Politics, Policy and English-Speaking Minorities in Quebec

Antonia Maioni
McGill University, Montreal, Quebec

I started my presentation in French, and then I switched it back to English, but I'm going to present tonight in English, because I want to focus on English language minorities. That is to say, the clientele group for which these projects have been designed and implemented, and to talk a little bit about the political context around that. And I really want to thank the organizers for giving me the opportunity to speak this evening, and also to congratulate them on quite a very interesting program. Since the theme of the conference is on overcoming language and cultural barriers, in the delivery of healthcare service to linguistic minorities, I thought it would be interesting, or the most useful role that I could play in fact, would be to help you overcome some political barriers that you might have in terms of trying to understand the policy environment surrounding healthcare in Canada today. And that leads me then to some reflections as to the place and fate of linguistic minorities, to the English language community minorities in the health policy environment. My own research, as the Dean referred to, looks at how political institutions shape policy outcomes.

So my main question this evening is very simple: How does politics affect health policy, or in other terms, is politics good for your health? And in this case, is politics good for the health of English language minorities in Quebec? More specifically, or more generally from that, how does politics affect the health of linguistic minorities? And so, I'd like to address this question by looking at three facets of that relationship. First, the state of play of healthcare policy overall in Canada and Quebec. Second, the state of play of the political situation; and here I have to say I'm coming from no partisan angle, and I don't speak on behalf of McGill University in case I say something to offend Health Canada, I just want to get that out there. And third, turning to a more specific glance, at the challenges of English language communities in Quebec and linguistic minorities overall.

So the first message is that even if we're talking about linguistic communities, or linguistic minorities, in a health policy environment, we need to think about the wider context of the state of healthcare in Canada today. So it's a context that involves not just these linguistic communities but Canadians overall. In other words, there are many challenges to healthcare in Canada that are common ones. And so the health and social services questions that we are asking in this conference and more broadly about linguistic communities don't exist in a vacuum. Across the Canadian provinces, what we've chosen to do as communities and as societies, is to implement healthcare systems that reflect the notion of health as a public good. And we have given our policymakers the margin of manoeuvre that's necessary to develop and implement financing and distribution of services based on equal access, and we hope, equitable distribution of this good. And in many ways, Canada has done remarkably well in realizing these lofty goals. Canada is a country that spends a lot in terms of healthcare, but one that also assures or ensures equitable access and universal access to healthcare. We're a country where we have advances that are being made every day in terms of 21st century medicine here at McGill, and across the country, so we are also in a

place where the sophistication and technological level of healthcare is something to be admired from afar and from close by.

However, we also have some weaknesses. Spending more does not always mean spending better, which you've often heard. Since the money that we spend is primarily taken from public revenues, we're in a sector that is very politicized. And so the decisions that are made about spending are important ones for citizens as a whole, but also represent some pretty heavy burdens for governments across the country. So while our healthcare system offers a compelling portrait of how to address this cost-access conundrum that every country in the world faces, we have in effect succeeded in many ways. We're able to foster a healthcare system that offers equal access that fosters world class clinical research, and redistributes health resources, even if it's not a perfect model. It's relatively expensive to finance though. There are recognizable gaps in terms of access to certain types of care. There are problems in the organization. There are specific challenges in terms of continuity integration of care. These are things that people on the group know, it's not a surprise. It's part of a larger portrait of the healthcare system across the country and across all communities. We are also faced with increased demands on the part of providers, right? So we don't live in a political bubble. Providers are not just providers of healthcare, they also have interests as professional groups, autonomous groups, as economic groups. We also have something that's happened on the part of users of the healthcare system, which is from a quite impressive support for the healthcare system as it is, to one in which we see more fragility around that consensus, and it's particularly an erosion of confidence in the healthcare system. We see governments that are more and more insistent on measurement and outcomes, and the kind of burden and challenge that that places on health delivery communities but also health professionals as well. And we also see a healthcare system that is not quite there yet in terms of its change management process, one that's needed to refocus the healthcare system to the needs of the 21st century, including what we know are going to be demographic challenges ahead.

With that as a backdrop, it's just to understand where the healthcare system is, while we talk about certain kinds of communities and linguistic minorities in terms of healthcare. And it's probably not useful at this point, this juncture tonight, to get into a discussion about financing of healthcare, because that usually ends up in that Goldilocks debate; you know, too much, too little, just right. So we're not going to go there, but I just want to point out that money is a crucial feature of healthcare policy and especially as politics. How do you put a price on health? Healthcare policies do not, they cannot, follow basic laws of supply and demand, even though some of my economist friends believe so. Demand is limitless. You know this if you work on the ground. Supply tends to be scarce. Consumers are not the ones actually making the purchasing decisions. And so that's why policy is in fact so important in healthcare, because it's governments that regulate demand and supply, and redistribute resources, finance healthcare services, negotiate with providers. Government is involved, and so too is politics. Decisions, and decision makers who put their stamp on policy directions, will affect how much money flows through the system, where those resources go. And for linguistic minority groups, decisions about the distribution of healthcare resources is made even more complicated by the multiplicity of institutional actors that are involved in the decisions about the financing and delivering of care in their communities. Federal, provincial, local, all of which are tinged with their own political conflicts and debates.

This brings me to my second point, and that is how healthcare is a politicized arena, the politics of healthcare, and a doubly politicized arena. What do I mean by that? On the one hand we have sort of traditional partisan politics that plays a big role, but on the other we also have the political tensions that are inherent in federalism. And, for communities here in Quebec, those between Ottawa and Quebec themselves. So partisan conflicts are important. We shouldn't be afraid of partisan conflicts, because we're talking about a public good, in which decisions are made about resource allocation, we should be having public debates about it, right? We should be allowed to have some kind of a public debate which is going to involve partisan voices. However, even though the reason why I think partisan conflicts in the healthcare sector are becoming more and more important is that even though there is an underlying public consensus around the values that support healthcare as a public good, one that ensures equal access for example, there is a steadily growing political divide on how to face the future in terms of healthcare reform. We see it across Canada, we see it here in Quebec. Not only in the classically ideological sense of left-right, or those kinds of party politics, but also in the way interest groups position themselves, and the discourse of public debate about our healthcare futures. However, in the case of healthcare, federalism conflicts are perhaps even more important. Healthcare after all is a provincial responsibility, even though the fiscal capacity of the federal government has been a crucial part of the public healthcare systems across the country since their inception. We have seen, none of you are immune to this, how healthcare has been used as a political tool in provincial-federal conflicts in the past, with the provinces flexing their autonomy and the federal government's political muscle through things like the Canada Health Act for example. The Liberal Party of Canada was particularly adept at carving out a federal role for healthcare, much to the chagrin of many governments including Quebec. But it dovetailed nicely with its other important commitment to linguistic communities, particularly English language communities here in Quebec from which it derived considerable support; and I mean voting support, electoral support. In fact, healthcare can be seen as a symbol about the success and dysfunction of the federal system in Canada. In particular, during questions about roles and responsibilities, reconciling jurisdictional capacities and fiscal capacities, ensuring equal access to services across such large diverse geographic, cultural, and economically disparate regions. We know about the 10-year plan, which came into place in 2004, which has, in effect, or was designed to reduce some of those tensions in provincial-federal relations over the financing of healthcare, by guaranteeing automatic increases. But in recent years, the presence of this 10-year plan has been accompanied by a paradoxical kind of federal leadership that is emerging in Ottawa. On the one hand, now we have a federal government that is willing to stretch over the domain of provincial functions to deal directly with policy challenges. If you read the latest budget, and its forays into training and manpower for example, which some provinces have chosen to speak to in a resistant tone.

At the same time, while you have these kinds of strategic forays, you also have a federal government that is sort of dissolving into the background like the Cheshire cat in Alice in Wonderland, in terms of leadership in policy reform. And I think healthcare is a prime example of that kind of backing off in a way. This leads me to characterize a new kind of federalism that's emerging in Canada. I call it a phantom federalism. It exerts its power through strategic strikes, you know like those phantom planes, it comes out and strategically strikes, on the one hand, and by policy drift where necessary or where chosen, on the other. Now, I can say this, because I'm a

political scientist and we think up these kinds of theories all the time, but what does it matter? Why would it matter if federalism is changing in Canada, for linguistic minorities, and in particular English language minorities in Quebec? And this is the jist of the third question I ask this evening.

I think if federalism is changing in Canada, and if partisan discourse is changing in Canada, it matters because linguistic minorities cannot afford to be in a situation in which their voice does not carry. If there's an absence of federal leadership or weakening of federal leadership in this particular policy arena, that is going to have an impact on linguistic minorities, more perhaps than in other communities. In fact, it could result, you might say, well on the one hand, if the federal government moves away from a leadership role in healthcare, what we may get is more innovation on the part of provinces, more cooperation on the part of provinces, and we've seen that happen to some extent with the Council of the Federation setting up working groups on financing and on innovation. However, we could also, in terms of the implementation of changes across the provinces, see more divergence and disparities between them as well. This could result in an even more fragile situation for linguistic minorities, who rely, at least in part, on an activist federal government to be attentive to their needs and protect their rights.

We have a federal government that, and again I say this from a completely non-partisan basis, it's a federal government that's not as interested in social policy as a domain, a policy interest, as we've had in governments in the past. It's a government that is more populist in its roots, and majoritarian, right? And so the question of minority rights doesn't really square with other parts of the program of this particular government. And it's not a government that has much of a resonance in terms of English language communities in Quebec. In other words, it owes no political favours to English language communities in Quebec. And of course, when you're talking about the politics of healthcare, this of course matters. It's doubly problematic, I think, for English language minorities. We know what the tensions are with French language minorities across the country, but for English language minorities here in Quebec, when you add this change in federalism to a new governance that we have in place with the Parti Québécois. Again, despite we have the political overtures, positive political overtures from people like Jean-Francois Lisée, we have, I think, something that could be referred to, and many people in this room are familiar with this, the steady stewardship of a health minister like Réjean Hébert who knows the healthcare system so well. But at the end of the day, we have a government that is committed to jurisdictional sovereignty in the area of healthcare and in most social services, not just as a means of asserting autonomy, but as a means to another end. And in so doing, the provincial government is committed to claiming back, clawing back – however you want to put it – every square centimeter of jurisdictional space and every single dollar of fiscal autonomy that goes with it for Quebec. And that can have, may have, future repercussions for linguistic minorities here. It's quite an interesting combination, this kind of federalism and this kind of governance in Quebec, I think it's historically unique. If we put that in context with the structural challenges that are facing English language communities, an aging population, uncertain demographic future projections, the question of the place of these communities in the policy environment becomes quite a question mark. But what is certain is that the voice of the community is becoming less politically relevant than it has been in the past.

Believe it or not, I have not meant to draw a gloomy portrait of what's going on in terms of health policy, politics, or English language minority communities, just a realistic one, just to kind of open some thinking about the process of the political challenges of the health policy world in which we live in, and in which at some point in time you have contact with working on the ground. In many ways, the linguistic minorities across the country have been remarkable and unique successes. If you think about it, the kind of vibrancy of francophone communities, new kinds of vibrancies of francophone communities across English Canada is quite impressive, including the age structure of these populations. That's a little bit different here in Quebec, where the age structure is one of the major challenges of our community. But, you know, another way you could say that what's been also interesting is the way in which the English language community, in terms of the delivery of health and social services has been able to adapt to a very unique model for the delivery of services in Quebec: the Quebec model, which is something that tries to integrate both health and social services, and the way that the English language community has been able to work within this new model since the 1970s.

And I think one of the ways to think about it too, is that there is a vitality in that particular service delivery area, and those of you who are at the conference today are going to talk to us about some of the challenges, but hopefully also some of the bright spots in terms of how training, educating, can also lead to the right kinds of services to help these communities, not just now but as an investment in the future as well. And let's also remember that the emphasis that we place on communities, on the cultural and linguistic specificities of healthcare services and delivery for these linguistic groups also points to something else. And that's the essential role of healthcare as something beyond medicine, rather to see it as an act of caring, taking care, taking care of a community of people for whom their language and culture are an important part of their overall health.