5. Healthcare & Social Services.

5.1. Ensuring the Full Range of Health and Social Services for Quebec's English-speaking population in the English language.

Key Takeaways:

OVERALL OBJECTIVE:

Ensure the same level of quality of health and social services to Quebec residents who are more comfortable in receiving their services in English as those Quebec residents who receive their services in French.

- **Common sense recommendations that will achieve the above objectives and lead to a better, more efficient healthcare system with better outcomes for all Quebecers.**

Unlike all other political parties, the *Canadian Party of Quebec* believes in straight talk when it comes to offering the full range of health and social services **(HSS)** to the English-speaking community of Quebec **(ESCQ)** in the English language throughout the Province of Quebec.

CaPQ readily acknowledges that the ongoing COVID-19 pandemic – in its seventh wave as of this writing – and the passage of *Bill 96* into law in **Spring 2022** have placed, and will likely continue to place, greater strains on Quebec's healthcare system – for francophones and anglophones alike. However, important factors prior to COVID and Bill 96 were already undermining HSS *access* and *delivery* for English speakers. If anything, these factors are coming further to the fore under cover of the Legault government's massive *Charter of the French Language* update, which the Party believes will restructure Quebec society in fundamentally illegitimate ways.

This section highlights why and how full HSS access and delivery is at risk for people who self-identify as English-speaking Quebecers, especially the most vulnerable in the ESCQ: seniors, recent immigrants, refugees, lower income people, and non-French speaking anglophones (350,000 to 400,000 people in Quebec by most measures).

At this time, the Party has chosen not to focus on HSS structures, like the *Centre intégré universitaire de santé et de services sociaux* **(CIUSSS)**, currently in place.

5.11. Before Bill 96 – Rampant Privatization undermines English Healthcare Rights.

In 1986, when the Quebec Liberal government of Robert Bourassa adopted *Bill 142* to ensure effective communication for ESCQ members, most of the services in the healthcare delivery system were offered by public institutions. This led to the guarantee of services in English being framed within the list of public institutions.

5. Healthcare & Social Services.

Over the next 35 years, *private for profit* and *not for profit companies*, as well as individual providers have been prioritized to offer much of the development and expansion of services in Quebec's healthcare network. While Premier Legault claims to believe in the public healthcare system, creeping privatisation under his government has been raised to a whole new level.

HSS access for English-speaking persons is a right conferred by Quebec's *Act respecting health services and social services*. **Article 15** states:

English-speaking persons are entitled to receive health services and social services in the English language, in keeping with the organizational structure and human, material and financial resources of the institutions providing such services and to the extent provided by an access program referred to in section 348.[1]

To some, Article 15 may appear to reassure HSS access in English throughout Quebec. However, this is far from reality on the ground. Regardless of the English-speaking presence in a particular region, the Quebec Community Groups Network's **(QCGN)** Health and Social Services webpage states:

Almost all private providers providing publicly funded health and social services, such as private medical offices, pharmaceutical services, and certain types of institutional services such as foster homes and intermediary resources, etc., do not have contracts with public institutions that guarantee their services will be available in English.[2]

Therefore, publicly-funded, privately delivered HSS became a convenient way for Quebec's *Health and Social Services Ministry* to avoid language guarantees re. the requirement to serve English-speaking patients in English. All Quebecers should be alarmed at recent privatization trends – by the government's own numbers, a nearly four-fold increase in public money spent on privatized healthcare workers via private worker agencies between 2017 and 2022[3]:

2017-2018: $201,022,961
2018-2019: $234,777,519
2019-2020: $349,205,763
2020-2021: $663,909,408
2021-2022: $875,129,373 (plus over $300M on private security for health facilities)

As part of this vicious circle, nurses are leaving the public system in droves for private healthcare clinics, citing worker burnout as well as higher pay and better working conditions. Of course, burnout has also resulted in nurses leaving Quebec's healthcare system altogether.

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[1] Légis Québec. S-4.2 - Act respecting health services and social services. https://www.legisquebec.gouv.qc.ca/en/document/cs/S-4.2 Retrieved 15 Aug 2022.

[2] Health and Social Services – QCGN. https://qcgn.ca/health-and-social-services/ Retrieved 15 Aug 2022.

[3] Matt Grillo, (2022, August 9). Quebec spending on private health-care workers up by 335% in last 5 years amid labour shortage. https://montreal.ctvnews.ca/quebec-spending-on-private-health-care-workers-up-by-335-in-last-5-years-amid-labour-shortage-1.6020491 Retrieved 15 Aug 2022.

CaPQ Recommendation: Eliminate to the furthest extent possible the contracting out of healthcare services to private concerns, as a means of improving accessibility guarantees and health outcomes. Furthermore, enshrine in the *Act respecting health services and social services* the stipulation that all private providers of HSS enter into binding legal contracts with public institutions that guarantee that their services will be available in English.

5.12. How Accessible are English Language Healthcare and Social Services?

In the *Guide to The Development of Access Programs for Health and Social Services in The English Language*, published **April 23, 2018**, the definitive word on English HSS access appears to be given on page 54:

Objectif du programme d'accès (2018)

Le programme d'accès vise à rendre accessible aux personnes d'expression anglaise une gamme de services de santé et de services sociaux en langue anglaise **qui soit la plus complète possible et le plus près possible du milieu de vie de ces personnes.**[7]

[7] Les services en langue anglaise peuvent être rendus dans leur localité, dans leur région, ou, le cas échéant, dans une autre région que celle des personnes d'expression anglaise.

In other words, some health and social services may not be offered in English anywhere in Quebec and primary care services, such as:

- *Routine services* by private providers delivering publicly funded health and social services;

- *Professional services* provided by a psychologist, a pharmacist, a private agency such as a non-profit community group or a for-profit agency providing institutional care, or an intermediate care resource

are not guaranteed to be offered in English.

5.13. The Importance of Communication.

The Government of Quebec is responsible for creating a statutory *Provincial Committee*, whose mandate is to advise the government on matters regarding HSS for the province's English-speaking population.

The Committee's objective is also to ensure that the healthcare system's contribution to health outcomes for the English-speaking population is comparable to that for the Francophone population of Quebec. For this objective to be implemented, the achievement of successful clinical interventions requires "effective communication".

5. Healthcare & Social Services.

Les services de santé et les services sociaux qui sont linguistiquement mal adaptés peuvent entraîner des erreurs médicales graves.[45]

The *Canadian Party of Quebec*, in line with its publicly stated *Action Plan against Bill 96* released to the media on **June 6, 2022**, demands that all Quebecers – including self-defined English-speaking Quebecers – be treated in HSS settings in the Canadian official language they are most comfortable with and understand best.

CaPQ Recommendation: Ensure that certain core publicly-funded health and social services, where language is a key component in ensuring a successful clinical intervention, are offered in English for all persons who are more comfortable to receive these services in English throughout Quebec.

These core services, where effective communication is key to successful clinical intervention, include psycho-social services, all public health services and all health and social services provided in an emergency situation, including pre-hospital [e.g., ambulance] services as well as welcome(*accueil*)/evaluation/orientation services.

CaPQ Recommendation: Ensure that all written information provided by the HSS network be provided in English for those persons who request it, as well as in French to all Quebecers.

Justification: While cognisant of the need to promote the general use of French in Quebec, the Party steadfastly refuses to place the burden on English-speaking Quebecers to communicate in French in healthcare and social service settings. Especially in matters of illness, injury, trauma, or mental distress.

Recall the English COVID-19 pamphlet controversy in 2020, when it took a public outcry and significant lobbying to ensure that the ESCQ receive vital information about the (at the time) new pandemic. The Quebec government must do everything in its power to ensure the population's health literacy. Otherwise, you end up with second rate services.

5.14. Health and Social Services Funding.

CaPQ Recommendation: Agrees that the *Canada Health Transfer* and *Canada Social Transfer* to Quebec should be raised from 22% to 35% of the overall HSS budget (approximately $6.5 to $7 billion annually), ***if and only if*** the Government of Quebec satisfies and fulfills all accessibility and patient-physician communication requirements as stipulated in its own legislation, and, where relevant, the *Canada Health Act***.**

[4] Ministère de la Santé et services sociaux. 2018. Guide pour l'élaboration du programme d'accès aux services de santé et aux services sociaux en langue anglaise. Gouvernement du Québec. p.53.

[5] Sarah Bowen (Preparé pour Santé Canada), (Nov 2001). Barrières linguistiques dans l'accès aux soins de santé https://www.canada.ca/fr/sante-canada/services/systeme-soins-sante/rapports-publications/accessibilite-soins-sante/barrieres-linguistiques.html Retrieved August 22, 2022.

CaPQ Recommendation: Ensure equitable funding from the Government of Quebec for non-governmental organizations **(NGOs)**, i.e., *Programme de soutien aux organismes communautaires* **(PSOC)** funds, in healthcare serving **ESCQ** clientele through the revision of PSOC funds criteria, followed by a prioritisation of new dollars in this program to ensure a similar range and intensity of community health and social services offered to francophones.

5.15. English-speaking Quebecers Deemed 'At Risk' Clientele.

CaPQ Recommendation: Ensure that English-speaking Quebecers, who are classified by the MSSS within one of the 'at-risk' target clienteles requiring additional specific services, receive the full range of health services and social services in their respective continuum of care, as well as the necessary primary care services, in English.

The list of *at-risk* target clientele includes: the frail elderly, those adults with intellectual incapacities and autism, physical incapacities, and mental health and dependency problems (e.g., alcoholism), as well as youth and families in difficulty.

For 'at-risk' English-speaking clientele requiring long-term healthcare services, as well as those clients requiring an overnight stay in a hospital, at least one of the providers providing daily care to each client must be able to communicate effectively in English.

5.16. Bill 96 – Making a Bad Situation Worse.

While tinkering with healthcare and social services governance structures (e.g., a flattening out of CIUSSS; *Santé Québec* for co-ordinating health system operations, etc.) may score politicians some short-term points, the reality is that compromising the ability of patients to communicate distress, pain and agony to their physicians in the language they are most comfortable with seriously jeopardizes quality care.

Likewise, if a physician is obliged to speak French – or deliberately speaks French (!) - to patients who don't understand French, health outcomes risk being severely compromised even if a translator is present. Yet, these scenarios may indeed come to the forefront with the passing of Bill 96 into law on **May 24, 2022** with Royal Assent **June 1, 2022**.

Why? Consider Premier Legault's definition of an 'historic' Anglophone, which distorts the actual make-up of the community, and consequently who is eligible for HSS in the English language. For example, if an historic Anglophone is defined as a person whose parents were educated in English somewhere in Canada, close to 600,000 people out of the true English Quebec population of 1,25 million people could be excluded from accessing HSS in English.

A proper definition would be closer to the Statistics Canada concept of *First Official Language Spoken* **(FOLS)** English for Quebec, which was over 1,1 million English-speaking Quebecers in the 2016 census and closer to 1,25 million according to the 2021 census.

After the tabling of Bill 96 on **May 13, 2021**, the *Global Opinion on the approval of Access Programs for health and social services in the English language* ("Global Opinion") – adopted **June 17, 2021** - was not in line with the Legault government's thinking on HSS access and delivery to English-speaking Quebecers. As a result:

- The recruitment, hiring, and retention of English-speaking healthcare workers for CIUSSS regions with large English-speaking populations will become more difficult, because of onerous requirements written into Bill 96 to justify bilingual hiring.

- The 2018 government *Guide for the development of access programs for health and social services in the English language*, defines an "English-speaker" as "a person who, in his relations with an institution that provides health or social services, feels more comfortable expressing his needs and receiving services in English" (page 11). With Bill 96's passage, it's unclear as to whether this definition will continue to be used by the government, and how it will impact the implementation of the 29 Access Programs submitted to the Minister of Health and Social Services in 2019 and 2020 which are awaiting government decree - since they were developed using the 2018 definition...[6]

5.17. CAQ Violation of Quality-of-Care Principles.

By delaying the approval of the access programs referenced above, the CAQ government is failing to live up to the *World Healthcare Organization* **(WHO)** statement on *quality of care*:

> *Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. Quality health services should be:*
>
> ***Effective** – providing evidence-based healthcare services to those who need them;*
> ***Safe** – avoiding harm to people for whom the care is intended; and*
> ***People-centred** – providing care that responds to individual preferences, needs and values*

To realize the benefits of quality healthcare, health services must be:

Timely – reducing waiting times and sometimes harmful delays;
Equitable – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
Integrated – providing care that makes available the full range of health services throughout the life course;
Efficient – maximizing the benefit of available resources and avoiding waste.[7]

CaPQ Recommendation: The Party has been calling for the repeal of Bill 96 in its entirety since its formation, and continues to do so as of this writing. In the interim, it calls on the Government of Quebec to remove all articles in Bill 96 that reference HSS, so that any and all uncertainty concerning the application of Article 15 of the *Act respecting health services and social services* for all 1.25 million English-speaking Quebecers be removed.

[6] Health and Social Services – QCGN. https://qcgn.ca/health-and-social-services/

[7] Quality of Care – World Health Organization. https://www.who.int/health-topics/quality-of-care#tab=tab_1 Retrieved August 29, 2022.

This necessarily includes all Bill 96 provisions that oblige the civil administration to use the French language. It should also eliminate bureaucratic preconditions for staffing which make it much harder to hire personnel capable of communicating in the languages of their clients.
CaPQ Recommendation: Immediately take steps to ensure the **ESCQ** receives health and social services in a manner which is *scientifically appropriate* to ensure effective *communication*, including certain health and social services that are legally guaranteed in English.

Implementation: Update healthcare and other legislation to allow for the full range of publicly funded health and social services to be eligible to be guaranteed in English by including the full range of publicly funded health and social services providers, and more specifically the addition of all the types of private providers described in *Article 108* of the *Act Respecting Health Services and Social Services*, to the list of providers included in the 29 Access programs referred to above.

CaPQ Recommendation: Maintain the following definition of an English-speaking person when it comes to the delivery of health and social services: "a person who, in his relations with an institution that provides health and social services, feels more comfortable expressing his needs and receiving services in English".

CaPQ Recommendation: Implement those recommendations in the *Global Opinion* concerning the access programs for services in English submitted by the *Provincial Committee* in **July 2021**, which are not addressed in the previous recommendations.
Conclusion.

The implementation of all these recommendations will improve the health and well-being of all ESCQ members, leading to a more productive workforce and a more cost-effective healthcare system in Quebec.

Far from the identity politics being played by the CAQ, and benign indifference shown towards ESCQ needs by the Parti libéral du Québec, the Canadian Party of Quebec believes in having a rational discussion on healthcare and social services with middle-class francophones that demonstrates benefits to them based on healthcare economics, improving systemic efficiencies, and saving money.

5.2. Eldercare, Senior's Living & Assistance Issues.

Key Takeaways:

- **Quebec's eldercare infrastructure investment deficit, Bill 96, and growing sense of isolation spell difficult times ahead for ESCQ senior citizens.**
- ***Canadian Party of Quebec*'s seven proposals and recommendations are a call for government accountability, and a return to more humane treatment for all Quebec seniors regardless of language.**

As Quebec's population continues to age, it's the provincial government's solemn duty to care for seniors, and show them the dignity and respect they so richly deserve after a lifetime of dedication and contribution to the building of Quebec's society.

Sadly, many seniors are left alone to face an increasingly complex world without assistance to handle the basics of living: rent and utilities' payments, grocery shopping, medical appointments, drug prescriptions, adaptive transportation, etc.

Seniors in Quebec's English-speaking community have additional challenges. All too often, their children live in other provinces or countries, and aren't capable of being a regular presence in their lives or caregivers, when necessary. Consequently, many are forced to navigate various government programs on their own – often with great difficulty – to obtain critical information and services.

All this in the province with the fewest hospital beds per capita in Canada[8], and the fewest long-term beds per capita. This is a ticking time bomb, as over 70% of Quebecers in long-term care currently have dementia[9].

The passing of **Bill 96**, as described in the previous section, only adds to the already significant uncertainty concerning the full range of health and social services to be provided in English for frail and elderly English-speaking Quebecers. It will be difficult enough for English-

[8] Conference Board of Canada, (2020, April 9). Staggered start: Variations in hospital bed capacity. https://conferenceboard.ca/insights/blogs/staggered-start-variations-in-hospital-bed-capacity Retrieved August 23, 2022.

[9] Adam Kovac, (2020, December 27). Dementia patients hit hard in isolated Quebec care homes. https://montreal.ctvnews.ca/dementia-patients-hit-hard-in-isolated-quebec-care-homes-1.5245705 Retrieved August 28, 2022.

speaking adults in a Bill 96 world – just imagine what it will be like for seniors who didn't have the opportunity to learn French in school.

5.2.1. Proposals and Recommendations.

The *Canadian Party of Quebec* acknowledges and applauds innovative eldercare programs in Quebec and elsewhere that aim to make life more pleasant and fulfilling for people in their golden years.

CaPQ also believes that the Government of Quebec must be held accountable for inappropriate decisions and ongoing policies that adversely affect Quebec seniors' quality of living and that of their caregivers.

To that end, the Party proposes and/or recommends the following:

1. Never forget the most vulnerable clienteles requiring long-term care, Mr. Legault!

In the next National Assembly session, a *Canadian Party of Quebec* MNA will re-introduce a motion calling for an independent Public Inquiry into the healthcare services provided to the frail elderly, intellectually and physically handicapped adults and other adults with mental health problems requiring long-term care across the range of sites that these Quebecers were living, including in their homes and in the various institutional care settings. Its mandate will include a description of the service cuts during the pandemic for each of the client profiles requiring long-term services in the various respective living environments where these individuals live. It will look at whether the cuts were repeated at different times during the pandemic and whether users received an appropriate alternative response on each occasion to compensate for the lack of public services.

The professionals in charge of the inquiry will also recommend measures to prepare for a future pandemic.

2. A return to private rooms for CHSLD residents.

It's totally unacceptable that the CAQ government increase the number of seniors permitted in CHSLD (long-term care) rooms from two to four. In fact, this move contradicts the advice of coroner Gehane Kamel in her report into long-term care homes during COVID-19's first wave, who recommended that there should be only one person per room.[10]

3. Minimum clinical ratio for residents in CHSLDs.

The Party will support the implementation of the necessary clinical ratios recognized in North America, i.e., a minimum of 4 hours per day of direct assistance and care to each CHSLD

[10] Touria Izri, (2022, August 22). Quebec 'temporarily' allowing four patients per room at long-term care homes. https://montreal.ctvnews.ca/quebec-temporarily-allowing-four-patients-per-room-at-long-term-care-homes-1.6034773 Retrieved August 23, 2022.

resident, to be implemented in the next 2 years, similar to the clinical ratios to be provided in long-term care facilities by the Ontario government by 2024.

4. Stop the Warehousing of frail Seniors! Alternate housing for the elderly requiring intensive long-term care.

Dignified seniors' living should be more than just sitting on a chair and staring out a glass window of a large, impersonal, institutional building for hours upon end.

Unfortunately, dumping people – often frail and with limited mobility – into small rectangular spaces seems to have been the go-to strategy for the Legault government's senior housing strategy during its four-year term.

The *Canadian Party of Quebec* supports the development of alternative models of housing for the frail elderly requiring intensive care.

The new model of care in Quebec is based upon American Dr. Bill Thomas' *Green House* Model[11] (rebranded as *Maisons des aînés* **(MDAs)** in Quebec) for long-term seniors' homes and nursing homes. The concept emphasizes ideas the Party supports: limited occupancy (10 to 12 units per home), open spaces, and more active and independent senior living, all desirable benefits. However, the Party deplores the CAQ government's cost overruns, strategic blunders, and overt politicking of the project to date, i.e.:

- Capital costs rising from $1 billion for 30 facilities to nearly $3 billion for 46 facilities in Quebec (3,480 beds) in three years.
- 4,160 people (and counting) currently on the waiting list. Where will the other 680 seniors go?
- Short-sighted customizations of the actual *Green House* model in the U.S.A. re. layout, staffing considerations. If it ain't broke, don't fix it!
- Why are 85% of the first phase MDAs going to be located in CAQ ridings?
- Deliberate neglect of the island of Montreal, where even the renovation of seven non-MDA facilities will not be completed before 2030.[12]

In light of all the above, CaPQ recommends the completion of those homes close to being ready, and a pause on all new construction.

During this period, there should be a review of the best long-term practices presently implemented in the OECD countries. For example, in Scandinavian countries, couples can continue to remain together when one requires a move to a setting requiring more intensive care, whereas Quebec offers institutional care in CHSLDs and intermediate resources, and

[11] The Green House Project. https://thegreenhouseproject.org/.

[12] Tu Thanh Ha, (2022, August 8). Quebec's nursing homes are betting big on the 'Green House' model of long-term care. Will it work, and could the rest of Canada follow? https://www.theglobeandmail.com/canada/article-quebecs-nursing-homes-are-betting-big-on-the-green-house-model-of-long/ Retrieved August 23, 2022.

obliges the resident to be separated from their spouse, at a moment in time when most of these couples want to remain together.

In Denmark, the frail elderly requiring the same level of intensive healthcare and their spouse are provided with an adapted home environment. Over the past 35 years, Denmark has reduced its long-term institutional beds from 48,000 places to under 5,000 places, while Quebec has increased its total of institutional places in CHSLDs and intermediate resources to 54,000 beds.

A comparison of the models of delivery of intensive long-term care to the frail elderly should be made, based upon the underlying concepts that are most desired by these seniors and their family members. This can be done once a full project revaluation of the present MDAs is completed. In the meantime, the Party will continue to pursue non-institutional solutions done right.[13]

5. Encourage Seniors to Remain in their Own Homes with Assistance.

Many people in their sixties and seventies feel obliged to downsize and leave their long-time homes upon retirement. Although this is a legitimate option in numerous situations, the lack of available units in Résidences pour personnes âgées **(RPAs)**, CHLSDs, and other publicly subsidized housing in Quebec today demands that we consider alternate solutions to the current seniors' housing crunch.

The *Canadian Party of Quebec* believes that stability and quality of life for seniors in reasonable health is best achieved in surroundings that they're most familiar with. Therefore, CaPQ proposes a major increase in provincial funding to pay for home and personal adaptations for persons with a physical incapacity, to be provided as soon as the clinical need is confirmed through a clinical assessment, along with a suite of individualised, adaptive home services (e.g., meal services and delivery, cleaning services, prescription drugs delivery, social visits, etc.) to facilitate remaining in their current houses, condominiums, or apartments.

The Party proposes to greatly increase government funding to non-profit groups developing housing for seniors and other persons with a physical or intellectual incapacity. It also proposes that the legislation and regulations concerning residential housing be tightened to prevent real estate speculators and landlords from exploiting seniors, and commit to defending their housing rights.

6. 'Wait Time' Guarantees.

The Party proposes to establish "wait time guarantees" for vulnerable clients with permanent disabilities that require long-term health and social services. These "wait time guarantees" should be established for [1] access to the full range and intensity of home care services and [2] access to services in alternative settings for the couple if the person can no longer receive the required intensive care to remain in their present home.

[13] Melissa Mancini, (2021, December 21). How smaller long-term care homes can help address big elder-care issues. https://www.cbc.ca/news/health/seniors-long-term-care-green-project-homes-1.6272306 Retrieved August 23, 2022.

This concept is similar to the clinical standards for access to surgical services or services for people with cancer. These "wait time guarantees" will give the frail elderly and others with a major permanent disability requiring long-term care services in their home, along with their family members, confidence in the ability of Quebec's publicly funded healthcare system to provide the necessary support, when required.

7. Guarantee Government of Quebec communication with English-speaking Quebecers re. seniors' programs in the English language.

It's basic common decency to communicate with elderly people in the language that they're most comfortable speaking. Creating barriers for English-speaking seniors who lack fluency in French from accessing the programs they are entitled to risks worsening their health and well-being, and bringing about a greater reliance on the utilization of professionals in the healthcare system. This will lead to greater medical and social costs for Quebec society as seniors will be more isolated, and left to their own devices, rather than feeling that they will be supported by government services, which they have paid for through their entire work life. It's a recommendation the Party believes all Quebecers can understand and support.

5.3. Frontline Issues in Healthcare.

Key Takeaways:

- **Increased funding and structural changes within Quebec's healthcare network aren't silver bullet solutions in and of themselves. Instead, make the system accessible for everyone.**
- **"Putting CARE back in healthCARE." (Dr. Michael Kalin)**
- **Offer practical solutions for medical intervention, nurses' working conditions in the public sector, information sharing, etc.**

5.3.1. Optimizing healthcare delivery via better collaboration, cross-professional teamwork.

Quebecers – whether they live in the métropole or Quebec's other regions – want and need a robust, public primary care network capable of withstanding crises (e.g., pandemics, natural disasters, etc.) as well as handling basic patient needs on a daily basis. These are goals that hospital administrators, MDs, nurses, and patients can all agree on.

So, instead of silo-ing the work of general practitioners, medical specialists, nurses, nurse practitioners, pharmacists, paramedics, physiotherapists, etc., why can't every component of the health sector combine their strengths, share responsibilities where appropriate, and better designate medical/hospital tasks according to priority, qualifications, and competence?

Simplicity is key to an improved health system.

~ Dr. Michael Kalin, Head of the Healthcare Roundtable, Reseaux locaux des services (RLS) Côte-Saint-Luc-NDG-Montreal West, CIUSSS de Centre-Ouest-de-l'Île-de-Montréal. Santé Kildare Clinic.

In Quebec, there are too many professions involved in health care delivery with too few members for any one profession to do it efficiently or well. Too many regulations, too many bureaucratic barriers to entry and practice – all of which contribute to a $54.1 billion annual healthcare and social services budget, 37.3% of the province's overall budget in 2022-23.

On the other hand, family doctors and other primary care workers need help.

CaPQ Recommendation: A medical intervention outreach system, whereby teams from larger regional hospitals could out into communities to help ease the load and pressure on existing family practices.

CaPQ Recommendation: The Fédération des médécins omnipracticiens du Québec **(FMOQ)** should redouble efforts to promote family medicine in medical schools, CEGEPs, and even high schools. Give publicly-funded medical graduates a better chance to practice in Quebec.

5.3.2. Improving wait times, front-line working conditions in the public sector.

Over the years, the evolution of various healthcare administrative structures over the years has led to abnormal practices becoming the norm in Quebec healthcare. For example, part of the problem today in hospital waiting rooms is that the *triaging* is done by a single person, often a nurse, who then tells the patient to wait. If there were more dedicated clinics available with triage specialists as well as doctors, patients could be treated immediately, i.e., get sutured, get a prescription, etc. then be discharged - or admitted for further treatment.

CaPQ Recommendation: For the short-term, senior medical staff spend a day or more per week in a hospital emergency room **(ER)** to help triage, treat patients, and give advice.

CaPQ Recommendation: Eliminate the *Plans régionaux d'effectifs médicaux* **(PREM)** permit system for allocating doctors within the CIUSSS regime; establish new criteria for distributing family doctors in a fair and transparent manner to all of Quebec's designated regions, including Montreal. This necessarily must include a fair distribution of bilingual doctors to regions with significant English-speaking populations.

The Party further recommends that an independent body be tasked to administer and allocate MDs to Quebec's regions based on actual need. Not unlike taxi permits, doctors' licenses should be transferable to other doctors - or the MDs themselves should be allowed to practice outside their designated territory, in order to alleviate temporary doctor shortages in different regions.

CaPQ Recommendation: Make public sector nursing attractive again! End mandatory overtime, offer better scheduling, regulate shift durations, and offer rest and relaxation areas for nurses to get away from the grind and recharge.

Recruit, train, and retain nurses with compensation and benefits (e.g., paid sick leave) that are competitive with the private sector.

CaPQ Recommendation: That public healthcare *innovation* be made a priority in Quebec, including technological innovation (e.g., medical robotics (robotics-assisted surgery; frontline worker support; low-level patient care)).[14]

[14] Marion Webb, (2022, May 12). Exec Chat: Israel's Authority on Medical Robotics Lifts Curtain Behind Technion's Success Stories. https://medtech.pharmaintelligence.informa.com/MT145400/Exec-Chat-Israels-Authority-On-Medical-Robotics-Lifts-Curtain-Behind-Technions-Success-Stories Retrieved August 28, 2022.

5. Healthcare & Social Services.

CaPQ Recommendation: That the Government of Quebec review all current legislation pertaining to patients' rights, with a view to updating and consolidating them into a robust *Patients' Bill of Rights for all Quebecers* – a law that would clearly define what every Quebec resident is entitled to when dealing with all aspects of the healthcare system.

5.4. Youth Protection Platform and Recommendations.

Key Takeaways:

- **The *Direction de la protection de la jeunesse* (DPJ) is in dire need of systemic reforms.**
- **The *Laurent Commission* – for all its good work – isn't justification for giving DPJ a blank cheque. Any funding increases must be tied to stricter performance criteria and better outcomes for children in DPJ custody.**
- **13 recommendations – including a willingness to transfer responsibility for Indigenous child welfare to the Indigenous communities themselves where desired and feasible.**

The *Canadian Party of Quebec*'s core message on youth protection and the *Direction de la protection de la jeunesse* (English: Youth Protection Directorate, hereinafter referred to as **DPJ**) is clear:

Stop Quebec's residential school history
from repeating itself
within the DPJ

François Legault's CAQ government has been steadfast in its refusal to acknowledge the existence of systemic racism in Quebec society, let alone in child protection. This attitude will only serve to perpetuate mistakes from the past – including the province's residential school system, which devastated and traumatized so many First Nations and Inuit people and is indisputable evidence of *cultural genocide* - recently acknowledged by Pope Francis after completing his recent trip to Canada.[15]

[15] Philip Pullela, (2022 July 30). Pope says genocide took place at Church schools in Canada for indigenous children. https://www.reuters.com/world/pope-says-genocide-took-place-church-schools-canada-indigenous-children-2022-07-30/ Retrieved August 21, 2022.

5. Healthcare & Social Services.

Régine Laurent, former president of Quebec's largest nurses' union, led a commission to deal with youth protection, culminating in a 550-page report submitted **May 3, 2021**. Acting on its many laudable recommendations will take years, if not decades.

CaPQ accepts several *Laurent Commission* conclusions about the DPJ, i.e.:

- Misallocated funds that deny vulnerable youth safe and healthy living conditions;
- Youth mistreatment in group homes, rehabilitation centres;
- Overrepresentation of Black and Indigenous children within the DPJ system;
- Social workers who are overworked, underpaid, and all too often lack the training and support they need to deliver essential and necessary services [16]

however, the Party proposes its own set of recommendations below:

CaPQ Recommendations:

1. On principle, a parent who hasn't committed a serious crime against their child such as sexual assault, criminal negligence or aggravated assault should never have their child removed from the home.

2. The *Youth Protection Act* must be amended to reflect the principle stated above, and should remove the nebulous security or development compromised test which is all too often used to justify the state-sanctioned, unlawful removal and detention of children.

3. The DPJ and Quebec's youth courts must overcome its inherent biases, i.e., *systemic racism*, against First Nations, Inuit, and ethnic minority communities. They need to respect their cultural traditions and differences for how these children should be raised. As such, it must stop targeting children from Black, Indigenous, and Persons of Colour **(BIPOC)** backgrounds.

4. Approximately five percent of Quebec's annual healthcare budget, i.e., between two to two-and-a-half billion dollars, is set aside for a youth protection system that prefers to accuse parents of child abuse than assist them in dealing with complex family and mental health situations. This budgetary allocation would be better spent on hiring more dedicated social workers and other specialists capable of offering support to troubled parents, teenagers and children.

5. Immediate measures must be taken to eliminate the DPJ's discriminatory practice of removing children from battered spouses and hovering over single mothers in hospitals who have recently delivered babies, in particular (but not only) young mothers who were once in the DPJ's custody.

[16] Benjamin Shingler and Jonathan Montpetit, (2021, May 3). Quebec's youth protection system failing children, urgent reforms needed, report says. https://www.cbc.ca/news/canada/montreal/quebec-laurent-commission-1.6011627 Retrieved August 21, 2022.

6. New DPJ measures requiring that parents intending to adopt internationally take special classes should be abolished as ethnocentric and discriminatory for attempting to assimilate kids. If anything, classes should be mandatory for parents who bully or exhibit racist behaviour toward adopted children of another race/ethnicity.

7. Journalists should be permitted to observe and write about Youth Court proceedings to ensure that the public is properly informed whether rules about procedural fairness and evidence are being respected. Prohibitions on publicizing the names of parents and children would of course be maintained for privacy purposes.

8. Former DPJ lawyers should be prohibited from being nominated as Youth Court judges due to the strong possibility of bias and conflict of interest. In many jurisdictions, 98 to 100% of cases are won by the DPJ, which is alarming and suggests that cases are infused with serious bias and violations of procedural safeguards.

9. Luring a child into a group home, youth centre, or foster home should become a statutory offence. Such occurrences are increasing, and are evoking Quebec's shameful residential school history, e.g., *The Sixties Scoop*. Filing of a DPJ complaint for improper and unjustified purposes should also be heavily sanctioned.

10. Better and more focussed recruitment, training, and retention of workers in group homes, foster homes and youth centers. Many of these people only have a high school education upon entry and aren't qualified to deal with troubled youth upon being hired.

11. A better vetting and screening process (*background checks*) of candidates applying to work in group homes, foster homes and youth centres is needed immediately. For example, Benoît Cardinal, found guilty in 2021 of murdering the mother of his six children, worked in the girls' section of a youth centre.

12. Counselling and intervention services offered by the Quebec government should be confidential, unless a counsellor or professional becomes aware of imminent physical harm to a child. At present there are serious issues surrounding the compromising of confidentiality.

13. The Legault government should abandon its appeal of federal law **C-92**, which seeks to transfer responsibility for Indigenous child welfare to the Indigenous communities themselves *where desired and feasible*.

5.5. Community-based Mental Health Services – A Concept whose Time has Come.

Key Takeaways:

- ***Ministère de la santé et services sociaux*'s contradictory approach to mental healthcare (centralised care, deinstitutionalisation) discourages local access.**
- **Walk-in Mental Health Services offer a solution that bridges gap between CLSCs, hospitals.**
- **Introduce a 6-month to 1-year Training Course for community health workers, triage specialists.**
- **Relax language requirements for all out-of-Quebec applicants to Training Course so long as there's a shortage of mental health community workers and triage specialists in Quebec.**

5.5.1. Current Situation.

Mental health is important at all stages of life: childhood, adolescence, adulthood, senior years. It encompasses our psychological, social and emotional well-being.[17]

Increasingly, Quebecers are coming to terms with the relationship between mental and physical health, especially as they live through the ongoing **COVID-19** pandemic. Too many people are being turned away or get inadequate attention when seeking help for both minor and serious mental health issues.

A consensus has emerged within Quebec's clinical psychology community today: There is a lack of timely, *local access* to individual mental health services. As services continue to be de-institutionalized:

- Patients are being sent back to their communities without being stabilised;
- Many patients' mental health situations are getting worse over time;
- People in need are being bounced around in a failing system;

[17] Centers for Disease Control and Prevention. About Mental Health. https://www.cdc.gov/mentalhealth/learn/index.htm Accessed August 19, 2022.

- Increasingly, people aren't able to see a professional at all

The *delivery* of medical and mental health services is also getting bogged down. People just aren't getting the help they need in a timely manner.

As in other areas of Quebec's health sector, the "one size fits all", centralized approach to mental healthcare is at the root of the problem. The *Ministère de la santé et services sociaux* **(MSSS)** has for years sent healthcare professionals mixed messages - on the one hand, centralised care and on the other, de-institutionalization.

The end results? Both short-term and long-term mental healthcare goals aren't being met. It's high time to find real solutions.

5.5.2. Reality on the Ground.

If you seek mental health advice, there may be a situation where, after the initial diagnosis by a healthcare professional, you'll have to wait two years (or more) for a follow-up in the public system. Then, you are offered six one-hour sessions with your therapist, and that's it.

Solve two years' worth of worsening mental health issues in six hours? Occasionally, a case can be made for prolonged services, but this involves lots of paperwork and the therapist is not incentivized to do either the paperwork or the follow-up, because they have a heavy patient case load and an even longer waiting list that they must attend to.

To make matters worse, salaries for mental healthcare professionals in the public system are about half of what's offered in the private system. This means that many talented people forgo the public system, leaving it with a severe shortage of workers. Practitioners who remain in the public system burn out very quickly and repeatedly, which makes the existing problem worse for colleagues who end up having to pick up abandoned case loads.

Public system practitioners are usually encouraged to take on large volumes of cases, double and triple bookings are typical. Most of them value the public good and just want to help. As a result, they take on the heaviest or most urgent cases first, thereby making the wait list longer for less critical cases and wasting precious resources on tasks that could be better undertaken by others, i.e., paperwork, referrals, etc.

CaPQ Recommendation: The *Canadian Party of Quebec* regards mental health as a fundamental human right as per the World Health Organization **(WHO)** definition.[18] As such, it demands a revitalization plan for the public system that levels the playing field with the private sector in terms of compensation, benefits, working conditions, and case load.

On the patient side, people need access to *local*, *community-based* clinics – as opposed to being shunted to hospitals or institutions located outside their neighbourhood, CIUSSS territory, town or region. They also need to have follow-up offered quickly.

[18] World Health Organization, (2022 June 17). Mental health: strengthening our response. https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response Accessed August 19, 2022.

CaPQ Recommendation: A more effective *triage* system performed by *junior practitioners*, on the ground. e.g.:

- Final year students, graduates in 3-year CEGEP professional programs like Nursing;
- Final year students, graduates in 2-year CEGEP pre-university Social Science programs (Psychology specialization highly desirable but not essential);
- Final year undergraduates, first-year graduate students in Psychology

This will permit psychologists to treat people faster, more effectively, and prevent the system from getting bogged down. An analogy would be supermarket checkout lanes: Regular or Express.

The key is having lots of clinics capable of seeing people quickly, and then having the ability to direct them to:

- The private system, i.e., practitioners in private practice;
- Public system specialists;

or offering short-term therapies on site if and when appropriate.

5.5.3. Walk-in Mental Health Service Clinics: Bridging the Gap between CLSCs and Hospitals.

In response to the inability to offer dedicated time slots (e.g., 1-hour) to would-be patients, *walk-in clinics* could be set up to offer people short-term fixes with 10 to 15-minute consultations, or to redirect them to specialized services elsewhere – ideally in the same neighbourhood or as close as possible to where they live.

This type of service allows professionals to triage out those who just need to vent their issue or be directed elsewhere, and reduces the time people waste waiting for the wrong kind of help.

5.5.4. How a Walk-in Service Works.

At a typical walk-in clinic, a team member has an initial meeting with the patient; initial assessment is given on the same day without an appointment, like in a hospital emergency room except that triage is happening in the waiting room and we aren't considering medical emergencies like heart attacks - those go immediately to hospitals, not CLSCs.

Imagine a triage nurse coming to the waiting room and redirecting patients within 10 minutes to the appropriate service.

Whether it's a phone call, a Zoom call, or in person, the patient will be seen for an initial 30 minutes and fill out some basic evaluation measures. The psychologist on duty quickly evaluates and triages cases, then their assistant will then either:

A. Send the patient to one of our in-house practitioners;
B. Send the patient to another facility where they can be better served by someone else.

The assistant helps patients make calls and secure appointments; the clinic makes sure that people are "caught" in the system before they go home.

Consider the following two individuals:

1. A 15-year-old English Quebecer with an anxiety disorder who lives off-island.
2. A 45-year-old Spanish-speaking immigrant going through a divorce whose child just got diagnosed with Rhett's syndrome.

Not every hospital or CLSC can help them, but a walk-in clinic can find the best fit for the situation. Nobody falls through the cracks or is sent away without an appointment for follow-up that's appropriate to their specific needs.

End result: Straightforward cases are dealt with quickly and efficiently, and the heavier cases don't end up on a long waiting list. The key is to have a team of professionals on site who are skilled at triage but not necessarily qualified to offer much in the way of therapy, diagnosis, or treatment.

This individualised approach fills the gap between community services and super hospitals like the McGill University Health Centre **(MUHC)**. A hybrid of specialised care in hi-tech facilities and low-tech one-on-one care in your community.

Advantages: Establishing community-based, walk-in mental health clinics doesn't require the hiring of highly-trained professionals (e.g., psychologists, psychiatrists). Small, local teams of professionals with varying degrees of skill are sufficient. Setting professionals up in their communities allows them to:

1. Use their community knowledge and attachment to quickly become triage experts;
2. Establish themselves as compassionate healthcare advocates for a public they already know

Walk-in clinics won't solve all the problems in Quebec's mental health system, but prioritising support staff at the ground level over specialised professionals/academics will definitely help.

5.5.5. Training Quebec's Mental Health Community Workers and Triage Specialists.

Appropriate training of frontline, lower-level skilled professionals is key. As opposed to waiting for young adults to complete 5-year PhD programs in psychology to fill positions that are a mismatch for their education and skill set.

CaPQ Recommendation: The *Canadian Party of Quebec* calls on the MSSS to create, certify, and fully fund a short 6-month to 1-year course to train tomorrow's mental health community workers and triage specialists throughout the province. With the goal of quickly providing

well-trained, low-level support for health and mental health professionals at the local (community) level.

CaPQ Recommendation: As long as there is a shortage of mental health community workers and triage specialists in Quebec, and local labour pools are insufficient for filling these positions, the *Canadian Party of Quebec* recommends that linguistic requirements for entering the course described above be relaxed for applicants from other Canadian provinces and other countries seeking to take it.

Justification: Mastery of either French or English isn't an indicator of competence in community-level healthcare. Conversely, other languages are often a tremendous asset in many parts of the Montreal region and elsewhere in Quebec (e.g., Spanish, Arabic, Creole).

5.6. Full Portability of Health Benefits for Quebecers throughout Canada.

Key Takeaways:

- **Immediate need for Quebec to join a pan-Canadian Reciprocal Medical Billing Agreement (RMBA).**
- **Insistence on the Health Ministry's full compliance with the portability provisions (Chapter 11) of the Canada Health Act.**

The ongoing COVID-19 pandemic has demonstrated how different provinces can help each other in times of need. Especially when it comes to *healthcare portability* in Canada.

The transfer of patients to intensive care units **(ICU)** out-of-province is a prime example. In late 2021, as the *Omicron* wave took hold, Manitoba and Saskatchewan in particular were overwhelmed by its patient loads. Fortunately, they were able to call on Alberta, Ontario, and each other at different times to help shoulder the burden.

Nine provinces and three territories have a *Reciprocal Medical Billing Agreement* **(RMBA)** in place, but Quebec has yet to sign on. Instead, when Quebecers get sick and require medical care out-of-province, they have to pay MDs out-of-pocket or via private insurance, then wait several weeks for (partial) reimbursement from the private insurer or the *Régie de l'assurance-maladie du Québec* **(RAMQ)**.[19]

5.6.1. The Nightmare Scenario: Out-of-Province Surgery Denied and Delayed.

The recent case of a Quebecer, Patrick Bélanger, who broke his jaw, cheekbone and bone around his left eye in an accident in British Columbia demonstrates the urgency of reciprocal billing in Canada.

Bélanger's surgery was cancelled, because the surgeon and the Kamloops hospital administration feared that RAMQ wouldn't reimburse them for services. Stunned and already "out of it" from painkiller use the night before, Patrick and his parents spent the next week pleading for the surgery to get done before his bones fused permanently.

Seven days of excruciating pain later, Bélanger got the surgery done at a B.C. hospital.

[19] Dr. Charles S. Shaver, (2021, Dec 29). Op-ed. Duclos should press for fully portable health benefits for Quebecers. The Suburban, A11.

"It's gross incompetence on the part of the hospital and a failure on the part of the Canadian health-care system," said Belanger's mother, Martha Ferris.[20]

In these cases, RAMQ covers hospital costs but no physicians' fees, because Quebec isn't part of the provincial-territorial billing agreement. Patients are often left to deal with their private insurer, or, failing that, apply directly for reimbursement from RAMQ.

It should be noted that while border areas of Ontario and New Brunswick are more knowledgeable about Quebec's public health insurance system, MDs from other jurisdictions are often reluctant to navigate its often-complex categories – especially if the information is only available in French.

5.6.2. Towards Making the Canada Health Act truly Canadian.

In light of Mr. Bélanger's out-of-province medical ordeal and others like it, the *Canadian Party of Quebec* believes that, after thirty-eight years, the time has come for the Quebec government to do the right thing.

CaPQ Recommendations:

- The Government of Quebec should negotiate and sign a RMBA with all the other provinces and territories that satisfies **Section 11** (Portability) of the *Canada Health Act*;
- The federal Minister of Health must insist that the Quebec Ministry of Health fully comply with the *portability* provisions (Section 11) of the *Canada Health Act*;

Interprovincial agreements that guarantee full payment by the Government of Quebec of health costs incurred by Quebec residents outside Quebec, and payments to Quebec by other provinces for medical services given to their residents, e.g.:

- Quebec physicians bill their own province's health plan (RAMQ);
- Quebec physicians receive their normal fee from RAMQ;
- RAMQ collects the fee from the patient's provincial/territorial Ministry of Health (e.g., Ontario Health Insurance Plan **(OHIP)** in Ontario)

are common sense ways to promote national unity.

Other Benefits:

- A preferential daily flat rate for Quebecers versus the amount charged to 'non-residents of Canada' when outside Quebec. The amount that Quebec reimburses to the other province/territory and vice-versa may amount to savings of several thousand dollars a day per patient;

[20] Camille Bains, (2022, July 7). Hospital 'nightmare' in B.C. for Quebec patient denied surgery: father. https://bc.ctvnews.ca/hospital-nightmare-in-b-c-for-quebec-patient-denied-surgery-father-1.5978125 Retrieved August 21, 2022.

5. Healthcare & Social Services.

- Peace of mind for Quebecers when traveling out-of-province for business or pleasure, knowing that unexpected illnesses and required medical attention (e.g., surgery) won't cost them thousands of dollars, regardless of whether they have private health coverage;

- Fully portable medical/physician benefits would make patient transfers to and from other provinces' hospitals during emergencies and pandemics easier to administer for Quebec MDs.