The **Health** and **Social Services** System in **Québec**

In brief

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ENSEMBLE on fait avancer le Québec

Québec

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du ministère de la Santé et des Services sociaux

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Masculine pronouns are used generically in this document.

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Context

The health and social services system as we know it was created in 1971 following the adoption of the Act respecting health services and social services (chapter S-4.2) by the National Assembly of Québec.

Québec's system is a public system, with the government acting as the main insurer and administrator.

Insurance Plans

The population has access to hospital and medical services dispensed by the government through two universal plans:

- the Hospital Insurance Plan, introduced in 1961;
- and the Health Insurance Plan, introduced in 1970.

In addition, a number of services are available to specific groups free of charge, provided they meet certain criteria. These include dental services, vision-related services and devices that compensate for physical impairments.

Public health sector coverage for all Québecers was completed in 1997, with the introduction of the Public Prescription Drug Insurance Plan, a joint universal plan based on a partnership between the government and private insurers.

Lastly, individuals may subscribe to private plans offering additional insurance to pay for services and drugs not covered by the public plans.

Funding for services

Most of the funding for health and social services is taken from the general tax base, meaning that the risk can be spread more fairly throughout society. Most of the revenues are derived from the income taxes and other taxes charged by the Government of Québec and paid into the Consolidated Revenue Fund, from the contributions paid by individuals and employers into the Health Services Fund, and the Fund to Finance Health and Social Services Institutions and federal government transfers.

Health Expenditure

In 2012, total health expenditure[1] in Québec roughly totalled $43.5 billion. This includes both public expenses (including direct expenses covered by the federal government for the clienteles under its responsibility) and private expenses (amounts claimed from private insurance plans, direct payments – such as contributions to accommodation (CHSLD) and for the purchase of drugs – made by individuals, donations, etc.). Public health expenditure, which rose to $30.5 billion in 2012, accounted for 70.2% of the total.

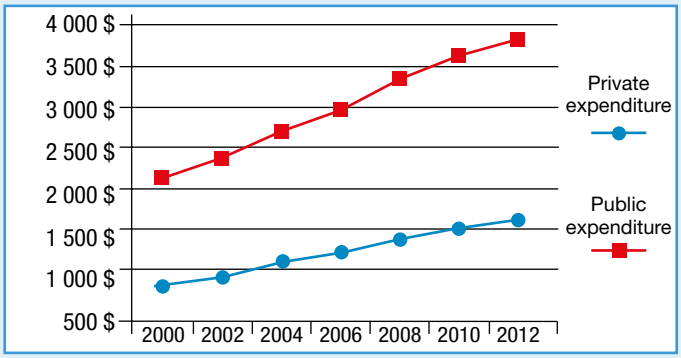
Comparative Health Expenditure, Québec and Canada, 2012

Expenditure	Québec	Canada**
Total health expenditure per capita*	$5,375	$5,911
Total health expenditure as a percentage of gross domestic product (GDP))	12,1 %	11,3 %
Public expenditure as a percentage of total health expenditure	70,2 %	70,6 %
Public health expenditure per capita*	$3,773	$4,175

* Data illustrated above are in current dollars.
** Including health expenditure in Québec.
Source: Canadian Institute for Health Information.

Between 2000 and 2012, public and private health expenditure grew annually by an average of 4.9 % and 5.8 % respectively.

Public and Private Health Expenditure per Inhabitant, in current dollars, Québec, 2000 to 2012



Source: Canadian Institute for Health Information.

1 Social services expenditure is not included in the estimates of the Canadian Institute for Health Information. It accounts for roughly 12% of total health and social services expenditure of the Government of Québec.

The Health and Well-Being of Québec's Population

The population's life expectancy at birth has risen since the 1920s, reaching 82.2 years in 2013.

Lifestyles have improved over recent years. However, in 2013, more than 50% of Québecers consumed fewer than five portions of fruit and vegetables a day. In 2011-2012, 22% of adults had a sedentary lifestyle and only 44% of adolescents were active during leisure time and engaged in active transport. The percentage of obese adults also increased from 11% to 18% between 1994 and 2013. Moreover, Québec has one of the highest percentages of smokers among the provinces of Canada.

An overwhelming percentage of the population describes themselves as being in good physical and mental health. Another positive sign is that, since the early 2000s, Québec's suicide rate has decreased, particularly among young men and adolescents.

In Québec, as in most industrialized countries, the increased prevalence of chronic disease and disability as well as the anticipation of greater needs related to long-term care are placing significant pressure on the health and social services system. Nearly half the population aged 15 or over reported at least one chronic health problem in 2010-2011. Today, 24% of Québecers aged 20 or over have high blood pressure, and 9% are diabetic (2012-2013).

The prevalence of cardiac disease and cancer is also increasing. Since 2000, cancer has been the leading cause of death despite an improvement in the survival rate five years after diagnosis. More than half of all new cancer cases involve prostate cancer, lung cancer, breast cancer or colorectal cancer. Alzheimer's disease and other types of dementia are also on the rise.

In 2010-2011, roughly 11% of the population, of all ages, had a moderate to severe disability.

This prevalence nevertheless increases with age. The disability rate among children has been increasing in Québec since 2001.

Québec's population is also ageing rapidly. The percentage of people aged 65 or over, which was between 12% and 13% in the late 1990s, will double to 25% by 2031. Only in Japan is the population ageing more quickly than in Québec.

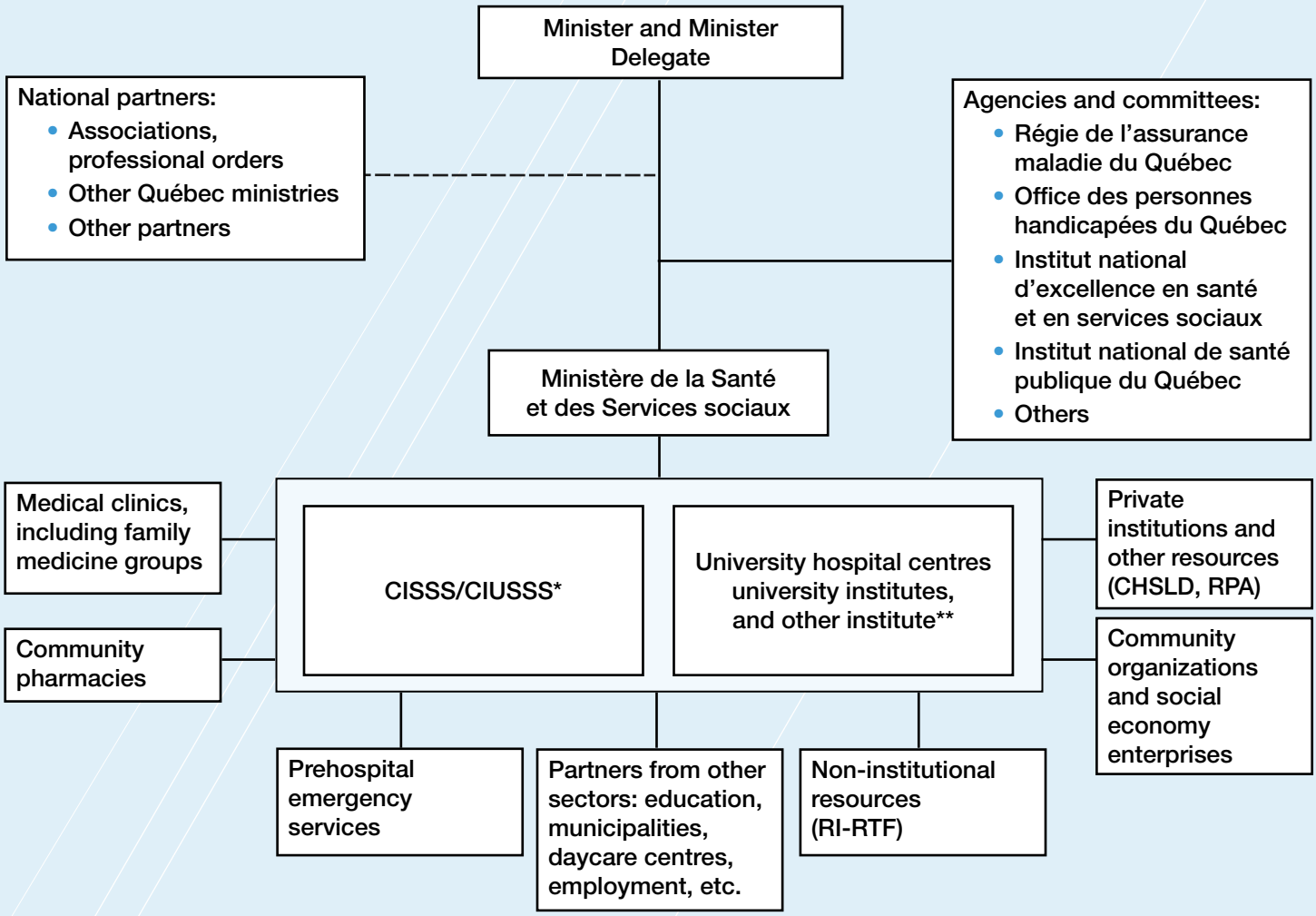
In addition to the pressure it places on the demand for health services and social services, this trend means that the supply must be adjusted to respond more effectively to the changing needs of people suffering from chronic diseases, cognitive disorders or disabilities in daily life.

In 2011-2012, 12% of the population were affected by diagnosed mental disorders.

A number of behavioral and social problems among Québec's population continue to be a challenge, such as problems related to alcohol, drug or gambling issues or dependency.

Lastly, despite gains made in recent years, health-related social inequalities still persist. These inequalities, which are related to poverty and other conditions, result among other things in a lower life expectancy and higher rates of chronic disease, drug and alcohol dependency and youth protection interventions.

Structure of the Health and Social Services System



* Nine of the 22 integrated centres can use the "integrated university health and social services centre" designation in their name.

** The following seven institutions are attached to the Ministère and provide specialized and highly specialized services beyond their health region border : CHU de Québec - Université Laval; Institut universitaire de cardiologie et de pneumologie de Québec - Université Laval; Centre hospitalier de l'Université de Montréal; McGill University Health Centre; Centre hospitalier universitaire Sainte-Justine; Montreal Heart Institute; Institut Philippe-Pinel de Montréal. These institutions were not merged under the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies

In addition, five public institutions offer services to a northern and aboriginal population. They are not shown in the above illustration.

Abbreviations

- **CHSLD**: residential and long-term care centre
- **CISSS**: integrated health and social services centre
- **CIUSSS**: integrated university health and social services centre
- **"Act"**: An Act to modify the organization and governance of the health and social services network, in Particular by Abolishing the Regional Agencies
- **RI/RTF**: intermediate and family-type resource
- **RPA**: private residence for seniors

Main Roles and Responsibilities

The Québec health and social services system is comprised of two management levels and an integrated model of health and social services. Health and social services agencies were abolished when the Act to modify the organization and governance of the health and social services network, in Particular by abolishing the regional agencies (CQLR, chapter O-7.2), came into force on April 1, 2015.

The functions and responsibilities of those agencies have been reassigned in part to the Ministère de la Santé et des Services sociaux (MSSS) and in part to new institutions that were created through the amalgamation of public institutions in a given region and its regional agency. These institutions are known either as integrated health and social services centres or integrated university health and social services centres. Integrated centres located in health regions where a university offers a complete undergraduate medical program or operates a centre that is designated as a university institute in the social field are called integrated university health and social services centres.

In health regions with more than one integrated centre (Montréal, Gaspésie—Îles-de-la-Madeleine and Montérégie), the previous agency has been amalgamated into only one of the new institutions.

Responsibilities of the Ministère de la Santé et des Services sociaux

- Regulate and coordinate the entire health and social services system;
- Determine health and welfare policy directions and standards that apply to service organization and human, material and financial resource management within the network, and ensure their application;
- Fulfill national public health functions (monitoring of population health; promotion of health and well-being; prevention of diseases, psychosocial problems and traumas; and health protection);
- Ensure interregional coordination of services;
- Ensure that inter-institutional service reference and coordination mechanisms are in place and functional;
- Divide financial, human and material resources fairly and monitor their use;
- Assess, for the entire network, results obtained compared to the goals set in order to improve system performance.

Responsibilities assigned to all health and social services institutions

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

Special responsibilities for integrated centres

- Ensure that the population participates in network management;
- Plan and coordinate services to be provided to the population within their territory in accordance with ministerial policy directions, the needs of the population and territorial realities;
- Put in place measures aimed at the protection of public health and the social protection of individuals, families and groups;
- Ensure availability of services for the whole population of their territory, with special attention to the most vulnerable;
- Establish any required regional or interregional service corridors and sign agreements with the institutions and other partners in their territorial service network so as to meet the needs of the population;
- Ensure the development and proper functioning of the local service networks within their territory;
- Subsidize community organizations and allocate funding to required private resources.

All integrated centres have identical functions and responsibilities, whether or not they have university designation. However, the composition of the boards of directors of integrated university health and social services centres is different, since two board members are appointed based on a list of names provided by the universities.

The Ministère and its Partners

The mission of the Ministère de la Santé et des Services sociaux (MSSS) and the health and social services network is to maintain, improve and restore the population's health and well-being by providing access to a range of integrated and quality health and social services and thereby, contributing to the social and economic development of Québec.

Here is the list of laws whose application falls under partial or complete authority of the Minister of Health and Social Services (**Appendice 1**).

Several agencies and other entities related field of health and social services are under the authority of the Minister.

These include:

- L'Institut national d'excellence en santé et en services sociaux;
- Héma-Québec;
- L'Institut national de santé publique du Québec;
- L'Office des personnes handicapées du Québec;
- La Régie de l'assurance maladie du Québec.

Québec Health Regions

The Ministry implements its mission by sharing its responsibilities with health facilities and social services in 18 regions health and social.

(View the map of health regions Québec in appendice 2)

Health and Social Services Institutions

Health and Social Services Institutions provide general and specialized services to the population that correspond to the five major missions defined in the Act Respecting Health Services and Social Services (CQLR, chapter S-4.2) and vary according to whether they are a:

- Local community service centre (CLSC);
- Hospital centre (CH);
- Residential and long-term care centre (CHSLD);
- Child and Youth protection centre (CPEJ);
- Rehabilitation centre (CR).

In Québec, institutions may carry out more than one mission. Thus, integrated health and social services centres and integrated university health and social services centres may operate one or more of the following: CLSC, CHSLD, CH, CPEJ or CR. Such mission groupings are aimed at improving the integration of services.

Local Community Service Centre

The mission of the local community service centre (CLSC) is to provide, to the population of its territory, frontline common health and social services, as well as preventive, curative, rehabilitative and/or reinsertion services and carry out public health activities. Integrated centres that assume this mission must ensure that persons needing such services for themselves or their loved ones are contacted, that their needs are evaluated and that the required services are provided at their sites or in the living environments of these individuals, meaning at school, at work or at home. If needed, the centres will ensure that they are directed to the centres, organisations or persons most likely to help them.

Hospital Centre

The mission of the hospital centre (CH) is to provide diagnostic services, as well as general and specialized medical care. There are two categories of hospital centres:

- General and specialized hospital centres;
- Psychiatric care hospital centres.

Residential and Long-term Care Centre

The mission of the residential and long-term care centre (CHSLD) is to provide temporary or permanent lodging, assistance, support and monitoring, as well as psychosocial, nursing, pharmaceutical, medical and rehabilitation services to adults who, because of their loss of functional and/or psychosocial autonomy, are no longer able to remain in their natural living environments.

Child and Youth Protection Centre

The mission of the child and youth protection centre (CPEJ) is to provide psychosocial services (including emergency social services) to youths who need them in situations defined by the Youth Protection Act (CQLR, chapter P-34.1) and the Youth Criminal Justice Act (SC 2002, chapter 1). This mission also covers child placement, family mediation, Superior Court child custody expertise, adoption and research of the biological family history.

Rehabilitation Centre

The mission of the rehabilitation centre (CR) is to provide adaptation and/or rehabilitation and social integration services to individuals that require them due to physical or intellectual disabilities, behavioural, psychosocial or family problems, dependency on alcohol, drug, or gambling issues, as well as any other form of dependency. Rehabilitation centres are also required to provide coaching and support for the immediate family of the people it serves.

Rehabilitation centres belong to one or more of the following categories, depending on their clientele:

- Rehabilitation centres for individuals with an intellectual disability or pervasive developmental disorder;
- Rehabilitation centres for individuals with a physical disability (hearing, sight, motor or speech);
- Rehabilitation centres for individuals with a dependency;
- Rehabilitation centres for youths in trouble of adaptation;
- Rehabilitation centre for mothers in trouble of adaptation.

Breakdown by types of institutions

Since the Act to modify the organization and governance of the health and social services network, in Particular by abolishing the regional agencies came into force on April 1, 2015, the Québec health and social services network includes the following:

- Twenty-two integrated health and social services centres, nine of which are designated as university health and social services integrated centres. Only integrated centres located in a health region where a university offers a complete undergraduate medical program or operates a university institute in the social field are entitled to use the wording “integrated university health and social services centre” in their title;
- Four university hospital centres (CHU), two university institutes (IU) and one institute;
- Five institutions offering services to an Aboriginal and northern population.

Each institution may offer services in several sites that are physical locations where health and social services are provided.

It should be noted that 17 institutions that were not amalgamated under the Act have been grouped into integrated centres, and are managed by the centre’s board of directors.

In addition to the services provided by public institutions, the population benefits from services such as lodging and long-term care that are provided by private institutions.

Moreover, four integrated university health networks (RUIS) promote collaboration and complementarity, and fulfill the combined mission of care, teaching and research that is incumbent upon the health institutions and the universities with which they are affiliated. These are the Université Laval, McGill University, Université de Montréal and Université de Sherbrooke integrated university health networks.

Partners of the system

In addition to institutional resources, the following partners contribute to the success of Québec's health and social services mission:

- General practitioners and specialists;
- Community-based pharmacists;
- Prehospital emergency services;
- Community organizations;
- Social economy enterprises for in-home support services;
- Intermediate and family-type resources;
- Private residences for seniors.

General practitioners and specialists

Although general practitioners and specialists are self-employed, an overwhelming majority of these physicians work exclusively within the public system, which has always been able to form partnerships with them.

The Régie de l'assurance maladie du Québec (RAMQ) is responsible for remunerating doctors that practice in the public system. New remuneration practices were introduced in 1999, but fee-for-service payment remains the principal method of remuneration for these health professionals.

Description of medicine groups

Among the various types of practice, family medicine groups (GMF), is favoured by Québec as a way of improving access to a family doctor for all citizens; and network clinics as well.

Family medicine groups

A family medicine group is defined as an organization of family doctors working as a group in close collaboration with nurses and other health professionals from the public network. These groups provide frontline medical services, with or without appointments, at its clinic or in patients' homes during weekday, weekend and holiday business hours. Registering with a family doctor who is a member of a family medicine group is voluntary and free of charge.

Network Clinics

Network clinics are designed on an organizational model that promotes access to frontline medical services.

Complementary to family medicine groups, network clinics provide access to a broader spectrum of medical services that are available during longer hours of operation. As an example, setting up a direct service corridor with an integrated health and social services centre or integrated university health and social services centre improves the general practitioners' access to technical platforms and specialized care .

Community pharmacists

Around 70% of pharmacists work in community-based pharmacies and 33% of them has their own pharmacy. In Québec, only a pharmacist may own a pharmacy, which is a unique situation in Canada.

Community-based pharmacists ensure access to pharmaceutical services for patients that receive ambulatory health care.

The role of the pharmacist is to assess and ensure the appropriate use of medication, in order to prevent drug-related problems in particular; and prepare, store and deliver medication in order to maintain and/or restore health.

Modifications to the Pharmacy Act (CQLR, chapter P-10), on June 20, 2015, permits pharmacists to exercise new activities such as:

- Extend a prescription;
- Prescribe medication when a diagnosis is not required;
- Prescribe and interpret laboratory analysis;
- Adjust a prescription;
- Substitute a medication should there be a break in supply;
- Prescribe medication for minor conditions in cases where diagnosis and treatment are known;
- Administer medication in order to demonstrate appropriate use.

Data on the health and social services workforce

The health and social services workforce represents approximately 6.9 % of the Québec's active population. As of March 31, 2014, the network employed:

- 975 managers, professionals and public servants at the Ministère itself, as well as 1,702 at the Régie de l'assurance maladie du Québec (RAMQ);
- 268,127 managers or employees in the regional authorities or other health and social services agencies, as well as public or private institutions under agreement:
  - 191,295 persons allocated to service programs including 112,973 nurses, nursing assistants or orderlies and 58,341 technicians or health and social services professionals;
  - 76,832 persons allocated to support programs or members of the management staff.

In addition, in 2013-2014, 30,318 professionals were remunerated by the RAMQ, of which 8,710 were general practitioners, 9,779 were specialist physicians and 3,544 were medical residents.

The health and social services agencies were abolished on April 1, 2015, when the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies (CQLR, chapter O-7.2) came into force. Part of their workforce was transferred in the new institutions and in the Ministère.

Prehospital emergency services

In addition to ambulance services, other steps have been taken to ensure the population of an efficient response to any emergency situation.

This is the case for 911 emergency services whose response is assured by the municipal or territorial emergency call centre, which in turn directs calls to the health communication centre (CCS) whenever ambulance services are needed. CCS medical emergency dispatchers determine the nature of the situation and very quickly contact ambulance services.

Ambulance service paramedics are responsible for evaluating the health status of patients, providing them with any necessary immediate care and transporting them to a hospital centre. Ambulance services in Québec are provided by private enterprises, cooperatives and Urgences-santé, which is a public sector enterprise covering the Montréal and Laval areas.

Community organizations

Subsidized community organizations are recognized by the Ministère and its institutions as independent partners of the health and social services system. Their main roles are:

- Providing prevention, assistance and support services that include temporary lodging;
- Conducting activities aimed to promote and defend the rights and interests of individuals that use health and/or social services;
- Promoting social development, improvement of living conditions and better health for the population of Québec;
- Meeting new needs by using innovative approaches or targeting specific groups of individuals.

Social economy enterprises for in-home support services

Social economy enterprises for in-home support services provide light and heavy housekeeping, wardrobe care, meal preparation, supplies and such to individuals with disabilities. The type of service is paid for in part by users based on their income, and in part by the government.

These partners also provide respite and monitoring services to family caregivers and personal assistance services for activities of daily living that require the help of a third party (washing, dressing, eating, etc.) or that relate to personal care, such as urinary and intestinal functions, measurement of vital signs and administration of medication. These services are complementary to the ones provided by the public sector.

Intermediate and family-type resources

Complementary to natural and institutional living environments, intermediate and family-type resources have their proper place within the range of Québec's health and social services. Their individualized response to a diversity of changing needs makes it possible for the individuals to foster and maintain social integration, participation and recovery within the community. They provide support and assistance services to individuals of all ages.

Acting in a spirit of partnership with the public institutions that ensure the professional monitoring of the individuals under their care, these resources complement the public institutional mission by providing quality health and social services to people who need them.

The main types of residential organization in intermediate resources are supervised apartments, rooming houses, shelters and group homes, while family-type resources include foster care for children and shelters for adults and the elderly.

Private residences for seniors

A new government regulation came into effect in 2013 in order to tighten up the certification process regarding private residences for seniors.

The use of the designation "private residence for seniors" is now dependant on receiving compliance certification. There are two categories of private residences, the first providing services to independent seniors and the second, providing services to semi-independent seniors. The government has established criteria and operational standards for each category in order to ensure quality of services and safety to the residents.

Territorial and local service networks

Territorial integration of health and social services is supported through area networks (RTS) designed to ensure both proximity and continuity of services.

Integrated health and social services centres or integrated university health and social services centres (integrated centre) are responsible for ensuring the development and proper functioning of all local health and social service networks that operate within its territorial service network.

Integrated centres and their partners share collective responsibility for providing integrated services that correspond to the needs of the population they serve, with a view to maintaining and/or improving health and welfare. In order to properly fulfill this population-based responsibility, they are required to provide comprehensive treatment and services in close proximity to the living environments of their clients. They are also required to ensure proper care and follow-up of their clients within the health and social services system. Among other principles, the model is based on service hierarchy, which facilitates complementarity of services and patient migration between frontline, secondary and tertiary services.

Integrated centres ensure the coordination of services provided by all partners in the network, which are the following:

- Medical clinics and family medicine groups (GMF);
- Community-based pharmacies;
- Community organizations;
- Social economy enterprises;
- Private institutions and other resources such as residential and long-term care centres (CHSLD) or private residences for seniors (RPA);
- Non-institutional intermediate and family-type resources;
- Unamalgamated university hospital centres

and institutes that provide specialized or highly specialized services to the population;

- If applicable, other integrated centres with supra regional mandates that provide specialized or highly specialized services to patients in the service network may be added in compliance with established service corridors, such as a hospital centre, a child and youth protection centre or a rehab centre;
- Partners from other sectors: schools, municipalities, employment, etc.

(Appendice 3)

Service and Support Programs

In Québec, the health and social services system is divided into service and support programs. This provides a framework for planning, budgeting, resource allocation and reporting.

There are currently nine service programs:

- Two designed to answer to general population needs:
  - **Public health,** that promote, prevent and protect health and well-being, and monitor general population health;
  - **General services–clinical and assistance activities,** which covers frontline care for health issues and temporary social problems.
- Seven service programs that deal with specific issues:
  - Support for independant seniors;
  - Physical disabilities, for impairments related to hearing, vision, language, speech and motor activities;
  - Intellectual impairments and autism spectrum disorder;
  - Youth with difficulties;
  - Dependencies such as alcoholism, drug addiction and compulsive gambling;
  - Mental health;
  - Physical health, which covers emergency services, specialized and highly specialized services, continuous services requiring systematic follow-up (for example, chronic disease, cancer, etc.), as well as palliative care.

The three support programs provide administrative and technical functions that support service programs. They are :

- Administration;
- Service support;
- Building and equipment management.

Appendice **1**

List of laws whose application falls under partial or complete authority of the Minister of Health and Social Services

An Act respecting clinical and research activities relating to assisted procreation (CQLR, chapter A-5.01)

Hospital Insurance Act (CQLR, chapter A-28)

Health Insurance Act (CQLR, chapter A-29)

An Act respecting prescription drug insurance (CQLR, chapter A-29.01)

An Act respecting Cree, Inuit and Naskapi Native persons. (CQLR, chapter A-33.1)

An Act to prevent skin cancer caused by artificial tanning (CQLR, chapter C-5.2)

Non-Catholic Cemeteries Act (CQLR, chapter C-17)

An Act respecting the Health and Welfare Commissioner (CQLR, chapter C-32.1.1)

An Act to provide for balanced budgets in the public health and social services network (CQLR, chapter E-12.0001)

An Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration (CQLR, chapter E-20.1)

An Act to establish the Fund for the promotion of a healthy lifestyle (CQLR, chapter F-4.0021)

An Act respecting Héma-Québec and the biovigilance committee (CQLR, chapter H-1.1)

Burial Act (CQLR, chapter I-11)

An Act respecting the Institut national d'excellence en santé et en services sociaux (CQLR, chapter I-13.03)

An Act respecting Institut national de santé publique du Québec (CQLR, chapter I-13.1.1)

An Act respecting medical laboratories, organ and tissue conservation and the disposal of human bodies (CQLR, chapter L-0.2)

An Act to ensure that essential services are maintained in the health and social services sector (CQLR, chapter M-1.1

An Act respecting the Ministère de la Santé et des Services sociaux (CQLR, chapter M-19.2)

An Act to implement the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (CQLR, chapter M-35.1.3)

Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, (CQLR, chapter O-7.2)

An Act respecting the sharing of certain health information (CQLR, chapter P-9.0001)

Youth Protection Act (CQLR, chapter P-34.1)

An An Act respecting the protection of persons whose mental state presents a danger to themselves or to others (CQLR, chapter P-38.001)

Tobacco-related Damages and Health Care Costs Recovery Act (CQLR, chapter R-2.2.0.0.1)

An Act respecting the Régie de l'assurance maladie du Québec (CQLR, chapter R-5))

An Act respecting the representation of family-type resources and certain intermediate resources and the negotiation process for their group agreements (CQLR, chapter R-24.0.2)

Public Health Act (CQLR, chapter S-2.2)

An Act respecting health services and social services (CQLR, chapter S-4.2)

An Act respecting health services and social services for Cree Native persons (CQLR, chapter S-5)

An Act respecting pre-hospital emergency services (CQLR, chapter S-6.2)

An Act respecting end-of-life care (CQLR, chapter S-32.0001

Tobacco Act (CQLR, chapter T-0.01)

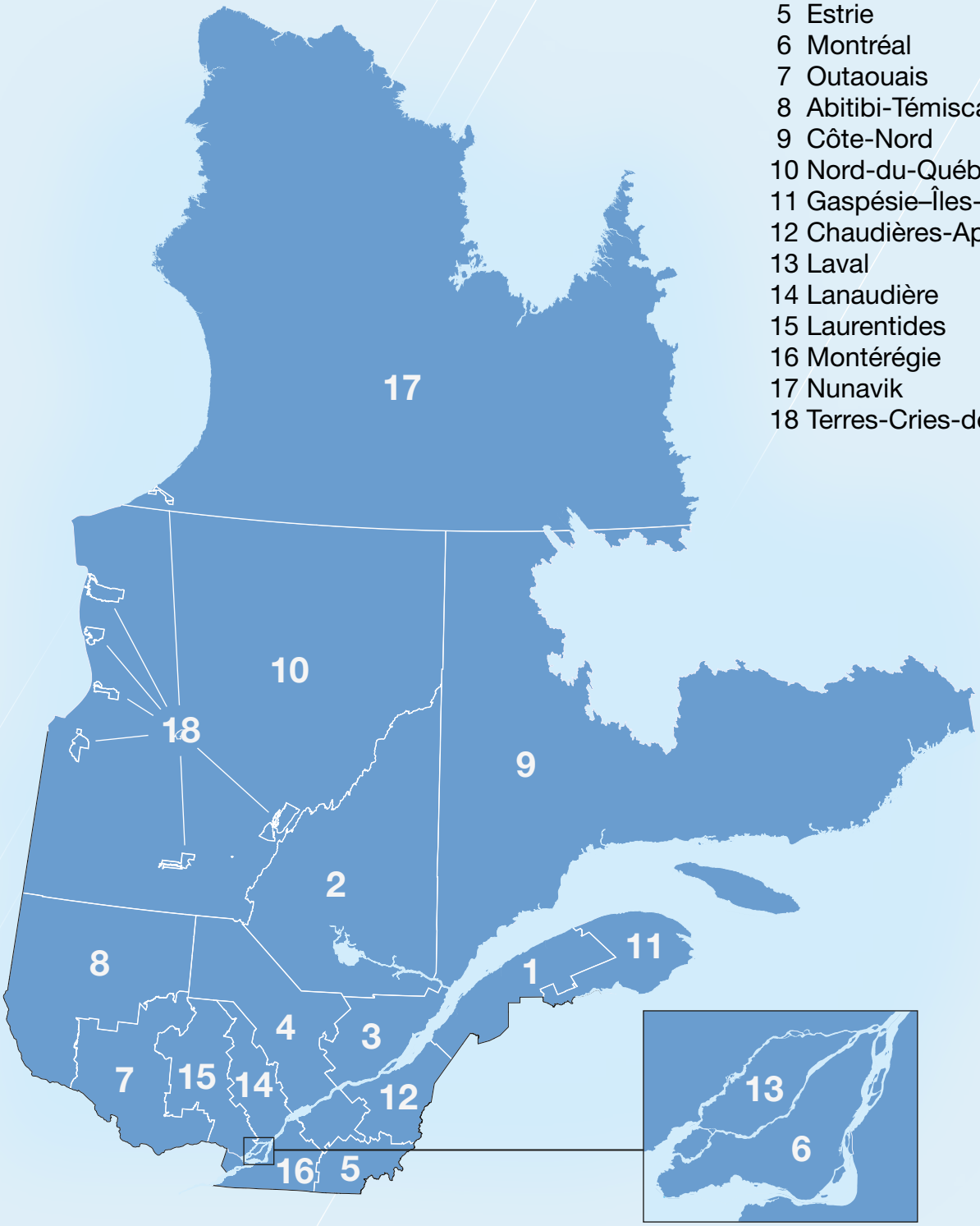
An Act respecting bargaining units in the social affairs sector (CQLR, chapter U-0.1)

Appendice **2**

The Ministère de la Santé et des Services sociaux fulfills its mission by sharing its responsibilities with health and social services institutions spread across 18 health regions. More than 60 % of the Québec population lives in the Montréal, Laval, Lanaudière, Laurentides and Montérégie regions.

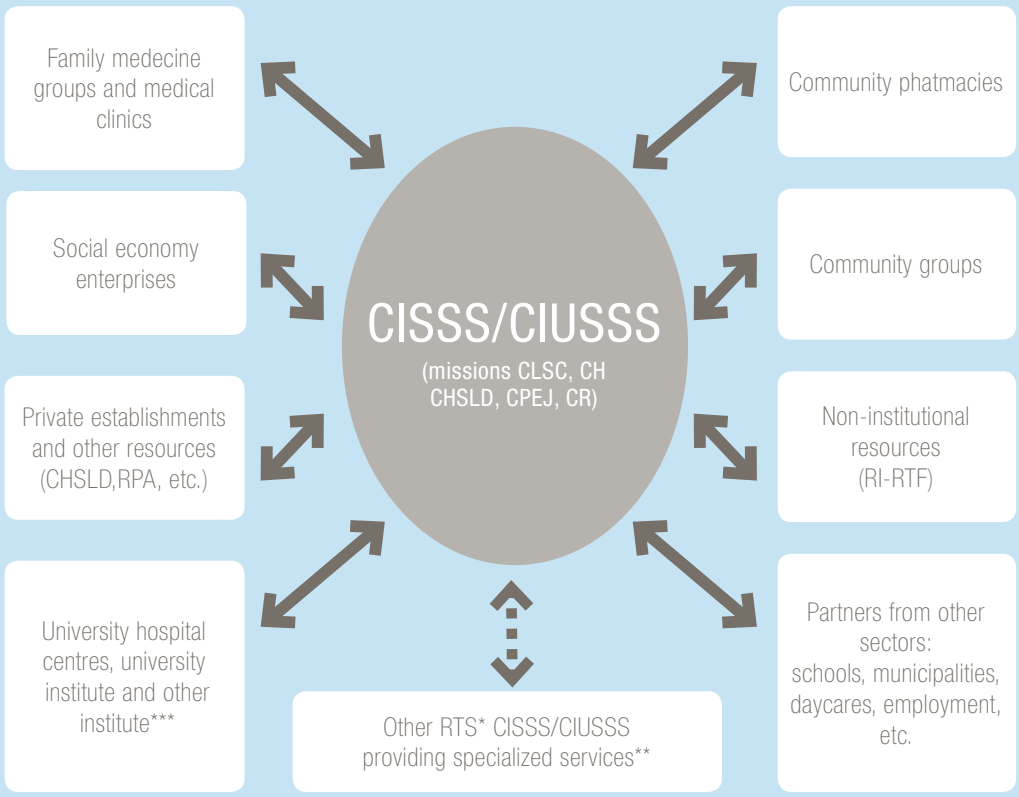
The Québec Health Regions

1 Bas-Saint-Laurent
2 Saguenay–Lac-Saint-Jean
3 Capitale-Nationale
4 Mauricie et Centre-du-Québec
5 Estrie
6 Montréal
7 Outaouais
8 Abitibi-Témiscamingue
9 Côte-Nord
10 Nord-du-Québec
11 Gaspésie–Îles-de-la-Madeleine
12 Chaudières-Appalaches
13 Laval
14 Lanaudière
15 Laurentides
16 Montérégie
17 Nunavik
18 Terres-Cries-de-la-Baie-James



Appendice **3**

MAIN ACTORS OF A TERRITORIAL OR LOCAL HEALTH AND SOCIAL SERVICES NETWORK*



* Any given RTS may include more than one RLS that uses identical categories and partners at the local level.

** The CISSS or CIUSSS must establish, if necessary, regional or interregional service corridors in order to complete the services provided to the population of their territory.

*** These institutions were not merged under the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies (CQLR, chapter O-7.2).

Abbreviations:

- CH: hospital centre
- CHSLD: residential and long-term care centre
- CISSS: integrated health and social services centre
- CIUSSS: integrated university health and social services centre
- CLSC: local community service centre
- CPEJ: child and youth protection centre
- CR: rehabilitation centre
- GMF: family medicine group
- RI/RTF: intermediate and family-type resource
- RPA: private residence for seniors

Appendice **4**

International Adoption

- Guide d'intervention en adoption internationale (2011)

Cancer

- Plan directeur en cancérologie : Ensemble, en réseau, pour vaincre le cancer (2013)
- Plan d'action en cancérologie 2013-2015 : Ensemble, en réseau, pour vaincre le cancer (2013)
- Mécanisme central de gestion d'accès à la chirurgie oncologique : cadre de référence (2012)
- Politique en soins palliatifs de fin de vie (2004)
- Programme québécois de lutte contre le cancer : Pour lutter efficacement contre le cancer, formons équipe (1997)
- Programme québécois de dépistage du cancer du sein : Cadre de référence (1996)
- Politique de suivi des femmes dans le cadre du Programme québécois de dépistage du cancer du sein (2013)
- L'évaluation et la désignation des établissements et des équipes 2005-2009 : bilan (2010)

Physical impairment, intellectual impairment and pervasive developmental disorders

- Bilan 2008-2011 et perspectives : Un geste porteur d'avenir – Des services aux personnes présentant un trouble envahissant du développement, à leurs familles et à leurs proches (2012)
- Plan d'action 2011-2014, pour l'intégration scolaire, professionnelle et sociale des personnes handicapées (2011)
- Plan d'accès aux services pour les personnes ayant une déficience : Afin de faire mieux ensemble (2008)
- Cadre de référence pour les services surspécialisés de réadaptation en déficience physique (2007)
- Pour une véritable participation à la vie de la communauté : Orientations ministérielles en déficience physique – Objectifs 2004-2009 (2003)
- De l'intégration sociale à la participation sociale : Politique de soutien aux personnes présentant une déficience intellectuelle, à leur famille et aux autres proches (2001)

Dependency and Homeless

- Plan d'action interministériel en itinérance 2015-2020 – Mobilisés et engagés pour prévenir et réduire l'itinérance (2015)
- Politique nationale de lutte à l'itinérance - Ensemble pour éviter la rue et en sortir (2014)
- L'itinérance au Québec : Cadre de référence (2008)
- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Programme-services Dépendances – Offre de service 2007-2012 (2007)
- Plan d'action interministériel en toxicomanie 2006-2011 (2006)

Sustainable development

Plan d'action de développement durable 2009-2015 : Prévenir et agir, pour la santé de notre avenir (mise à jour 2013) (2013)

Women

- Au féminin… À l'écoute de nos besoins : Plan d'action en santé et bien-être des femmes 2010-2013 (2010)

Youth in difficulty

- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Programme-services Jeunes en difficulté – Offre de service 2007-2012 (2007)
- De la complicité à la responsabilité : Rapport du Comité sur le continuum de services spécialisés destinés aux enfants, aux jeunes et à leur famille (2004)
- La protection des enfants au Québec : une responsabilité à mieux partager – Rapport du Comité d'experts sur la révision de la Loi sur la protection de la jeunesse (2004)
- Stratégie d'action pour les jeunes en difficulté et leur famille (2002)

Home support

- Cadre de référence - Les ressources intermédiaires et les ressources de type familial (2014)
- Cadre de référence sur le soutien communautaire en logement social : Une intervention intersectorielle des réseaux de la santé et des services sociaux et de l'habitation (2007)
- Chez soi : Le premier choix – La politique de soutien à domicile (2003)

Chronic disease

- Cadre de référence pour la prévention et la gestion des maladies chroniques physiques en première ligne (2012)

Medication

- La politique du médicament (2007)

Organization of the health and social services network

- Politique ministérielle de sécurité civile – Santé et Services sociaux (2014)
- Plan stratégique du ministère de la Santé et des Services sociaux 2015-2020 (2015)
- Cadre de référence pour la désignation universitaire des établissements du secteur des services sociaux : Mission, principes et critères (2010)
- Cadre de référence des établissements publics du réseau de la santé et des services sociaux pour l'autorisation d'une recherche menée dans plus d'un établissement (2014)
- Programme de financement et de soutien professionnel pour les groupes de médecine de famille (GMF) (2015)

Age-related loss of autonomy

- Approche adaptée à la personne âgée en milieu hospitalier : Cadre de référence (2011)
- Un défi de solidarité : Les services aux aînés en perte d'autonomie – Plan d'action 2005-2010 (2005)
- Un milieu de vie de qualité pour les personnes hébergées en CHSLD : Orientations ministérielles (2003)
- Orientations ministérielles sur les services offerts aux personnes âgées en perte d'autonomie (2001)

Perinatality and early childhood

- Programme québécois de dépistage de la surdité chez les nouveau-nés - Cadre de référence (2012)
- Stratégies de mise en œuvre de la Politique de périnatalité 2009-2012 : Un projet porteur de vie (2010)
- Politique de périnatalité 2008-2018 : Un projet porteur de vie (2008)
- Les services intégrés en périnatalité et pour la petite enfance à l'intention des familles vivant en contexte de vulnérabilité : Cadre de référence (2004)
- Naître égaux – Grandir en santé : Un programme intégré de promotion de la santé et de prévention en périnatalité (1995)

Respect for individuals

- Cadre de référence pour la promotion, le respect et la défense des droits en santé mentale (2006)
- Cadre de référence pour l'élaboration des protocoles d'application des mesures de contrôle – Contention, isolement et substance chimique (2015)

Mental health

- Plan d'action en santé mentale 2015-2020 Faire ensemble et autrement (2015)
- Orientations relatives à l'organisation des soins et des services offerts à la clientèle adulte par les équipes en santé mentale de première ligne en CSSS (2011)
- Guichet d'accès en santé mentale pour la clientèle adulte des CSSS (2008)

- Prévention du suicide - Guide de bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux (2010)
- Prévention du suicide : Guide de soutien au rehaussement des services à l'intention des gestionnaires des centres de santé et de services sociaux (2010)
- L'implantation de réseaux de sentinelles en prévention du suicide : Cadre de référence (2006)
- Stratégie québécoise d'action face au suicide : S'entraider pour la vie (1998)

Public health

- Pour une prestation sécuritaire des soins de santé au Québec - Plan d'action ministériel 2015-2020 sur la prévention et le contrôle des infections nosocomiales (2015)
- Programme national de santé publique 2015-2025 : Pour améliorer la santé de la population du Québec (2015)
- Stratégie de soutien à l'exercice de la responsabilité populationnelle (2011)
- La prévention et le contrôle des infections nosocomiales : Cadre de référence à l'intention des établissements de santé du Québec (2006)
- Plan québécois de prévention du tabagisme chez les jeunes 2010-2015 (2010)
- Cadre de référence en matière de sécurité alimentaire : Mise à jour 2008 (2008)
- Investir pour l'avenir : Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012 (2006)
- Plan d'action de santé dentaire publique 2005-2012 (2006)
- Plan québécois de lutte à une pandémie d'influenza : Mission santé (2006)
- Cadre d'orientation pour le développement et l'évolution de la fonction de surveillance au Québec (2007)
- Pour une prestation sécuritaire des soins de santé au Québec : Plan d'action ministériel 2015-2020 sur la prévention et le contrôle des infections nosocomiales (2015)
- Stratégie québécoise de lutte contre l'infection par le VIH et le sida, l'infection par le VHC et les infections transmissibles sexuellement : Orientations 2003-2009 (2004)

General services

- Orientations relatives aux standards d'accès, de continuité, de qualité, d'efficacité et d'efficience : Services sociaux généraux – Offre de service (2013)
- Services Info-Santé et Info-Social : Cadre de référence sur les aspects cliniques des volets santé et social des services de consultation téléphonique 24 heures, 7 jours à l'échelle du Québec (2007)

Domestic violence and sexual assault

- Orientations gouvernementales en matière d'agression sexuelle (2001)
- Politique d'intervention en matière de violence conjugale : Prévenir, dépister, contrer la violence conjugale (1995)