting the organization of services in the health and social services system in order address new priorities for improvement of health outcomes in English-speaking minority communities. The current stage of reform of the Quebec system presents opportunities to introduce measures of improvement into emerging clinical and organizational projects. Other opportunities exist with the establishment of integrated university health networks and the implementation of the Quebec Public Health Program 2003-2012.

The evaluation of the first effects of the primary health care transition projects showed that initiatives aimed at the reorganization of services were the most difficult to implement because of the complexity of long-term system change and the limited scope of short term projects in influencing the larger context. While many measures were deemed as successful in the short term, with respect to improvement of the offer of services in English, project promoters and community partners identified sustainability as a major issue.[87] Consequently, a strategy is proposed to target points of entry in order to maximize capability of service providers to ensure access and improve health outcomes in English-speaking minority communities. The goal is to secure continuous and quality services in English as a permanent feature of Quebec's health and social services network.

Incubation of new service models

The development of new models of services delivery that are incubated and introduced into the system is an innovative approach to effecting the structural changes necessary to create the critical mass of demand to justify service offers.

The model for the organization of services to the English-speaking population of the Québec region is an example of adapted service model development. The integration of the Jeffery Hale Hospital, Saint Brigid's Home and the Holland Centre aims to make the widest possible range of primary level health and social services available to the English-speaking community. These services include: general medical services; services for

[87] ENAP, *Final Report: Evaluation of the Implementation and Initial Impact of the Primary Health Care Transition Project of the CHSSN,* October 2006, p. iii.

seniors ranging from a day centre to long-term care; and services for families, youth and adults that include early childhood services, a “Healthy Schools” program, and mental health services.

The model concentrates demand in order to create sufficient client bases. It regroups service providers and professionals for whom serving the English-speaking population is a priority. It also works within the public system through partnerships in order to extend the range of accessible services.

The innovative service model is demonstrating other promising gains. It is enhancing participation in clinical projects being developed by certain health and social services centres; ensuring participation in regional coordination mechanisms involving other service providers; developing information and analysis of the English-speaking population and its needs; developing new services; developing research partnerships and disseminating the model to other English-speaking minority communities through its partnership with the Community Health and Social Services Network.

A second example is the use of Telehealth to deliver prevention and promotion programs to isolated or underserved English-speaking minority communities. These programs include cancer prevention, mental health, drug and alcohol addiction, bullying, dyslexia, attention deficit disorders, among others. The community partnership with McGill University and the McGill University Health Centre has resulted in an innovative service model that was initially evaluated as effective, but has not been integrated into the system and recognized as a normal platform for delivery of prevention and promotion programs in English. The incubation of the service model has reached a stage where combined efforts of the institutional and community partners are required to move the model from the “incubator” into the system itself. This will require further evaluation in order to promote the model in the new context of organization of services. Mobilization of Quebec’s four integrated university health networks and the public health system will be a critical part of the next stage. A desired outcome is improved delivery of Telehealth that supports expansion of the range of health promotion programs available to more English-speaking minority communities.

Broad system intervention

Effecting strategic system-wide changes that have structural or long-term impacts on access to English-language services is a second entry point for action. One example is the reform of the Info-Santé system. Significant infrastructure adaptation was undertaken to create four central operations to ensure 24 hour, 7 day a week access to the health information line in English. The full implementation in accordance with orientations of the Québec *Ministère de la Santé et des Services sociaux*, requires that further investments be made to ensure that the expanded mandate to include social interventions takes into account the needs of English-speaking people. As well, sustained action is needed to ensure that prevention and promotion programs under the Public Health Program, delivered through Info-Santé and Info-Social, are adapted for English-speaking people. This requires translation of response protocols for campaigns that address, among other public health issues, West Nile Virus, SARS, outbreaks of hepatitis and contaminated drinking water warnings.

Another example of broad system intervention is a CHSSN proposal, supported by a provincial advisory body to the Quebec government, to reform client information systems in the health and social services network.[88] Currently, client information systems do not systematically track English-speaking clientele. As the *Ministère de la Santé et des Services* sociaux launches a major upgrade of client tracking systems, a strategic intervention to ensure new systems identify English-speakers would address a serious gap in the current capacity of the health and social services system to identify the needs of English-speaking service users. The lack of client information about English-speaking users often means that consideration of their needs is absent from planning, and subsequently absent from service programs.

Adaptation of clinical and organizational projects

Each of the 95 newly created health and social services centres are responsible for defining clinical and organizational projects to ensure that the entire population of its territory has continuous access to a broad range of general, specialized and superspecialized health services and social services. The elements comprising each plan include: the social and health needs as well as distinctive characteristics of the population; the objectives to be pursued to improve the health and well-being; the supply of services required given needs and particular population characteristics; and the organizational structures to deliver services.

The clinical and organizational projects are at the core of the exercise of the new population-based responsibilities coordinated by the health and social services centres. They constitute a natural entry point for federal resources supporting new priorities to improve health outcomes for specific population groups. A targeted federal contribution would constitute an important lever supporting Quebec's initiatives to improve access to services for English-speaking communities in eight intervention programs defined for the whole population. These programs are:

- Public health;
- Physical health;
- Seniors and those with loss of autonomy;
- Youth and families;
- Mental health;
- Physical disability;
- Intellectual disability and development disorders; and
- Alcohol and drug addiction.

[88] Letter from the Committee for the dispensing of health and social services in the English language to the Quebec Minister of Health and Social Services with respect to its opinion regarding the integration of the results of the federal Action Plan into the health and social services system, December 19, 2006.

Sustaining improvements in health outcomes for English-speaking minority communities is an objective shared by English-speaking minority communities and the public institutions that serve them. The *Ministère de la Santé et des Services sociaux* has set guidelines that link the development of the clinical and organizational projects with the development of programs of access to health and social services in English.[89] The access programs are approved by the Quebec government and establish the entitlement of services in English by identifying in decrees the service providers and the programs they offer in English.

Adaptation of service 'corridors' and integrated university health networks

Institutions must establish service 'corridors', or channels in which patients can move from one tier of medical services to another. These include local hospital medical services, usually part of the health and social services centre, regional medical services of a regional hospital centre, and provincial services provided by university hospital centres and university-affiliated institutions and hospital centres. The corridors correspond to particular health issues such as cancer, loss of autonomy through aging, chronic disease, and others. Service continuity is ensured by referral mechanisms and special agreements between institutions in a given 'corridor' arrangement.[90] A government social and health survey determined that 27% of people waiting three months or longer to see a medical specialist considered that the delay in consultation was too long.[91] The introduction of service corridors will help address the issue of timely access to specialized and superspecialized medical services.

An opportunity to introduce measures to promote timely access for English-speaking people is opening up with the procedure each health and social services centre must undertake to establish service agreements to cover the needs of the population. The agreements must provide for patients to be returned to their health and social services centre of origin when specialized or superspecialized medical services are no longer needed. Models of tracking and referral of English-speaking patients and conclusion of agreements that ensure linguistic needs are met are actions that promote adaptation of tiered medical services.

Each of four integrated university health networks has a main territory for which it is responsible for providing superspecialized services for a target clientele. The networks also have territorial mandates as teaching hospitals with respect to training of personnel. Although there is no absolute application of territorial exclusivity in order to respect patients' and professionals' freedom to choose, the integrated university health networks are concentrating efforts on organizing services to meet needs of the other tiers of medical services in their assigned 'corridors'.

An entry point for new models of service delivery for English-speaking people lies with both intra and inter-network agreements that will be necessary to ensure that English-speaking people that are unable to be served in English in their 'corridor' of residence, can be served by another university health network.

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[89] *Frame of reference for the implementation of programs of access to health and social services in the English language for English-speaking persons,* MSSS, March 2006.
[90] *Guaranteeing Access : Meeting the challenges of equity, efficiency and quality,* MSSS, 2006, p. 24.
[91] *Enquête social et de santé 1998,* Institut de la statistique du Québec, Gouvernement du Québec, 2001, p. 397.

Adaptation of prevention and promotion initiatives

The Quebec Public Health Program 2003-2013 identifies the strategies to guide action to improve the determinants of the health and well-being of the Quebec population. The public functions include: surveillance of health status and its determinants; promotion of health and well-being; prevention of diseases, psychosocial problems and injuries; and health protection. Six areas of intervention form the basis of public health programs at the provincial, regional and local levels. They include: development, social adjustment and integration; lifestyles and chronic diseases; unintentional injuries; infectious diseases; and environmental and occupational health.[92]

The development of regional and local Action Plans that determine the public health programs offered in each region and local territory is an essential first step to ensure implementation of the Public Health Program. The plans constitute an important entry point for models of delivery of public health programs to English-speaking minority communities. In light of the poor level of access to public health information experienced by English-speakers[93], innovative models, such as Telehealth, can be introduced into regional and local plans as a means to reach all English-speaking minority communities.

STRATEGY THREE: INFORMING PUBLIC POLICY AND INFLUENCING GOVERNMENT ACTIONS

Governments and their agencies are important stakeholders in the implementation of strategies to improve access to services for English-speaking minority communities. Informed public policy and effective government action is an essential condition for the success of efforts to consolidate gains and secure resources over the long-term to support the vitality of English-speaking minority communities. Demonstrating the impact of investments not only meets accountability requirements, but is also an important tool in shaping public policy that will have a long-term impact on health status and vitality of communities. Evaluation of results is therefore an important means for government to assess its current commitments and decide future action.

The Community Health and Social Services Network is promoting a joint review of the evaluation results by the three promoters of the federal Action Plan measures.[94] The objective is to encourage knowledge transfer among the organizations sponsoring the measures and prepare for a coordinated strategy to take key recommendations forward to policy-makers, planners and decision-makers at both levels of government. An examination of the combined effects of the three measures will support a coordinated strategy to integrate the results of the measures into Quebec’s health and social services system. A joint evaluation review will assist bodies advising both levels of government on the definition of new priorities and actions.

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[92] *Main Québec health and social services prevention and promotion initiatives,* MSSS, 2003.
[93] Joanne Pocock, *Baseline Data Report 2005-2006,* CHSSN, February 2006, p. 85.
[94] The *École nationale d’administration publique* (*Centre de recherche et d’expertise en évaluation*) is evaluating the three Action Plan measures. Evaluations were carried out of the networking measure (Quebec Community Groups Networks) and the primary health care transition measure (Community Health and Social Services Network). Evaluation is underway of the training and human resources development measure (McGill University).

The Committee for the dispensing of health and social services in the English language[95] has played an important role in advising the Quebec Minister for Health and Social Services on the integration of the federal investments into the health and social services system. The mandate of this government-appointed body complements that of the federal advisory committee (CCESMC). In a recent opinion provided to the Minister, the provincial committee recommended a series of ministerial actions that would support the integration of the results of the Action Plan measures into the health and social services system.[96] Of significance is a recommendation that the Minister commit, on behalf of the Government of Quebec, to renewing an agreement with the Government of Canada, in order that the federal government can continue to make a contribution to Quebec's initiatives to improve access to health and social services in English.

STRATEGY FOUR: STRATEGIC KNOWLEDGE DEVELOPMENT

Developing strategic knowledge is crucial for mobilizing all stakeholders engaged in initiatives to improve access to English-language services. Two principal activities characterize this strategy: knowledge development and dissemination; and promotion of research partnerships in the university, institutional and community milieus.

Demographic data, survey information and health determinant profiles are providing comprehensive portraits of the health status and vitality of English-speaking minority communities in Quebec. This information has been generated by the provincial network and is used in network-building. The availability of reliable and detailed data on English-speaking minority communities has provided community organizations, service providers and planners with valuable new information which is modifying perceptions of the health status of English-speaking minority communities and supporting actions to address priorities. An example of this is the publication by the CHSSN of socio-demographic data on the English-speaking population of each of the 95 territories served by the health and social services centres. The release of this information was timed for the process of revision of access programs of services in English coordinated by the health and social services agencies. The new information is also valuable for the preparation of clinical and organizational projects, and supporting communities in knowledge-based community development.

The strategy promoting research partnerships supports a range of opportunities. Stakeholders are involved in efforts to develop inter-university research programs, create community-university research alliances and develop at least one national strategic cluster to promote access to research knowledge. Other research partnership initiatives are promoting research links between community and service providers in order to develop an applied research approach specifically addressing the realities of institutional and community environments.

[95] The advisory body is comprised of representatives of English-speaking minority communities appointed by the Minister and has a legislated mandate to advise the Quebec government on access to English-language health and social services and on the approval of access programs of services in English.
[96] *Avis sur les mesures à prendre pour améliorer la prestation des services de santé et des services sociaux en langue anglaise,* Committee on the dispensing of health and social services in the English language, December 2006.

One outcome of current research partnership initiatives is a shared understanding of the long-term nature of research, and the considerable mobilization effort required to generate support to carry it out. Representation on advisory bodies to Canadian Institutes of Health Research and Statistics Canada is an important aspect of this mobilization effort. Promotion of active links between researchers and research partnerships associated with the Official Language Minority Communities is an important development in the broader effort to promote a national research agenda.

NEEDS, PRIORITIES AND RECOMMENDATIONS

The following Intervention Plan proposes actions that build on progress and address new challenges regarding promotion of the health and well-being of English-speaking communities in the context of ongoing reform of Quebec's health and social services system.

INTERVENTION PLAN

MAINTAINING AND BUILDING NETWORKS OF COMMUNITIES AND PUBLIC PARTNERS

Needs and priorities:

- Structural changes to the health and social services system aiming to improve access to services for English-speaking minority communities will take time. Public institutions have little or no resources to support the communities' network coordinating role over the long-term if current support is reduced or withdrawn.

- Networks function effectively under community governance in order to ensure the interests of English-speaking minority communities are fully represented in the public system. If network funding ceases or is reduced, transfer of the community agenda to the coordination and consultation mechanisms of majority institutions risks marginalizing the concerns of English-speaking minority communities in the planning and delivery of services.

- Demographic and health determinant information points to many vulnerable English-speaking minority communities. Current networks reach only 27% of administrative territories comprising 21% of Quebec's English-speaking population.

- Implementation of networks shows differences emerging between communities with and without networks. Communities with networks are experiencing more positive impacts of the different measures aiming to improve access to health and social services in English.

Recommendations:

It is proposed that:

1. Based on an evaluation of the results achieved, the 11 networks currently funded receive ongoing stable funding beyond 2007-2008;

2. Vulnerable communities in another 24 territories, comprising up to 30% of Quebec's English-speaking population, receive support for the development of networks; and

3. Vulnerable communities unable to mobilize resources to participate in calls for network proposals receive special funding to assist them in accessing a network development program.

STRATEGIC LONG-TERM INVESTMENT IN NEW MODELS OF SERVICE ORGANIZATION TO IMPROVE HEALTH OUTCOMES FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

Needs and priorities:

- The measures to improve access to primary health care and first level social services occurred over a short time frame, while the reorganization of the system is taking place over a longer period.

- All stakeholders recognize that current investments in the improvement of primary health care for English-speaking minority communities must be sustained and carried forward into the next phases of restructuring Quebec's health and social services system.

- New priorities of Canada's Government to improve the health of specific populations requires that new federal resources earmarked to improve health outcomes of English-speaking communities be integrated into the relevant intervention programs of Quebec's new community-based services. These services aim to serve the needs of local populations, including English-speaking minority communities.

- New federal investments are required to support structural improvements in the organization of services to English-speaking minority communities. New federal investments must be aligned with the multi-year, multi-step reform of the Quebec health and social services system.

Recommendations:

It is proposed that:

4. Designated portions of federal funding to improve the health of Canadians and, in particular, to support Quebec's initiatives to reform its health and social services system, be directed to the development of new models of service delivery for English-speaking communities in a manner consistent with Quebec's multi-year reform plan; and

5. A multi-year federal contribution be accorded for the development of new models of service delivery for English-speaking minority communities in accordance with five strategic areas of intervention to ensure lasting effects of measures to improve access to health and social services in English. They are:

    - Support for institutions acting as incubators of new models for eventual integration into the system;

   - Broad system interventions that maximize the impact of improvement measures in the health and social services network, such as Info-Santé and Info-Social, and client information systems;
   - Adaptation of clinical and organizational projects;
   - Adaptation of service corridors and integrated university health networks; and
   - Adaptation of prevention and promotion programs.

MAINTAINING AND EXPANDING TRAINING AND DEVELOPMENT OF HUMAN RESOURCES

Needs and priorities:

- The demand of Francophone professionals to receive English-language training is exceeding the original forecast by 37%.
- Quebec's human resources in the health and social services sector are in constant movement due to extensive reorganization of personnel and retirement of professionals from the system. This poses major challenges for institutions striving to ensure its personnel can provide continuous quality services in English.
- A challenge exists with respect to standardization of the levels of language competence required for different types of professional intervention.
- A challenge exists with respect to integration into the workplace of the language skills acquired by professionals participating in language-training programs.
- There is a lack of recurring support for language training in professional development budgets allocated to each region.
- Second language training is not necessarily integrated into the human resources development plans of public institutions.
- Adapting internship practices in the health and social services system to attract English-speaking professionals poses challenges for institutions, which lack personnel and resources to support internship programs.
- Youth out-migration and underrepresentation of English-speaking professionals in Quebec's health and social services system are two factors supporting the need for targeted action to attract English-speaking youth into English-language professional degree programs in the health and social services fields.

- Recruitment and retention of professionals in the regions are a challenge in the context of scarcity of human resources. Recruitment and retention of English-speaking professionals presents additional obstacles because of incentives to leave Quebec, lack of comfort working in a Francophone milieu, lack of professional supports and lack of sufficient French-language competency to join a professional order or meet the language requirements of a Francophone administration.

- The expansion of the demand of English-speaking minority communities for public health programs delivered through Telehealth is placing greater pressure on the limited resources available for this program.

- More extensive evaluation is required of the Telehealth program to validate best practices and test feasibility for its general application to delivery of public health programs for English-speaking minority communities.

- Videoconferencing to provide English-language prevention and health promotion programs to distant or isolated English-speaking communities is not recognized as a priority program for use of Quebec's telecommunications network.

- The creation of integrated university health networks with designated 'corridors' for access to services requires agreements to ensure all English-speaking minority communities have access to Telehealth programs providing public health information in their language.

- More extensive evaluation activities are required of the longer term impacts of language training on the offer of services in English. More evaluation is required to determine best practices emanating from pilot partnerships promoting internship programs to recruit English-speaking students to the regions.

Recommendations:

It is proposed that:

6. A multi-year federal contribution be accorded for the training and development of human resources of Quebec's health and social services system to support their capacity to serve English-speaking people in their language;

7. A second phase of language training place priority on development of a model to document and evaluate the impact of different variables related language training and their effect on the offer of services in English;

8. A second phase of language training place a priority on: (a) the development of measures to support maintenance of second language skills that include professionals, training organizations and other stakeholders; (b) the integration into the workplace of the language skills acquired by professionals participating in language-training programs;

9. A second phase of internships and retention initiatives place priority on development of tested models of internship and retention of professionals in the regions;

10. A second phase of internships and retention initiatives place priority on targeted action to increase the capacity of English-language professional degree programs in the health and social services fields to recruit English-speaking youth into their programs;

11. A second phase of distance community support be extended to increase capacity to provide public health programs to isolated or underserved English-speaking minority communities. A priority should be placed on an evaluation of best practices and the impact of the measure on the offer of services in English;

12. A second phase of distance professional support be funded in order to extend capacity in accordance with the development of corridors of access to specialized and superspecialized health services to each integrated university health network;

13. A new investment in training and human resources development encourage knowledge-building, new evaluation approaches and support a research promotion program; and

14. A new investment in training and human resources development promote information technologies as a means of supporting professional development through networking between health and social services professionals serving distant or isolated English-speaking minority communities, and other professionals serving English-speaking people.

PROMOTING RESEARCH AND STRATEGIC INFORMATION

Needs and priorities:

- Research focussing on the health of Official Language Minority Communities has not yet achieved the status of a fundable field of research within major funding bodies.

- Progress is slow regarding development of a coordinated strategy in the research community to pursue research on the health of English-speaking minority communities in Quebec. There is currently little incentive for researchers to pursue the community as an area of study.

- Mobilization of research, particularly within large university settings, is difficult in the absence of a defined field of research.

- English-speaking minority communities need more resources to develop capacity to generate knowledge and act as full partners in research.

Recommendations:

It is proposed that:

15. A federal action plan with dedicated funding for research on Official Language Minority Communities be implemented; and

16. A federal action plan include the following elements:

    - Coordinated departmental commitments to fund research;
    - A national policy to promote Official Language Minority Communities as a research field in order to orient research funding bodies to open competitions;
    - Creation of university chairs and training programs to recruit young researchers;
    - Creation of joint research funding programs involving federal departments and the research bodies;
    - Promotion of data access protocols with Statistics Canada;
    - Implementation of a funding program to promote community capacity to generate knowledge and research and participate in research partnerships; and
    - A strategy to link research between Official Language Minority Communities and with Quebec universities and funding bodies;
    - A funding program to support knowledge transfer through partnerships between learning institutions and English-speaking minority communities in order to promote the widest application of new knowledge.

PROMOTING TECHNOLOGY TO BETTER SERVE ENGLISH-SPEAKING MINORITY COMMUNITIES

Needs and priorities:

- English-speaking minority communities experience a low level of access to public health information provided by public institutions.
- English-speaking minority communities in isolated regions and rural areas experience obstacles in accessing prevention and health promotion information due to a lack of critical mass to warrant an offer of services in English in their region.

- A sustainability plan is required to significantly expand Telehealth as a normal cost-effective model of delivery of English-language services, within the new context of the organization of health and social services in Quebec.

Recommendations:

It is proposed that:

17. Envelopes to develop services to English-speaking minority communities be earmarked in major infrastructure programs such Canada Health Infoway, the Canadian Foundation for Innovation and other federal contribution programs supporting Quebec's Telehealth development; and

18. Federal interdepartmental partnerships with the English-speaking minority communities support expansion of the role of new Community Learning Centres in the delivery of health and social services in English. Specifically, funding would increase community capacity to coordinate distance community support programs in the area of public health using new videoconferencing networks.

PROMOTING POPULATION AND PUBLIC HEALTH STRATEGIES FOR ENGLISH-SPEAKING MINORITY COMMUNITIES

Needs and priorities:

- English-speaking minority communities continue to experience a low level of access to public health information provided by public institutions.

- Certain target communities are successfully applying health promotion strategies that support mapping of health determinants, engaging different sectors and bringing English-speaking minority communities directly into the development of population health models in newly created local services networks.

- Adapted Quebec public health programs to target English-speaking communities are required to ensure that English-speaking people have the same level of access to prevention and health promotion programs as the rest of the population.

Recommendations:

It is proposed that:

19. A federal contribution be provided to Quebec's English-speaking communities in order to support their participation in Quebec's Public Health Plan establishing new public health initiatives at the provincial, regional and local levels; and

20. The Public Health Agency of Canada actively promote English-speaking minority communities as stakeholders in the development of a new national public health strategy.

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