REPORT OF THE TASK FORCE
ON THE FUNDING OF THE HEALTH SYSTEM

FEBRUARY 2008

GETTING OUR MONEY'S WORTH

ACCESSIBLE PATIENT SERVICES
SUSTAINABLE FUNDING
A PRODUCTIVE SYSTEM
SHARED RESPONSIBILITY

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LETTER AND SIGNATURES OF THE THREE MEMBERS OF THE TASK FORCE

Madam Minister of Finance,
Minister of Government Services,
Minister responsible for Government Administration
and Chair of the Conseil du trésor,

Mr. Minister of Health and Social Services,
Minister responsible for the Capitale-Nationale region

Last June 27, the Cabinet confirmed and concretized the mandate entrusted to our Task Force on the occasion of the Budget Speech of the previous May 24.

Upon the conclusion of our reflections and analyses, we hereby submit the report on the work undertaken at your initiative.

We hope that the recommendations presented in this report will fulfill the expectations you formulated and thereby contribute to meeting the major challenge represented by funding of the Québec health care system.

As you will observe, our Task Force could not achieve unanimity on all of the recommendations and proposals presented in the report. Michel Venne recorded a dissenting position on three points specifically identified in the report. This position is explained in one of the appendices.

To prepare this report, our Task Force benefited from the effective and devoted support of public servants belonging to the Ministère des Finances, the Ministère de la Santé et des Services sociaux, the Secrétariat du Conseil du trésor and the Ministère du Conseil exécutif. We must emphasize the importance and value of this support, which greatly facilitated our work.

In particular, we want to mention the support provided by Brian Girard, Secretary of our Task Force, Pierre Côté, Assistant Secretary and Alain Boisvert, Michèle Bourget, Jacques Cotton and Jean-Pierre Pellegrin.

Thank you for the confidence you have shown in us, and please accept our best regards.

Claude Castonguay
Chair of the Task Force on Health Funding

Joanne Marcotte
Vice-Chair of the Task Force on Health Funding

Michel Venne
Vice-Chair of the Task Force on Health Funding

PREFACE

Over the past few decades, there have been profound transformations in every sector of activity of the industrialized world. These transformations have accelerated under the influence and pressure of trade liberalization and globalization.

Such a movement necessitated adaptation and modernization of postwar Welfare State policies. The mandate entrusted to us falls within a similar perspective, one of adapting the social policies arising from the Quiet Revolution to the new economic context and to globalization.

A general movement of change

All the industrialized countries are confronted with the same problem. The challenge everywhere is to continue improving the quality of care and access to care, while controlling the growth of public health spending. In the past twenty years, health care systems all over the world have thus been the object of multiple reforms.

Some countries have even literally engaged in a permanent process of change. The Scandinavian countries, the cradle of social democracy, have blazed the trail. They have initiated the movement followed by Germany, the United Kingdom and most of the industrialized countries.

Canada and Québec

However, it must be observed that Canada and Québec have not been as systematic in engaging in such a movement. In Québec, the health care system was considered one of the achievements of the Quiet Revolution and thus has long been perceived as untouchable. In the other provinces, the health care system has become the symbol differentiating Canadians from their American neighbours.

On the political level, any reconsideration of the system and its funding modes risked denunciation as an attempt to introduce a two-tier system. To control the growth of public health spending, successive governments have thus resorted to rationing methods and authoritarian governance. Wait times have lengthened. The system's productivity has declined. Employee motivation has plummeted. Public dissatisfaction with the health care system has been accentuated.

We must face facts: today, the public system does not seem to be able to satisfy public demand.

Questions of the utmost importance

Our health care system raises questions of the utmost importance. Its future concerns most Quebecers and affects them to varying degrees in their daily lives.

In general, the growth of public health spending is the number one challenge of our public finances. Above all, it is encroaching ever increasingly on the State's other missions. The growth rate of public health spending is unsustainable, because of all the implications arising from it. This is an inevitable certainty.

Major and judicious changes have been made to our health care system in the past few years. Despite these changes and the massive injection of funds by the government, the situation regarding access to care remains clearly unsatisfactory. The problem of funding the system remains unresolved.

The Task Force's proposals

In accordance with the mandate entrusted to us, we have formulated proposals which essentially are intended to ensure the system's permanence and protect its universality, while reducing the growth of public health spending to a sustainable level.

This is an extremely demanding objective, especially since population aging, a process well under way in Québec, will accentuate the upward pressure on costs. The experience of the past decade teaches us that hasty and necessarily risky decisions must be avoided in a climate of crisis.

Our proposals seek a necessary update of our health care system. They establish a healthy balance between everyone's rights and obligations.

We appeal to everyone's realism and sense of responsibility. We invite the government, health professionals and the general public to enter into a new social contract, in order to ensure that all citizens have timely access to the care they require, in respect for our collective ability to pay.

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INTRODUCTION

The Task Force on Health Funding was established by the Gouvernement du Québec on the occasion of the *2007-2008 Budget Speech* of May 24, 2007.

At that time, the Minister of Finance announced "the creation of a task force that will make recommendations on how best to ensure adequate funding for the health care system"[1], to be chaired by Mr. Claude Castonguay. The two Vice-Chairs were appointed after consultation of the opposition parties.

One of the documents appended to the *Budget Speech* specified that "based on the recommendations the task force presents in its report, the government will then announce an action plan to ensure sustainable health funding"[2]. The nature of the mandate and the issue at stake were thus clearly defined from the outset.

❑ The mandate defined by the government

On June 27, 2007, the government adopted an Order-in-Council defining the mandate entrusted to the Task Force[3] and appointing Ms. Joanne Marcotte and Mr. Michel Venne as Vice-Chairs.

The mandate is set out as follows.

"… the mandate consists of formulating recommendations on the best means to ensure adequate health care funding.

… this Task Force's mandate [also] includes the following four main components:

a) propose additional sources of health care funding to the government;

b) define the role the private sector can play to improve access to care and reduce wait times, while ensuring that a strong public system and its characteristic values are maintained;

c) propose a structure for the new "health account" in order to make health funding more transparent, better inform the general public and illustrate the problem of funding in the medium term, particularly regarding the level of federal health transfers;

d) study changes that could be suggested so that the necessary adjustments are made to the *Canada Health Act* (R.S.C. 1985, c. C-6)."

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1 *Budget Speech*, p. 23, *Budget 2007-2008*, May 2007, Finances Québec.

2 *Meeting the Challenge of Health Funding*, p. 19, *Budget 2007-2008*, May 2007, Finances Québec.

3 Décret N° 506-2007 du 27 juin 2007, concernant la constitution du Groupe de travail sur la financement du système de santé.

❑ The principles recalled by the government

In the Order-in-Council, the government also specified the framework for development of the Task Force's reflections.

> "… this task force… [must ensure]… that its recommendations are compatible with the principles that have characterized Québec's health care system since its inception:
>
> a) maintaining a strong public health care system;
>
> b) protecting the most disadvantaged regardless of their social status and income level, notably with respect to access to care;
>
> c) maintaining high-quality criteria for both the public sector and private delivery of care."

The Task Force carefully read the mandate entrusted to it.

The three principles recalled by the government correspond to values fully endorsed by the members of the Task Force.

❑ The challenge of health funding

The mandate is clearly focused on the question of funding of the health care system and the challenge this funding represents.

The document published at the same time as the *Budget Speech* explains the nature of this challenge[4]: in Québec, as in the rest of Canada and the other industrialized countries, health spending exerts strong pressure on public finances. The growth of health spending far exceeds the growth of government revenue. Ultimately, it threatens the balanced budget and the funding of the State's other missions. The creation of the Task Force is specifically intended to provide answers to a situation that is no longer sustainable in the long term.

The Task Force is aware of the scope of the mandate the government has entrusted to it.

To fulfill this mandate as adequately as possible, the Task Force discussed the different elements on which it was possible to act to ensure the system's long-term funding – whether the organization of the services offered to the public, the way the available means are mobilized to ensure these services, or the funding mechanisms.

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4 *Meeting the Challenge of Health Funding*, op. cit.

The question of health care system funding thus was covered in its broadest sense: the Task Force is convinced that to ensure this funding and thus the permanence of the system, it is necessary to act both on revenue and on expenditures, set clear objectives regarding public coverage and make the system's managers, health professionals, the sector's workers and the general public aware of the issues at stake.

The Task Force, of course, established its recommendations based on an analysis of the strengths and weaknesses of the existing system in Québec, while drawing certain lessons from the experiences observed in other countries.

❑ Health and social services

The Task Force did not make a distinction between health care in the strict sense of the term and social services. According to its understanding of its assigned mandate, the health care system to which the mandate refers encompasses both health and social services. In the report, the term "health" should thus be read in its broadest meaning, and implicitly covers social services.

As for the scope of its reflection and analysis, the Task Force concentrated on the leading factors contributing to the growth of costs, regardless of whether they concern health care or social services.

❑ Defining a central objective

From the outset, the Task Force wanted to define a central objective for its approach, illustrating its priorities and vision.

The Task Force considers that Québec must ensure the permanence of the public health care system by increasing its productivity and adjusting the growth of public health spending to the growth of collective wealth, while improving access to care and the quality of services.

As we will see later, this objective could serve as the core of a new "social contract", recognized as such by all Quebecers.

❑ The preferred approach

To fulfill its mandate within the deadlines, the Task Force adopted an approach that wanted to be as effective as possible:

— Throughout autumn 2007, even though it had not been mandated to hold public hearings, the Task Force met with a certain number of individuals and organizations whose analyses could fuel its reflection[5]. The Task Force would like to emphasize the cooperation it received from the persons contacted. They unhesitatingly and generously shared their analyses and their assessment of the situation with the Task Force's members.

— The Task Force commissioned several studies, covering specific points for which an in-depth opinion seemed necessary[6].

— The Task Force also benefited from the support of an effective and experienced team, which was unsparing in its support[7].

The Task Force considered all the written or oral comments received. It kept informed on public statements on the issues it had to debate.

The Task Force also benefited directly from the different public consultations held over the past few years in the health sector.

❑ Outline of the report

The report is articulated around six parts, reflecting the different stages of the process.

— In **Part 1**, the Task Force defines the vision it proposes, embodied in a new social contract.

— **Part 2** of the report is devoted to the state of the health care system in Québec. The goal is to return quickly to this system's strengths and weaknesses and put them into perspective in relation to the international context.

— In **Part 3**, the Task Force defines a frame of reference, setting realistic and equitable limits for public funding of the health care system.

— **Part 4** of the report consolidates the proposals for improving services, with the aim of ensuring that the right person offers the right service at the right time. This part will contain the Task Force's reflections on the role of the private sector.

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5 The list of individuals and organizations met can be found in Appendix 5.

6 See Appendix 6 for the list of studies commissioned by the Task Force.

7 The list of the Task Force's different collaborators can be found in Appendix 4.

— In **Part 5** of the report, the Task Force discusses how means are mobilized, particularly governance of the system, allocation of resources, the work organization and the use of new information technology. The Task Force identifies several options to give Quebecers the benefit of a productive and effective health care system.

— Finally, **Part 6** of the report deals with funding of the system in the strict sense, namely revenue sources, with the twofold concern of the long-term view and sharing responsibilities. This last part of the report discusses two points explicitly mentioned by the government in the mandate entrusted to the Task Force, the health account and the *Canada Health Act*.

The **conclusion** of the report returns to the nature of the orientations proposed by the Task Force, and the spirit in which these orientations were formulated.

The report also includes **six appendices**, respectively dedicated to:

— the principal recommendations of the Task Force (Appendix 1);

— a summary of several rationalization proposals (Appendix 2)

— the dissenting position presented by Mr. Michel Venne on three points of the report (Appendix 3);

— the members of the Task Force and the support staff (Appendix 4);

— the individuals and organizations met by the Task Force (Appendix 5);

— the studies commissioned and the documents received by the Task Force (Appendix 6).

PART 1
The vision: a new social contract

The Task Force considers that the time has come for Quebecers to agree on what could constitute a new social contract, for the purpose of ensuring the permanence of a system to which all are profoundly attached, but maintenance of which cannot be assured without a vigorous effort and collective awareness of the issues at stake.

- This social contract is primarily an appeal to responsibility.
- It is based on a certain number of values and principles which everyone should recognize as applying to them.
- It is embodied in a set of obligations incumbent on the system's main players.
- It should allow the removal of the taboo regarding the role of the private sector, by clearly defining the contribution and the responsibilities the community agrees to entrust to it.
- It includes a distribution recognized by everyone of the responsibilities that each of the system's players would undertake to assume.

By defining the social contract it proposes to Quebecers from the very beginning of its report, the Task Force approaches the question of health funding on the only level that can provide an effective response to a question that concerns all of us.

An appeal to responsibility

The social contract proposed by the Task Force first arises from an obvious reality: among all our public programs, the health care system is the most important expression of the solidarity that unites all citizens to respond collectively to one of the basic needs of every human being.

❑ The health care system: at the heart of our solidarity

As in most of the industrialized countries, the health care system is at the heart of the solidarity on which Quebecers have built their collective life. It is an extraordinary mechanism for wealth and risk sharing.

Created during the Quiet Revolution, it quickly became the biggest service organization in Québec. Its very principle was established on the basis of a social contract, whereby everyone is asked to contribute according to their means to the funding of a system that must offer everyone access to the care required by their state of health.

At the time the health care system was established there was a profound conviction that Quebecers were going to be freed financially, to some extent, from the risk of disease. The universal health care system appeared to be a pledge of freedom, security and development.

❑ A social contract in peril

Forty years later, however, the health care system is going through a crisis of confidence.

— Patients wait unduly for surgery or emergency care.

— One quarter of them have no access to a family doctor.

— The data collected by the Task Force, to which we will return later, are clear in this regard: our system is costly in relation to our collective wealth and is not as productive as it could be.

Citizens continue to fulfill their part of the contract by paying high taxes. However, they increasingly have the feeling that they aren't getting their money's worth. Some are abandoning the public system or have lost confidence in it, calling for private solutions.

The problem is real and goes beyond the question of health as such. By mobilizing nearly half of the government's spending programs, health is gradually crushing the State's other missions.

❑ Inadequate responses

Everyone is aware of the health care system's difficulties, yet the situation is not changing fast enough. The reason is simple: nobody dares to challenge the special interests at stake.

There is also another reason for this immobility: we have set up some characteristics of our system as dogmas – characteristics which have long been called into question in other countries.

In the past few years, we believed that we could solve the system's problems by rationing services or massively injecting new funds. These responses quickly proved inadequate. The solutions to the health care system's problems only partly involve financial resources. They depend much more on how these resources circulate in the system and are utilized.

❑ Prevailing over the special interests

The first condition to improve our public system is to accept that funds circulate differently and be utilized optimally. To fulfill this condition, each of the system's players, from citizen to Minister, must agree to reconsider his or her acquired rights and prejudices.

— Today, neither patients nor health professionals seem to be really aware of the system's costs.

— Coverage of services by the public system is incoherent and introduces inequities.

— The incentives present in the system favour the status quo instead of rewarding performance.

— The government maintains centralized and bureaucratic governance of the system, which hinders innovation and initiative.

In this frozen context, we must not be surprised that the medical federations and the unions and professional orders do their utmost to defend their parcels of power or their privileges.

If bureaucracy and games of influence resulted in improvement of the system, nobody would complain. But this is not the case. Staffs lose motivation. Doctors are frustrated. Patients wait. And all these problems end up in the partisan political arena instead of being resolved by modern and efficient management.

This situation has undermined the general public's confidence in the public system. The crumbling of the social contract of the 1960s endangers our ability to maintain the health care system we need in the long term.

❑ An objective: the permanence of the public system

To restore the situation, the Task Force is convinced that we must not go backward: we must not seek to reproduce the conditions of forty years ago. Nor can we count on cyclical measures.

In fact, we must redefine the social contract on which our health care system is based, proceed with this review gradually, clearly identify the objective to be achieved and build momentum for change, by relying on means that have proven themselves elsewhere. Finally, we must confront all the players with their individual responsibility regarding the health care system.

This social contract must be concluded around the above-mentioned central objective – to ensure the permanence of the public system by increasing its productivity and adjusting the growth in public health spending to the growth of collective wealth, while improving access to care and the quality of services[8].

Some will find this objective ambitious, even audacious. Precisely what our society needs these days is ambition and audacity.

The objective is demanding but realistic. Other societies have achieved it. The Task Force is persuaded that we are capable of this as well.

Values and principles

This new social contract must be based on a number of values and principles.

The Task Force has identified six, on which all citizens should agree.

— The first principle is universality: the funding modalities of the health care system must favour universal coverage of the general public.

— Secondly, every person must have access to the medical and hospital care required by their state of health, regardless of their socioeconomic status or income. This is a question of solidarity: the most disadvantaged must be protected. This solidarity must also be expressed between the generations, both towards older citizens who suffer from chronic conditions, and towards younger citizens to whom society does not have the right to bequeath an undue financial burden for the future.

— The new social contract must be based on a third principle, equity. Equity is understood here as the balance between what each person is entitled to expect and what society is entitled to expect of each person. Thus, while those who have a greater ability to pay must contribute more than those who have less means, neither must the latter group be totally exempted from contributing – provided, of course, that this contribution is geared to their capabilities.

— Fourthly, the system must respect a principle of efficiency. Concretely, this means that citizens must get their money's worth. The system must produce a sufficient quantity of quality services to meet the needs, at the lowest possible cost.

— The fifth principle identified is responsibility. The funding modalities must favour the exercise of each person's responsibility in this system – both the patients who have a role to play regarding their personal health, and the caregivers, who are accountable.

[8] See above, page 3.

— The sixth proposed principle, and not the least, is freedom. The funding modalities must be based on the patients' autonomy, respect for their inviolability and dignity, and on their ability and their recognized legal right to choose by whom, how and when they are treated. These modalities must also favour managerial autonomy and account for the care providers' professional freedom.

For the Task Force, it is self-evident that these six principles interact and must be interpreted in relation to each other.

— For example, the freedom to choose one's physician must be exercised responsibly, which means that the funding system must give people an incentive to use the most appropriate service, accounting both for the patient's condition and the costs generated by this service.

— While physicians enjoy professional freedom, they must also act responsibly and provide the appropriate care at the lowest possible cost. The physician's professional freedom is certainly an important principle, but in complex systems like those of today, it can no longer be exercised without any guidelines.

— Similarly, universality does not mean that the coverage applies to all the services available on the market. The system will not be able to produce the best services at the lowest costs if it pays for costly services of doubtful effectiveness.

Precise obligations for each player

The social contract proposed by the Task Force reminds us that each of the system's players enjoys rights but must also honour obligations.

❑ For citizens: awareness of the costs and responsibility

A citizen's first commitment should be to assume his share of the responsibility for his own health, by adopting a healthy lifestyle and consulting the health services regularly.

This same citizen must contribute to the health care system's funding according to his means and, complementary to this, in relation to his consumption of care.

The Task Force thus has formulated several recommendations intended to foster public awareness of the system's limits and costs. These recommendations, to which we will return later, have the purpose of inducing citizens to assume their responsibilities through prevention and through registration with a health clinic and a family doctor.

❑ For health professionals: quality and continuity

The principal responsibility of health professionals, and especially of physicians, is to provide the right service to the right person at the right time.

— Health professionals are the guarantors of the quality of services.

— In return for fair compensation, they must agree to comply with best practices and submit to evaluations.

— Health professionals also have the duty to ensure the continuity of care and good collaboration between different classes of professionals.

The Task Force report contains many recommendations with the aim of inducing health professionals to assume these responsibilities, such as the adoption of care protocol and practice guides or the establishment of contractual relationships with the institutions[9] and the regional agencies.

❑ For managers: efficiency

The managers are the guardian's of the system's efficiency.

In return for greater recognition of their local autonomy and fair compensation, they are responsible for offering efficient services at the lowest possible cost.

As we will see later, the Task Force thus recommends fundamental changes in the way money circulates in the public health care system, so as to reward performance and penalize inefficiency.

❑ For interest groups: cooperation and disarmament

In 1988, the Rochon Commission had observed that the Québec health care system was the hostage of its constituent interest groups. The unions, the medical federations, the associations of institutions and the professional orders, in particular, exercise influence and power in the health care system and often have the real power to block change. [10]

The system cannot evolve if these different interest groups are unwilling to make concessions and cooperate in the essential reforms. The necessary changes have all the more chances of success if they are implemented with the contribution, influence and cooperation of the players involved.

The absence of cooperation would put the system itself in peril.

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[9] On the concept of "institution" according to the nomenclature of the Ministère de la Santé et des Services sociaux, see page 20 below.

[10] ROCHON, Jean. *Rapport de la Commission d'enquête sur les services de santé et les services sociaux*. Québec, Publications du Québec, 1988, 803 pp.

The groups involved should be aware of this. The Task Force invites them to cooperate. Disarmament is necessary to ensure the system's permanence.

❑ For the government: coherence and vision

The government's first duty is coherence.

— Once a health and welfare policy is established, determining the priorities for the years ahead, the government will have to redefine a basket of medically required services which is clear, well defined and reviewed regularly.

— After establishing the limits of the public system's commitment, the government will have to take steps to keep its promises.

— The government will also have to verify the quality of the services provided, evaluate the system's performance and implement the necessary incentives in this regard.

The Ministère de la Santé et des Services sociaux (MSSS) must agree to restrict its role to the major governance functions and thus withdraw from care delivery.

— As we will see later, the Task Force has formulated a great many proposals aimed at changing the governance of the system, so as to leave the responsibility and autonomy necessary to perform this work to the care providers at the local level and to the regional agencies.

— The MSSS must reduce the bureaucratic burden and commit itself to the new dynamics that the Task Force supports throughout its report.

Finally, it is the government's responsibility to ensure that it provides the health care system with the financial resources it needs, on a predictable basis. The system has suffered too much from rollercoaster funding in the past few years. The Task Force has formulated recommendations to ensure sustainable, equitable and predictable funding.

The federal responsibility is also challenged. The federal government must relax the requirements contained in the *Canada Health Act*. The federal government must also play its part in the social contract by providing stable funding.

The complementary role of the private sector[11]

A new social contract for health care cannot be defined without including a reflection on the role of the private sector. Such a reflection is explicitly mentioned in the Task Force's mandate.

❑ The opposite of privatization

For the Task Force, the private sector's contribution must be considered as a complementary resource: this means giving Quebecers greater freedom of choice in how to meet their health care needs, while providing essential backup to the public system and introducing elements that will favour dynamism and emulation.

This vision is the opposite of privatization.

The Task Force is convinced that the private sector can be assigned a role while respecting the foundations of the public system. This means recognizing the private sector as an ally of the public system, while setting clear boundaries for its role, instead of continuing to consider it needlessly as a menace.

❑ Participation by the private sector

The Task Force report contains several proposals regarding the private sector. They are an integral part of the proposed social contract.

These proposals concern the organization of first-line care, specialty clinics, medical practice, personal insurance, accommodation of seniors who are losing their autonomy and home assistance services.

They are accompanied by the wish that the proposed changes and other measures in continuity with the openings already created by the government be evaluated after five years, in order to verify:

— whether the care is provided at a competitive cost compared to interventions performed in an institution;

— whether the quality and safety criteria are in fact observed;

— whether or not these changes have an effect on the availability of competent human resources for public institutions.

[11] See the dissenting position of Mr. Michel Venne on certain points related to this question in Appendix 3, page 297.

Clearly circumscribed roles

None of the elements of the social contract we have just presented calls into question the foundations of our public health care system.

On the contrary, the main proposal formulated by the Task Force is to invite Quebecers to renew their confidence in the public system within a collective vision, which makes each of the system's players responsible – from the citizen to the Minister.

As we have just seen, the proposed social contract implies that each person has a role to play and obligations to honour.

- For citizens, this will mean assuming their share of the responsibility for their own health and becoming aware of the costs of the care provided by the public system.
- Physicians and other health professionals, more than ever, will have to ensure the quality of care and comply with best practices within the context of interdisciplinary collaboration.
- The commitment expected from the managers is self-evident. They must ensure the effective and efficient organization of care.
- For the interest groups, the unions, the medical federations, the associations and the professional orders, the Task Force calls on these organizations to cooperate in implementing the necessary reforms.
- The commitment asked of the government is just as clear and just as self-evident. The government must clearly and transparently define the scope of the public system and then take all the means required to keep its promises.
- Within the Québec State, the Ministère de la Santé et des Services sociaux must agree to allow autonomy to those responsible at the local level.
- The federal government is also challenged to reduce the restrictions it imposes on the provinces and to maintain stable funding.
- The private sector is invited to play a complementary role, within a clearly defined framework.

PART 2
The current situation: the health care system in Québec and elsewhere

It was important for the Task Force to begin its reflection by reporting on the current situation of the health care system in Québec, as it perceives it.

— In **Chapter 1**, the Task Force thus attempted to establish the strengths and weaknesses of this system.

— **Chapter 2** is devoted to the international context, with the objective of generating sources of inspiration eventually applicable to the Québec situation.

CHAPTER 1 – THE HEALTH CARE SYSTEM IN QUÉBEC: ITS STRENGTHS AND WEAKNESSES

The existing health care system in Québec is the principal public program established and administered by the Québec State in terms of cost. The system we know today is the culmination of several decades of evolution.

It is important to review some of its successes before focusing on its two main weaknesses – its difficult access and insufficient productivity – and then discuss the question of the system's funding, at the very centre of the Task Force's mandate.

1.1 A health care system to which Quebecers are deeply attached

Nearly 80% of the Québec population benefits from medical services each year. This simple statistic illustrates the scope of the health care system's use, as well as the resulting cost of meeting the public's needs.

The Québec population is deeply attached to the public health care system. Universal access to health care has gradually become a fundamental value of our society.

❑ Five key dates

The health care system currently in place in Québec is one of the achievements of the Quiet Revolution.

Five key dates mark the establishment of the system we know today.

— The hospitalization insurance plan was adopted in 1961. This plan assures the funding of acute hospital care and diagnostic laboratory and radiology services.

— The biggest reform took place in 1970, with the creation of the health care system and the establishment of the health insurance plan. This plan entrenches the principle of universal access to health care and social services.

— In 1992, the government regionalized the system by the creation of the Régies régionales de la santé et des services sociaux (regional health and social services boards), with the main mission of organizing the services within their territory and allocating budgets to the institutions.

— In 1997, the system's coverage was expanded with the establishment of the prescription drug insurance plan. This is a mixed public-private system,

guaranteeing all citizens equitable access to the medications required by their health status.

— In 2004 – we will come back to this later – the government created the local health and social services networks, with the objective of improving coordination of services to make them more accessible.

The Québec health care system: some statistics (in 2006-2007)[1]

- 297 institutional establishments, including:
  - 95 health and social services centres (known as CSSS, or Centres de santé et de services sociaux);
  - 29 general and specialized hospital centres, five of which have university status (CHU).
- 2,000 medical clinics of general practitioners and specialists (including more than 130 family medicine groups and 23 network clinics).
- 7,710 general practitioners, 8,160 medical specialists and 2,360 medical residents.
- 238,500 employees, including 100,550 nurses, nursing assistants and patient attendants.
- Nearly 6 million people who received medical services [(2)].
- Over 632,000 hospitalizations and more than 462,000 surgeries performed[(2)].
- Over 284,000 people who received health care at home, including over 157,000 seniors suffering loss of autonomy [(2)].

1 *Rapport annuel de gestion 2006-2007*, Ministère de la Santé et des Services sociaux.
2 Statistics taken from *Rapport annuel de gestion 2004-2005*. More recent data unavailable.

The concept of "institution", for the Ministère de la Santé et des Services sociaux

In the nomenclature defined by the Ministère de la Santé et des Services sociaux, the term "institution" refers to:

- the health and social services centres (CSSS), which include the local community service centres (known as CLSC, or Centres locaux de services communautaires), the residential and long-term care centres (known as CHSLD, or Centres d'hébergement et de soins de longue durée) and certain hospitals,
- the hospitals (hospital centres, known as CH, or Centres hospitaliers),
- the affiliated university centres (such as the affiliated hospital centres, known as CHA, or Centres hospitaliers affiliés),
- the university hospital centres (known as CHU, or Centres hospitaliers universitaires),
- the institutes (such as the Heart Institute, the Geriatric Institute or the university institutes),
- the rehabilitation centres (such as rehabilitation centres for physically impaired persons, rehabilitation centres for mentally impaired persons or rehabilitation centres for persons suffering from alcoholism or other problems of addiction),
- the child and youth protection centres (known as Centres de protection de l'enfance et de la jeunesse).

❑ The most recent evolutions

The Québec health care system has gone through numerous reforms, all aimed at making the administrative structures more efficient and improving the organization of care. The Task Force simply wishes to recall the most recent of these.

■ Consolidation of the network and strengthening of the first line

To favour a better takeover of patients and better coordination of interventions, two changes were implemented in the past few years:

— In 2001, the creation of the first family medicine groups was announced[12]. Deployment of the family medicine groups has accelerated since that date. This concept was adapted to urban realities to take the form known as "network clinics".

— In 2004, the government grouped the local community service centres (CLSC), the residential and long-term care centres (CHSLD) and the hospitals into 95 health and social services centres (CSSS)[13]. The CSSS are care providers, ensuring coordination among the different organizations located in their territory.

■ Strengthening of first-line mental health care

In 2005, the government initiated decentralization of mental health services to the first line. The action plan[14] implemented at the time aims at strengthening first-line mental health care intended for persons suffering from moderate or common mental disorders, consistent with the development of first-line services in physical health. Implementation of this plan represents a considerable challenge, given the heavy concentration of resources in second and third-line specialty services.

■ Improvement of youth protection services

Over the past few years, major efforts have been applied to improving youth protection services. Since 1998, a nearly 80% reduction in evaluation waiting lists has been noted. In 2006, major amendments were made to the *Youth Protection Act*, particularly with the aim of promoting continuity and stability for children, in order to ensure the exceptional nature of the State's intervention in family life and to promote the active participation of children and their parents in the decisions that concern them.

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12 The creation of the family medicine groups resulted from one of the Clair Commission's recommendations.

13 *Act respecting local health and social services network development agencies*.

14 Plan d'action en santé mentale 2005-2010, *La force des liens*, Ministère de la Santé et des Services sociaux, 2005.

■ Reduction of wait times

Major efforts – essentially financial – have been invested to reduce the wait times in obtaining care in the public health care network.

These efforts are already producing measurable results:

— In 2003, there were 44,000 people who had been waiting for surgery for more than six months.

— In autumn 2007, the number of people waiting for surgery had been cut in half to 22,000.

— Substantial progress is also noted in radio-oncology and cardiology.

■ Bill 33

In December 2006, the government obtained the adoption of Bill 33[15]. This legislation provided for the implementation in hospital centres of a central mechanism for managing access to services.

The Act also contains the following provisions:

— A legal framework for carrying on medical activities in specialized medical centres is created to ensure the quality and safety of such activities. With the Act, a specialized medical centre can provide the medical services determined by the Minister by regulation.

— An institution which operates a hospital centre may enter into an agreement with an associated medical clinic for the provision of specialized medical services to the institution's patients. The objective of this initiative is to free hospital operating rooms from the lightest cases.

— A person may enter into a private insurance contract covering the cost of surgery specified by law. The surgery must be provided in a specialized medical centre where only physicians not participating in the health insurance plan practice.

[15] *Act to amend the Act respecting health services and social services and other legislative provisions.*

■ Revision of certain practices in the work organization

In December 2003, the government obtained the adoption of Bill 30[16], drafted to reduce the number of bargaining units and decentralize the negotiations of certain collective agreement provisions to the local level[17].

The goal pursued was to allow a more efficient work organization and respond more directly to the institutions' special needs.

■ Incentives in the agreements made with the physicians

In 2007 the government made agreements with the medical specialists and the general practitioners. These agreements tie a substantial portion of the salary increases granted to service accessibility improvement plans. The objective over the next few years is to translate the implementation of these agreements into greater availability of physicians and better takeover of vulnerable clienteles.

❑ A system with little change in its modes of funding

In contrast with the many reforms over the years to the administrative structures and the organization of care, there has been little evolution in the mode of funding of our health care system.

■ A public system almost exclusively funded by general taxation

In Québec, a little over 60% of public health spending is funded by general taxes (excluding federal transfers) or from revenue sources that also serve to fund all of the State's missions[18]. A similar funding model is found in the United Kingdom and Australia, as well as in the rest of Canada.

In countries such as Germany, France, Japan or the Netherlands, health care funding comes from funds created for this purpose. The resources allocated to health care are thus separated from the revenue serving to fund the State's other missions.

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16 *Act respecting bargaining units in the social affairs sector and amending the Act respecting the process of negotiation of the collective agreements in the public and parapublic sectors.*

17 Several of the provisions of Bill 30 were invalidated by the Québec Superior Court on November 30, 2007. The government appealed this decision on December 21, 2007.

18 See below, page 216.

■ Payment for medical services mostly on a fee-per-service basis

Since the adoption of the health insurance plan in 1970, the physicians receive most of their fees according to the number of medical acts performed: this is called fee-for-service.

Over the past twenty years, different recommendations have been submitted to the government to change the mode of remuneration of physicians, particularly to favour takeover and systematic follow-up of patients[19]. The government has only applied these recommendations in part. However, we note the recent development of other types of remuneration – such as contract fees. These types of remuneration currently represent 22% of the physicians' total remuneration[20].

■ Gradual introduction of a new mode of allocation of resources at the regional level

Starting in 2004, the Ministère de la Santé et des Services sociaux gradually introduced a new mode of allocation of resources at the regional level[21]. The resources are allocated according to the population's needs and the regional clinical characteristics[22]. The objective pursued is to improve interregional equity.

■ A large proportion of the institutional budgets is still established on a historical basis

However, the budgetary resources allocated to the health care system most often are divided among the institutions according to a historical method, namely by indexing the institutions' expenditures of the previous year[23].

■ Health spending assumed privately in part

A substantial share of health spending is assumed privately by individuals – directly or through private insurance. This is not a new phenomenon.

— In 1975, the private sector accounted for 21.2% of total health spending in Québec[24].

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19 In particular, we are referring to the recommendations of the Groupe de travail sur la rémunération des professionnels de santé (Task force on remuneration of health professionals) (1980), the Rochon Commission (1988) and the Clair Commission (2000).

20 Data from the Régie de l'assurance maladie du Québec.

21 See below, page 173.

22 The method used is the Diagnosis Related Group (DRG) method.

23 See below, page 174.

24 CIHI, National Health Expenditure Trends, 1975 to 2007.

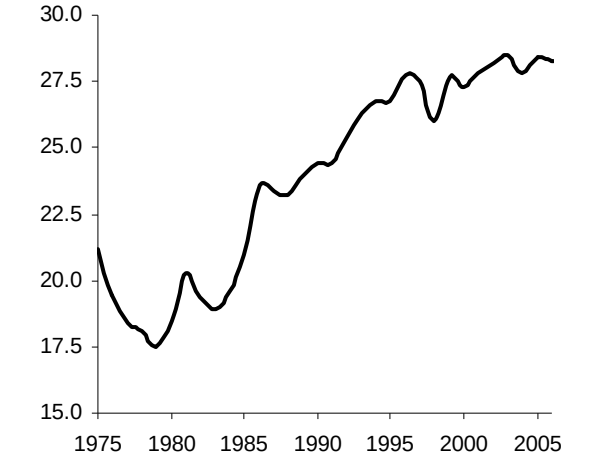
— After decreasing for several years, this share increased regularly starting in 1985, but seems to have levelled off since 2000. In 2007, it reached 28.3%[25].

— If we compare the private sector's share of total health spending of certain industrialized countries, we find that in 2005, this share stood at 28.4% in Québec, twice as high as in the United Kingdom and Sweden, and higher than in Japan, France and Germany[26]. However, this share was lower than in Australia and the United States.

GRAPH 1

Private sector share of total health spending in Québec, 1975 to 2007

(percentage)

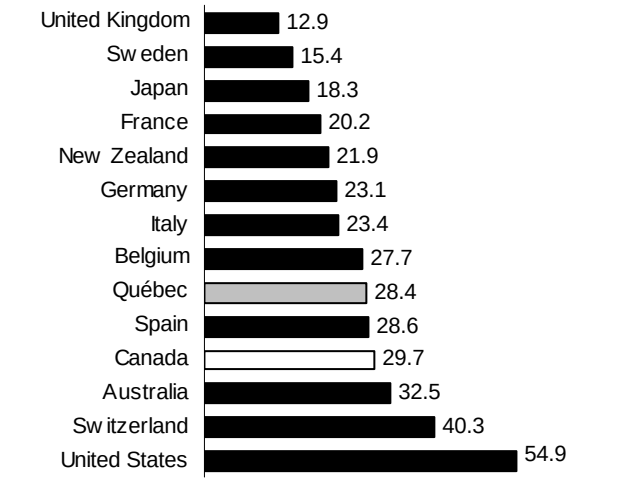


Source: CIHI.

GRAPH 2

Private sector share of total health spending for certain industrialized countries, 2005

(percentage)



Sources: OECD Health Data 2007 and CIHI.

1.2 Citizens satisfied with the services rendered, but difficult access and insufficient productivity: the health care system could do a lot better.

The Québec health care system offers a very wide range of services to the public, with high quality, regardless of each patient's ability to pay. The vast majority of citizens say they are satisfied or very satisfied with the services rendered, once they have received these services.

25 CIHI, National Health Expenditure Trends, 1975 to 2007.

26 OECD Health Data, 2007.

That's the problem: Québec citizens do not have easy access to their health care system's services. It is also found that, in terms of productivity, the Québec health care system is positioned poorly in relation to what is observed in several other jurisdictions.

❑ High satisfaction with services rendered

Last January 10, the Ministère de la Santé et des Services sociaux released a survey conducted by the Institut de la statistique du Québec, confirming Quebecers' high satisfaction rate with the services received through their health care system[27].

According to the survey conducted in 2006-2007, 93% of citizens are satisfied or very satisfied with the services they received (33% said they were satisfied and 60% very satisfied).

This survey provides an encouraging snapshot of the state of mind of citizens who benefited from the services offered by our health care system.

It is still necessary to have access to these services, however. The health care system's weaknesses essentially relate to its accessibility.

❑ Difficult access to care

Regarding accessibility of care, Québec residents are less well served than those of other provinces. Despite recent improvements, this reality persists.

— It is in Québec that the proportion of the general population with a regular family doctor is the lowest in Canada: 75%, compared to 95% in Nova Scotia and 86% in Canada as a whole[28].

— Quebecers have to wait an average of 19.4 weeks between visiting a physician and undergoing surgery or receiving therapeutic treatment, compared to 15.0 weeks in Ontario and 18.3 weeks in Canada as a whole[29].

— According to the Institut national de santé publique, "Québec is where the proportion of persons mentioning unsatisfied health care needs is the highest among all Canadian provinces"[30].

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27 *Enquête sur la satisfaction des usagers à l'égard des services de santé et des services sociaux du Québec, 2006-2007*, Institut de la statistique du Québec, December 2007.

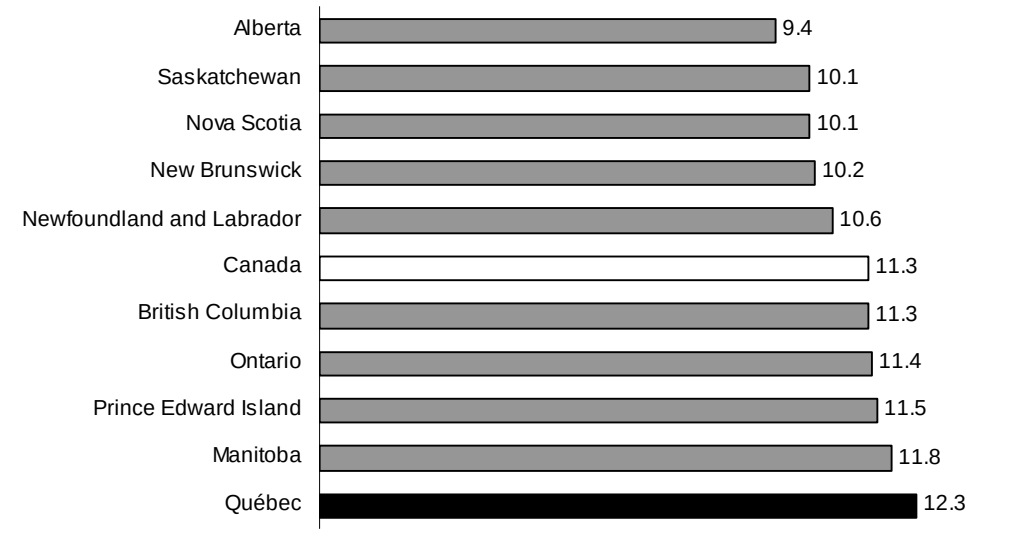
28 *Health Indicators, 2006*, Statistics Canada and CIHI, N° 82-221-XIF.

29 *Waiting Your Turn: Hospital Waiting Lists in Canada*, 17th Edition, The Fraser Institute, October 2007.

30 Institut national de santé publique du Québec, citing *Canadian Community Health Survey 2005*, Statistics Canada.

GRAPH 3

Proportion of persons age 12 and over reporting unsatisfied health care needs, Canadian provinces and Canada, 2005
(percentage)



Source: *La santé au Québec, comparée, analysée et interprétée*, Comparaisons canadiennes, Institut national de santé publique du Québec.

— This finding is especially significant in that Québec is one of the jurisdictions in Canada with the highest number of physicians per capita. In 2006, Québec thus had 215 physicians per 100,000 inhabitants, compared to 190 physicians in Canada as a whole[31].

— Many seniors suffering loss of autonomy are waiting for a place in a CHSLD and occupy acute care hospital beds until a place is found for them.

— Québec, like many other industrialized societies, is experiencing a substantial growth in the number of seniors. Today, there are about a million people age 65 and over, and another 400,000 will be added within the next ten years. The proportion of seniors in Québec will increase from 14% to 20% during that period.

— About one in five seniors needs services due to an incapacity, and nearly 4% are accommodated in a residential and long-term care centre (CHSLD)[32]. The growing number of seniors poses a major challenge in terms of delivery of home care services.

[31] See below, Table 11, page 182.

[32] Ministère de la Santé et des Services sociaux, *Plan d'action 2005-2010 sur les services aux aînés en perte d'autonomie: Un défi de solidarité*, p. 9.

❑ The productivity of the health care system is insufficient

Moreover, the productivity of the health care system raises many questions.

A recent CIRANO[33] study reveals that Canada and Québec rank among a group of OECD countries where productivity in the delivery of medical care and of the health care system in general declined regularly between 1995 and 2003.

More precisely, it found:

— no growth in the number of visits to a physician during the period studied;

— a significant decrease in the number of medical examinations performed in relation to the number of physicians;

— higher wait times than in 1999 between a visit to a general practitioner and treatment.

The poor productivity of the Canadian and Québec health care systems is confirmed when the system's general performance is compared to other jurisdictions.

— In 2000, a World Health Organization study ranked Canada 30th among the 191 member countries, ahead of the United States (in 37th place) but far behind France (ranked first), the United Kingdom (ranked 18th) and Sweden (ranked 23rd)[34].

— In 2007, the Commonwealth Health Fund[35] published a study which ranked Canada second of last out of seven countries in terms of access to care[36].

  According to this study, Canada and the United States rank last among the seven countries analyzed in terms of coordination of care.

  In these two countries, the transmission of information between medical specialists, hospitals and first-line physicians is the most faulty. These countries also have the greatest probabilities of seeing patients repeat their case several times to different professionals, repeat the same tests because they are prescribed by several professionals, or visit a doctor's office without timely transmission of examination results or before their medical records are available.

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33 *Analyse comparée des mécanismes de gouvernance des système de santé de l'OCDE*, Centre interuniversitaire de recherche en analyse des organisations (CIRANO), Joanne Castonguay, Claude Montmarquette, Iain Scott, September 2007.

34 WORLD HEALTH ORGANIZATION. *The World Health Report 2000: Health Systems: Improving Performance.* Geneva: WHO, 2000, pages 174-177.

35 *Toward Higher Performance Health Care Systems: Adults' Health Care Experiences in Seven Countries*, The Commonwealth Health Fund, 2007.

36 The other countries are Germany, Australia, United States, New Zealand, Netherlands and United Kingdom.

This finding of inefficiency in the coordination of care is not surprising, given that Canada is the country where first-line medical practices have the least computerized medical records and thus benefit the least from the advantages such records offer in management of their practice and follow-up of their patients. The rate of use of patients' electronic records by first-line physicians in Canada is thus 23%, while in several other large countries, this rate can reach 80% or more[37,38].

— In February 2006, the Conference Board of Canada released a study ranking the Canadian provinces according to 119 public health indicators. Québec was in the middle of the pack, behind British Columbia, Alberta and Saskatchewan, respectively ranked 1st, 2nd and 3rd[39].

The Québec health care system is confronted with serious problems regarding human resources.

— The Ministère de la Santé et des Services sociaux estimates that there is currently a shortage of 3,000 nurses in Québec, and that this number could climb to 10,000 in 2014 and 17,000 in 2019[40].

— The proportion of overtime hours worked in relation to the total hours worked by nurses rose from 1.71% during the period between 1985-1986 and 1995-1996 to 4.55% in 2005-2006.

1.3 The question of funding of the system

The Québec health care system, with its strengths and weaknesses, is confronted with a fundamental problem – the entire question of its funding.

— From 1995 to 2003, the system went through a succession of crisis related to its underfunding.

— Since that date, the health care sector is the government's top financial priority. However, the government is confronted with another problem, resulting from the fact that public expenditures allocated to health care are growing faster than collective wealth and government revenues.

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37 *Exploring Technological Innovation in Health Care Systems, Centre for Health Care and Innovation, Health Care and Wellness*, The Conference Board of Canada, August 2007.

38 PROTTI, Denis, *Comparison of Information Technology in General Practice in 10 Countries*, Electronic Health Care, 2007.

39 *Healthy provinces, healthy Canadians: a provincial benchmarking report*, The Conference Board of Canada, February 2006.

40 *Projection de la main-d'œuvre infirmière, de 2004-2005 à 2019-2020*, Ministère de la Santé et des Services sociaux, March 2005, p. 29.

1.3.1 A succession of crises

From 1995 to 2003, the Québec health care system went through a succession of financial crises, which we will only recapitulate here.

— Starting in 1995-1996, the federal government significantly reduced its financial contribution to the provinces for health care. In 1977-1978, the federal government funded 24% of total public health spending. In 2000-2001, this proportion was only 11.2%.

  The agreement on health care reached in 2004 restored the federal government's share of the funding to a level comparable to that of 1977-1978. In the meantime, however – between 1994-1995 and 1997-1998 –, the federal government's cuts forced Québec to imposed major budgetary restrictions in the health care network.

— In 1996, the National Assembly unanimously adopted the *Act respecting the elimination of the deficit and a balanced budget*. Coupled with the federal disengagement, the application of this Act forced the government to proceed with major spending cuts - including health spending. Between 1994-1995 and 1997-1998, the budget appropriations allocated to health and social services were frozen or reduced.

— Among the measures implemented to achieve a zero deficit, the voluntary retirement program directly affected the health care network. This program particularly led to the departure of 4,200 nurses in 1996, followed by 1,200 physicians – including 720 medical specialists – in 1997 and 1998[41], which had profound and still perceptible effects on the network's operation.

— The budgetary restrictions were put in place just as the central component of the Rochon Commission's recommendations, the shift to ambulatory care, was being implemented. The shift to ambulatory care was hindered considerably by the reduction of the available financial resources.

What are ambulatory services?

Ambulatory services are diagnostic and therapeutic care and services provided on an outpatient bases, such as in professionals' offices and outpatient clinics, as opposed to care and services provided to hospitalized patients.

The term "ambulatory care" generally implies that the patient visits a given location to receive care and services and leaves the same day.

[41] According to an evaluation taken from LEMIEUX, V., BERGERON, C. and BÉLANGER, G. (eds.), *Le système de santé au Québec: organisations, acteurs et enjeux*, Québec: Presses de l'Université Laval, 2003, pages 308 and 282.

1.3.2 Resumption of the growth of public health spending

In 2007-2008, the expenditure budget of the Ministère de la Santé et des Services sociaux reached $23.9 billion, representing a 6.3% increase over 2006-2007.

Since 2002-2003, this budget has increased by one third. Over a five-year period, public spending on health has thus increased an average of 5.9% each year.

❑ Some findings

Between 2002-2003 and 2007-2008, public health spending grew by nearly $6 billion.

In analyzing the expenditure budget, we find that 85% of the increase in public health spending comes from three budget items:

— care insured by health and social services institutions ($3.6 billion, or 61% of total growth);

— medical services (nearly $850 million, or 14% of total growth);

— pharmaceutical services and drugs (a little over $650 million, or 11% of total growth).

TABLE 1

Expenditure budget of the Ministère de la Santé et des Services sociaux by program and program element, 2002-2003 and 2007-2008

(in millions of dollars)

	2002-2003	2007-2008[1]	Variation	Average annual growth (%)	Growth over 5 years (%)
Program 1 – National Operations					
Administration and Departmental Management	90	93	3	*0.6*	*3.1*
National Activities	127	205	78	*10.1*	*61.8*
Other	3	9	6	*24.6*	*200.0*
Subtotal	220	307	87	*6.9*	*39.6*
Program 2 – Regional Operations					
Health and Social Services Agencies	95	93	-2	*-0.5*	*-2.5*
Health and Social Services Establishments	10,647	14,281	3,634	*6.0*	*34.1*
Community Organizations and Other Organizations	268	371	103	*6.7*	*38.4*
Related Activities	1,523	2,035	511	*6.0*	*33.6*
Debt Service	498	614	115	*4.3*	*23.2*
Subtotal	13,031	17,393	4,362	*5.9*	*33.5*
Program 4 – Régie de l'assurance maladie du Québec					
Medical Care	2,822	3,670	848	*5.4*	*30.0*
Optometric Care	31	36	5	*3.0*	*16.0*
Dental Care	121	111	-10	*-1.7*	*-8.4*
Pharmaceutical Services and Drugs	1,450	2,102	652	*7.7*	*45.0*
Other Services	185	217	31	*3.2*	*16.9*
Subtotal	4,610	6,136	1,526	*5.9*	*33.1*
Other Programs[2]	49	67	18	*6.3*	*35.9*
TOTAL PORTFOLIO	**17,911**	**23,903**	**5,992**	***5.9***	***33.5***

1 Initial appropriations in 2007-2008.
2 Office des personnes handicapées du Québec and Promotion and Development of the Capitale-Nationale Region.
Source: Secrétariat du Conseil du trésor, October 2007.

A brief analysis of the evolution of public health spending leads to two major findings.

— The hospital system has mobilized 60% of the increase in health spending. The preponderant place occupied by the hospitals shows the extent of the importance that must be attached to their governance.

— The remuneration of physicians and professionals, managers and employees explains 62% of the increase in health spending. It is thus understood that the Task Force insists on the importance of an efficient work organization[42].

1.3.3 Public spending that increases faster than collective wealth

Since 1998-1999, the economy has grown at an average annual rate of 4.8%. During the same period, public spending allocated to health and social services has increased by an average of 6.4% per year.

❑ A continuous increase in the share of program spending

Year after year, this distortion between the growth of public health spending and the growth of collective wealth has reduced the government's financial leeway to fund the State's other missions adequately.

A continuous growth of the share of health spending in the government's program spending is thus observed.

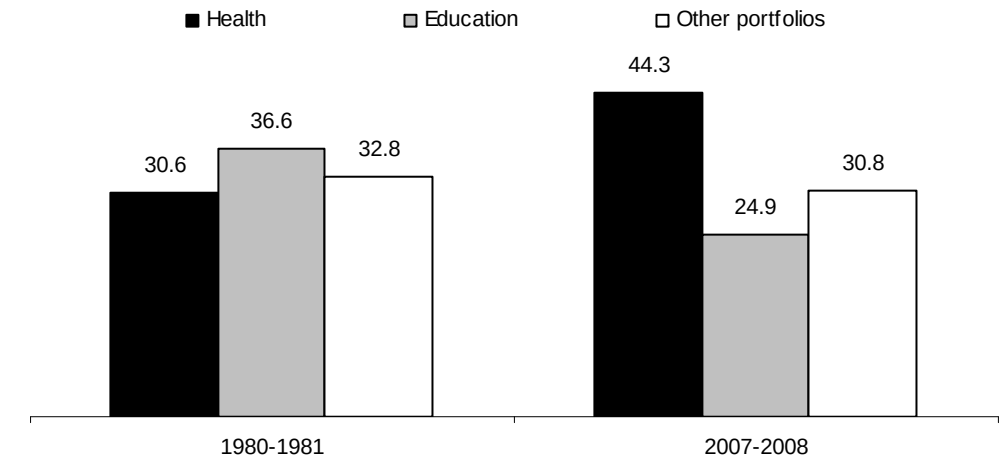
— In 1980-1981, the expenditures allocated to health and social services represented 30.6% of program spending, less than education and almost the same percentage as all other portfolios combined.

— In 2007-2008, this share stands at 44.3%, compared to 24.9% for education and 30.8% for all other portfolios. In fact, the proportion of program spending allocated to health and social services has increased continuously, on a basis of 5 percentage points per decade.

[42] See Chapter 12 below on the work organization, page 181.

GRAPH 4

Expenditures on health, education and other portfolios, 1980-1981 and 2007-2008
(percentage)



Source: *Expenditure Budgets*, Secrétariat du Conseil du trésor.

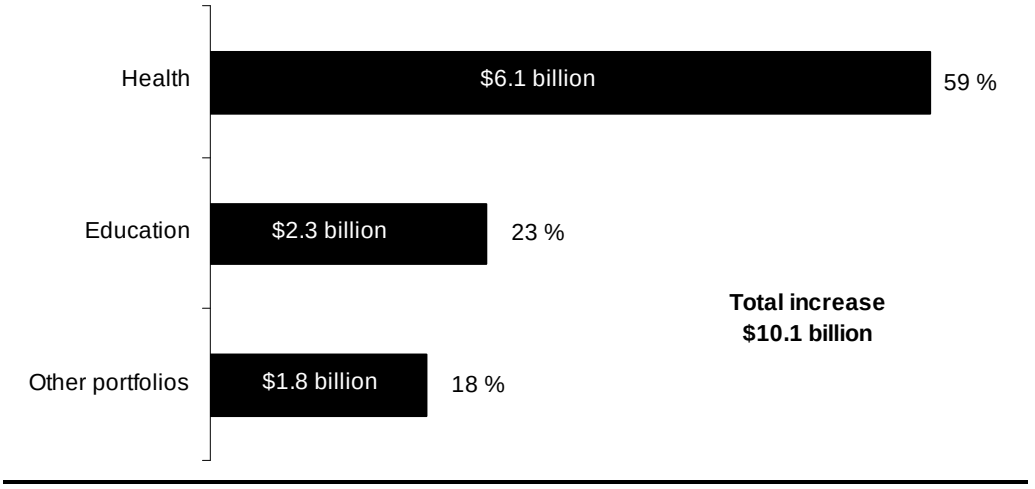
❑ Accelerating dynamics since 2003

As we have just seen, these dynamics have accelerated over the past five years. For the period between 2003-2004 and 2007-2008, nearly 60% of the growth of program spending was allocated to health and social services.

In absolute value, as we have noted, the program spending allocated to health has increased by $6 billion in five years, while the total increase in program spending has amounted to $10.1 billion.

GRAPH 5

Increase in program spending, 2003-2004 to 2007-2008
(in billions of dollars and in percentage)



Source: Secrétariat du Conseil du trésor.

❑ Pressure that will be maintained in the future

Everything indicates that the upward pressure on health care costs will be maintained in the future.

— New technologies and new medications are going through rapid and costly developments, which have an impact on the costs of offering care.

— Chronic diseases related to population aging are increasing in importance, and contribute directly to increase the demand for care.

— More generally, the demographic changes under way will have an impact on the types of medical services required, and thereby on health care costs.

— The latest salary increases granted to the medical specialists and the general practitioners will have an impact on health care costs that can already be quantified. In the case of the medical specialists, the payroll will be $1.3 billion higher in 2014 than its current level.

In all, the forecast annual growth of health spending, according to the projections established by the Secrétariat du Conseil du trésor, would be 5.81% per year for the 2008-2018 period. It must be remembered that in July 2005, the Ménard Report projected 5.1% in annual expenditure growth for the period up to 2020[43,44].

[43] *Pour sortir de l'impasse: la solidarité entre nos générations*, Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, July 2005.

[44] The 5.1% scenario accounted for the improvement of the population's healthy life expectancy.

TABLE 2

Forecast annual growth of health spending (structural growth), 2008-2018
(percentage)

	Share of expenditures	Average annual growth	Contribution to growth
Health Services	37.6	5.9	2.20
Social Services	34.1	4.1	1.41
Public Health	1.9	2.4	0.05
Remuneration of Physicians	14.9	7.5	1.12
Prescription Drug Insurance Plan	8.8	11.0	0.97
Other RAMQ Programs	1.2	2.8	0.03
Administration	1.5	2.0	0.03
AVERAGE ANNUAL GROWTH[1]			**5.81**

1 This is the upper limit of the forecast annual structural growth of 5.47% to 5.81%, as estimated by the Secrétariat du Conseil du trésor.
Source: Secrétariat du Conseil du trésor.

This growth is called "structural" because it is the quantifiable basis of the foreseeable evolution. However, it does not account for a certain number of phenomena, which could further increase public health spending.

We are referring here to the following phenomena:

- the increase in the aggregate remuneration of health and social services personnel, in order to account for certain specific problems (normative clauses, changes made to tasks);
- the hiring of nursing staff to alleviate the current needs;
- the increase in the network's debt service, due to the application of the new Québec Infrastructure Plan (this plan includes the elimination of the fixed asset maintenance deficit);
- the new developments in the health care network;
- the revision of the budgetary bases to put an end to recurring deficits.

❑ A significant gap

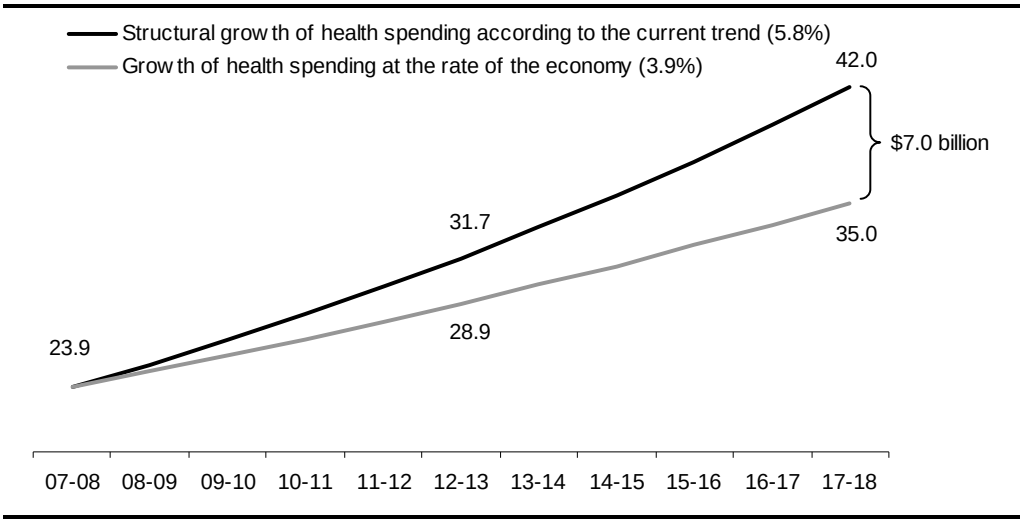
According to the forecasts made by the Ministère des Finances in autumn 2007, the growth of the economy and government revenues should be around 3.9% per year up to 2017-2018.

This means that a significant gap is anticipated between the increase in government revenues and the increase in health care costs, based on essentially conservative evaluation. In absolute value, taking the year 2007-2008 as a base, this gap would be $2.8 billion in 2012-2013 and could reach $7.0 billion in 2017-2018.

The entire problem of health funding is summarized in these figures. To fill this gap, the government has no other choice than to take new initiatives in order to act both on expenditures, to slow its growth, and on revenues, to reduce the pressure on public finances.

GRAPH 6

Projection of public health spending, 2007-2008 to 2017-2018
(in billions of dollars)



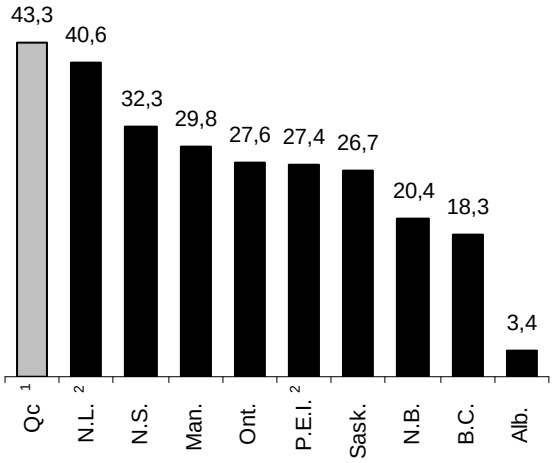
Source: Ministère des Finances du Québec.

1.3.4 Reduced leeway

The leeway available for public finances is reduced, due both to the weight of the current tax burden and the debt level of the Québec State.

GRAPH 7

Total debt of Canadian provinces as at March 31, 2007
(in percentage of GDP)



1 Total debt before the accounting reform.
2 Since the 2006-2007 public accounts have not yet been published, the debt level is that of March 31, 2006.
Sources: Ministère des Finances du Québec, public accounts of governments and Statistics Canada.

Fiscal competitiveness imperatives and fairness to future generations limit the possibilities of financing the growth of health care costs further by taxation or borrowing.

One can appreciate the magnitude of the financial challenge the government must face to ensure long-term funding of the health care system.

However, the current system's strengths, like its weaknesses, allow us to anticipate several paths to provide operational and constructive responses to the current situation.

CHAPTER 2 – THE INTERNATIONAL CONTEXT: A SOURCE OF INSPIRATION FOR QUÉBEC

The questions raised by the operation of the Québec health care system and its current and future funding are posed in often analogous terms in most of the industrialized countries.

Even a rapid review of the international context allows us to identify values and problems common to these countries. It especially results in a number of possible solutions in terms of the reforms and improvements it is possible to provide to health care systems, which everywhere are considered to be the core of public policies.

2.1 An ever improved health status

A first common point appears everywhere when we analyze the health situation in the industrialized countries: since the Second World War, enormous progress has been achieved in the improvement of the health status of the populations of Western countries. A child born today can expect to live nine years longer, on the average, than a child born in 1960.

This improvement in everyone's health is explained by a set of reasons, such as the higher level of education, the improvement of the labour market, the growth of workers' incomes, better housing conditions or healthier lifestyles.

But quite obviously, generalized access to more effective and better quality health care has largely contributed to this improvement. Considerable progress has marked every field of physical and mental health. Advances in science, technology and pharmacology allow ceaseless progress and obtain increasingly effective results.

However, it must be observed that no clear connection could be established between a country's level of health spending and the population's health status.

2.2 A common value, identical problems

In all the industrialized countries – except the United States – universal access to care is the common value and fundamental objective.

The goal of health policies is to ensure that everyone has adequate access to essential care, according to his or her needs. In general, this common objective is implemented by means of public systems, always completed by a private sector which varies in importance depending on the country.

All the industrialized countries are also confronted with problems very close to those noted in the case of Québec.

❑ Ever growing costs

In 1970, public and private health spending averaged 5% of the GDP in the industrialized countries. In most cases, this share has doubled and the expenditures allocated to health are close to 10% of the GDP.

As in Québec's case, this increase in expenditures is largely explained by the progress of medicine and by greater access by the public to an ever wider range of care.

As in Québec as well, we are seeing increased pressure on health care costs, for demographic reasons. The costs of health are rising as the population ages. As many postwar baby boomers turn sixty, most countries must anticipate upward pressure on their health spending.

❑ Health spending is rising faster than collective wealth

This phenomenon is occurring at the same time as the relative size of the active population is decreasing in relation to the total population. Thus, a gap is anticipated, which will amplify between the growth of health-related expenditures and the increase in wealth – which poses the problem of the financial viability of health care systems.

All countries are confronted with the same difficulty: public health spending is increasing faster than collective wealth and government revenues. Despite the efforts made to improve the productivity of the systems, it is feared that health spending will continue to grow at a pace one to two points faster than collective wealth, as measured by the gross domestic product.

Since three quarters of health spending is financed from public funds, this gap is causing serious imbalances and crises in the public finances of several countries.

The challenge everywhere is to improve access to care and the quality of care, while limiting the growth of health spending.

❑ An inevitable rationing

In all countries, forms of rationing in the broad sense are noted, regardless of the level of public and private health spending.

This rationing is manifested in various ways: depending on the country, we observe prolonged waits, services rendered inaccessible, care that is no longer insured or a decline in the quality of the care provided.

All countries have the objective of reducing or mitigating the most negative effects of rationing. But no country claims that it can totally eliminate all forms of rationing.

❑ The quality of care

One last problem is common to most of the industrialized countries: for the past few years, we have seen a growing public awareness of the question of the quality of care.

The following difficulties are reported:

— Some operations are performed when they should not be performed according to the existing medical standards.

— Patients who could benefit from certain primary care do not always benefit from it.

— Many errors are reported in the delivery of care – such as faults concerning medication or mistakes regarding the organ to be operated on.

There are many signs of serious breaches of quality. They result in deaths, disabilities or aftereffects which should not have occurred. They significantly increase the costs of the health care systems.

2.3 Reforms under way everywhere

To solve these problems and meet these challenges, the health care systems of the industrialized countries have been the object of multiple reforms over the past twenty years. For example, Germany has engaged in five major reforms in the past few years, and the United Kingdom in at least three.

All these reforms and all these changes have been the object of in-depth studies and analyses[45]. This results in a series of broadly shared conclusions and the identification of promising solutions to improve the health care system's performance.

These reforms also show that many changes based on laudable objectives have produced negative results and thus have suggested solutions to avoid.

❑ The ideal system does not exist

In the first place, we find that the ideal health care system does not exist.

The research shows that no health care system is fundamentally superior to the others. In terms of quality of care, the work performed on the existing systems does not allow a conclusion that one type of system is better or worse than the others.

[45] In particular, see the studies performed on the initiative of the World Health Organization, the OECD, the King's Fund, the Institut Montaigne and the Rand Corporation.

We also find that no obvious correlation exists between better access to care and a higher level of quality of the care provided.

❑ Citizens' rights and obligations

Basically, the World Health Organization recalls that citizens must have a good understanding of their rights and obligation. This is an essential condition to ensure the success of the efforts to improve the health care systems.

According to the World Health Organization, it is necessary to deal with the public's expectations, which may be inordinate, by getting people to understand the notion of compromise. Citizens on the whole want everyone to have everything. To ensure the system's viability, the necessity must be explained of applying some kind of rationing or imposing limits.

Since no solution can satisfy everyone, the governments must clearly indicate the choices made and the governments proposed.

❑ Priority to first-line care

In all industrialized countries, it is found that an agreement exists as to the priority that must be given to ambulatory care and first-line services[46].

In this regard, the development of well organized medical clinics with clearly defined objectives makes it possible to improve the accessibility and quality of care. Not being subject to hospital red tape, medical clinics can obtain significant cost reductions. According to some, the 21st century thus should be the century of ambulatory care.

❑ Mixed practice

In most industrialized countries, physicians can practice both in the public system and privately, outside the system. However, physicians who choose this possibility must satisfy certain obligations to the public system, before providing care on a purely private basis.

In general, practice outside the public system remains relatively limited. Its importance differs from one country to another and varies by medical specialty. The OECD notes that even in countries where a large part of the population contracts private insurance to cover the costs of private care, this type of insurance tends to represent a relatively low proportion of total health spending: the coverage is often geared to minor risks, instead of the costliest treatments.

[46] See above, on page 30, what is meant by ambulatory services and see page 76 for the meaning of first-line services.

❑ Improvement of performance

One very encouraging common point emerges from the analyses of the reforms made to the health-care systems in the industrialized countries.

It is observed that the changes made to these systems since the 1990s allow the conclusion that it is completely possible to improve the performance of health care systems significantly from the threefold perspective of quality of care, accessibility and costs.

More precisely, the systems' effectiveness can be increased through greater productivity, a reduction of superfluous or irrelevant expenditures and an increase in the cost-effectiveness ratio of care.

■ More effective ways to spend

The international data confirm that it is possible to improve the cost-effectiveness ratio of health care systems by spending better.

Market imperfections and massive intervention by public authorities are factors likely to lead to excessive or poorly allocated expenditures. This may result in wasted resource.

The financial or administrative incentives must be well calibrated according to the efficiency objective pursued.

— In some cases, the incentives established only deter the recipients from applying the best methods. Some budgetary practices often only have the effect of inducing institutions and professionals to do less.

— These contraindicated incentives must be replaced with other practices, which encourage the development of medicine based on better ways of doing things and, finally, the optimization of care delivery. Improvement of the quality of care also often translates into a reduction of its costs.

■ The risks of an artificial limit on incomes and prices

Some countries have succeeded in slowing the growth of spending by applying budgetary and administrative controls on the supply and prices of care and services. When this type of experience is analyzed, it is found that the systems that artificially limit professional incomes and prices are at great risk of downgrading quality, while being confronted with recruiting problems and an insufficient supply of care.

It thus seems that improving efficiency is the best way to reconcile the increase in the demand for care with the constraints of public funding. It is not possible to be more efficient simply by reducing costs, but by changing the way spending is done.

❑ Improvement of governance

In several countries, the health care systems have gone through major changes that sought to improve their governance.

— In general, they seek to reduce the politicization of systems, while establishing clear lines of accountability.

— In the systems where funding and delivery of care are public responsibilities, the measures taken to separate the role of the insurers or buyers from those of the service providers have generally turned out to be effective.

In many countries, the emphasis is placed on decentralization. The goal pursued is that decisions can be taken at the level of the action. By moving away from measures or programs imposed from the top down, innovation and motivation are favoured.

— The people responsible can manage their institutions and clinics more effectively by implementing flexible approaches better suited to their needs.

— Decentralization makes it possible to define performance and quality objectives and thus evaluate performance.

— Finally, decentralization makes it possible to clarify the chain of accountability, by defining who is accountable for what, at each level.

❑ Evaluating performance

The search for performance depends on its evaluation, which must account for the complexity of the search for greater effectiveness.

It is fundamental to measure the performances obtained carefully against specific indicators, perform comparative evaluations between care providers and between jurisdictions, and finally, share the information thus obtained. It will then be possible to identify effective practices and the conditions under which the observed results were achieved.

To arrive at this, it is indispensable to have better data recording and tracking systems regarding the patients, their health and the care provided to them. Paper medical records, prescriptions and examination reports do not favour precision, accessibility and sharing of information.

It is observed that wherever they have been put in place, automated information systems have had a very positive impact, both on the quality of care and on its cost.

2.4 Reform: a permanent process

One conclusion is necessary when we consider the state and evolution of health care systems in the industrialized countries: there are few simple, quick and definitive solutions with results that can be seen in the short term, given the complexity of the systems and the constant progress of medicine and needs.

It is also found that in all the industrialized countries, health policy makers manifestly have a good idea of the measures that can allow a large part of their objectives to be achieved.

These objectives are found from country to country. Policy makers simultaneously want to ensure:

- equitable access to care,
- health improvement,
- disease prevention,
- establishment of viable and equitable funding of health and dependency services,
- control of the growth rate of public spending.

In general, all health policy makers seek to improve the performance of the health care systems, while restoring the growth of public spending to a desirable level.

To accomplish this, some countries – including the United Kingdom – have committed to a permanent reform process, and this may be the most important lesson to be learned from this overview of the international context.

PART 3
A frame of reference: setting realistic and equitable limits

The approach proposed by the Task Force is articulated around a central objective, identified in the introduction of this report: if it wants to ensure the sustainability of a system to which it is deeply attached, Québec must increase this system's productivity and adjust the growth of public health spending to the growth of collective wealth, while improving access to care and the quality of services[47].

The Task Force recommends that this objective be concretized in a frame of reference, setting quantitative and qualitative limits to the public health care system.

- The quantitative limit chosen has just been stated. It is justified and explained in **Chapter 3**.
- **Chapter 4** is devoted to the qualitative limit proposed in this report: the Task Force is referring here to the delimitation of public coverage and the establishment of priorities.

[47] See page 3 above.

CHAPTER 3 – A QUANTITATIVE LIMIT: ADJUST THE GROWTH OF PUBLIC HEALTH TO THE GROWTH OF COLLECTIVE WEALTH

The frame of reference proposed by the Task Force first includes a quantitative limit.

- Limits have always been applied to the services offered under the public system. It seems essential to recall this in the first place.
- The Task Force finds that, more than ever, new limits must be defined to provide a framework for the public health care system and that choices are necessary in this regard. The reasons that compel us to impose these limits must be highlighted once again.
- The Task Force proposes that these choices translate into a quantified target, representing the quantitative limit applied to the growth of public health spending. The proposed limit is demanding, but it is not impossible to attain – on condition that the corresponding means can be mobilized.

3.1 Limits that have always existed

There was a time at the beginning of the 20th century that health services were mainly delivered by solitary physicians armed with a black leather satchel. Illness was a private matter and the medical act sought to reverse the course of the disease with the means available in that era. Access to care was hit or miss. In those days, nobody raised questions about the limits to impose on health services. These limits were defined by themselves.

❑ Limits applied early in the implementation of the public systems

After the Second World War, with the development of medical technologies and the birth of the Welfare State, health care began to be produced by complex systems, offered in a public framework.

Health services became progressively more effective, but also much costlier. Access to care was transformed into a central political issue, because it was perceived both as an individual right and a collective asset, allowing maintenance of a healthy population.

From the beginning, limits were applied to the coverage offered. Both in Québec and in Canada, these limits thus have always existed.

— In the case of Québec, as we have just seen, the public plan covers almost all medical care and hospital care, medications and certain services related to loss of autonomy.

— But once people leave the hospital and look for the services of a dentist, an optometrist, a podiatrist or any other health professional who is not a physician, they no longer benefit from public coverage. Only those who can pay cash or contract supplemental private insurance are covered against risks. More than one third of Canadians and 32% of Quebecers have no insurance of this nature[48].

This reality is the same everywhere. All health care systems around the world impose limits one way or another.

— In the United States, over 45 million citizens have no health insurance.

— In Europe, patients must pay a user fee to have access to care.

❑ Another form of limit: rationing

Independent of this first series of limits, resulting from the coverage of care, health care systems have limits of another nature, this time related to rationing resulting from the restrictions applied to the supply of care available.

In Québec, as has been noted, the health care system has been subjected to budget cuts, resulting from the dramatic reduction of federal health transfers and the budget deficit elimination policy.

— To limit the growth of costs, the government for several years adopted a logic of constricting the supply. For years in Québec it was believed that it was sufficient to limit the number of physicians and medical school enrollments to reduce the demand for care. The government also closed hospitals, especially in Montréal.

— This policy ended up having negative consequences on access to health services, particularly in terms of waiting lists and wait times and especially for elective surgery. Despite a recent improvement[49], the fact that one quarter of Québec citizens have no access to a family doctor illustrates this rationing and its consequences.

Rationing is not an acceptable solution in a developed society like ours.

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[48] Facts & Figures. Life and Health Insurance in Quebec, 2007 Edition, Canadian Life and Health Insurance Association, page 3.

[49] See above, page 22.

Rationing favours power struggles. Each citizen and interest group tries to pull the blanket to his side of the bed. Choices are no longer made according to the needs of the population or the quality of care, but according to the balance of power existing within or on the periphery of the system, which is contrary to the very principles of a truly democratic society.

3.2 The obligation to make choices

To escape this trap, another, more fair and reasonable way must be found to set the limits of our public system.

❑ A theoretically unlimited demand

In theory, the demand for health care is unlimited. Technological progress gives reason to anticipate that the range of therapeutic tools to respond to this demand is also without limits.

Most health policy analysts are convinced that in the future, no country in the world, even the richest, will be able to offer its population everything that science and technology will make it possible to offer. Society will never be able to meet all the demand for care, and never could.

This reality shatters certain utopian visions. Western populations are accustomed to chasing a dream, seeking to make all of technology's promises accessible without exception to the greatest number.

It is time to introduce reality into this vision, in which questions of relevance and efficiency are asked frankly. More than ever, all societies must ask themselves what health services must be given priority, determine which ones will be covered by the public system and which ones will depend on personal forethought.

What the World Health Organization says in its June 2000 report is no different. The international organization points out that a national system necessarily must make choices and priorities, in order to define all the services to offer the general public. We thus can read in the report that "all countries need **[...]** to ensure that limited resources are spent in identified high priority areas"[50].

❑ Defining the extent of solidarity

However, as soon as one considers the limits to be applied to the public health care system, the questions multiply.

[50] WORLD HEALTH ORGANIZATION. *Health Systems: Improving Performance. The World Health Report 2000.* Geneva: WHO, 2000, p. 65.

As biomedical technologies become increasingly efficient, they are producing real miracles. They are overcoming previously fatal diseases and increasing the intellectual, psychological and physical capacities of individuals.

On what grounds can the use of these increasingly costly technologies be controlled? Is the role of a public health service to repel death at any price? Is national solidarity responsible not only for ensuring a cure but for taking charge of the full comfort of aging people, assuming individual choices regarding fertility or sterilization, having all citizens share the exceptional risks of individuals who drive deathtraps on the roads, smoke like chimneys or engage in extreme sports at the peril of their lives?

Ethicist Hubert Doucet poses the problem well: "to help us escape the current impasse, the question must be posed not in terms of the right of individuals to receive all the care their believe necessary, but in terms of a specifically ethical concern of solidarity. How far should this solidarity go? What forms should it take? These are questions we have to debate publicly. If we do not pose the problem in this way, our debates will be summed up as power struggles for control of the system"[51].

❑ Protecting the State's other missions

Some people have trouble accepting that limits must be imposed on health services.

— They forget that limits already exist.

— They neglect the role of the State's other missions and other dimensions of society, which are fairly important. They assign a moral superiority to health, which ought to be relativized.

Health is a priority mission of the State because health is generally a condition of the exercise of freedoms and equal opportunity. By defending individuals from disease, health care protects their capacity to fulfill themselves and participate in the country's social, political and economic life. It supports their capacity to act as citizens.

But health care is not the only essential good.

— Several other functions of the State protect the capacity of individuals to act, such as education, culture, job creation, protection of the environment or poverty reduction.

[51] Doucet, Hubert ; "Quelles finalités pour le système de santé québécois?", in *Santé, pour une thérapie de choc!*, a work published by the Conseil de la santé et du bien-être and the daily Le Devoir, at Les Presses de l'Université Laval, 2001, pp. 13-17.

— It must also be realized that other aspects of collective life interact with the health care system to maintain a healthy population. The improvement of health is conditioned by education, income level, housing conditions and lifestyles.

— The experts agree to emphasize the influence of social factors on health. Social and economic disparities produce health inequalities. This means that the decisions that affect economic growth and social policy have a direct impact on health care needs.

In this perspective, universal access to medical and hospital services is insufficient to achieve equity in relation to disease. The health care system is not equitable if its share of public expenditures compromises the State's capacity to offer everyone access to education, fight poverty or protect the environment. A society that manufactures sick people does not always redeem itself by offering free care.

❑ The obligation of performance

In addition to the obligation to make choices, the OECD indicates another dimension – that of performance. The international organization points out that: "ultimately, increasing efficiency may be the only way of reconciling rising demands for health care with public financing constraints"[52].

The term performance is used here in the sense of obtaining the best possible results, in view of the available resources. It must be remembered that if resources are not used efficiently, this means that less resources will be available to meet the real needs. Efficiency and productivity are conditions of equity in the health care system.

The Task Force thus focused part of its reflections on the means of improving the system's performance, which is inseparable from the choices to be made to define the limits of the public system.

3.3 Setting an objective

The limits to be applied to the public health care system first have a quantitative dimension: at the beginning of the report – and as recalled in the introduction to this section – the Task Force emphasized that Québec had to aim at reducing the growth of public health spending, while improving access to care and the quality of care[53].

[52] *Towards High-Performing Health Systems*, OECD, 2004, page 17.

[53] See above, page 3.

❑ The proposed target

The Task Force is convinced that the government must associate a quantified target with this objective. It will take much more than good will to contain the growth of health spending.

The approach proposed to the government consists of setting an objective that is clear and comprehensible to everyone, for which implementation can be easily evaluated and quantified. For the Task Force, it thus appears just and equitable that the growth of health spending follow the growth of collective wealth.

Recommendation

The Task Force recommends that the government adopt the objective, over a horizon of five to seven years, of reducing the growth of public health spending so that it does not exceed the growth of collective wealth.

This objective means calibrating our public health spending according to society's ability to pay, without undermining the possibility for the State to act in other fields that are also important.

This objective is neither new nor inherently original.

— The Clair Commission had recommended the establishment of a benchmark limit on health spending in relation to other government expenditures[54].

— The Ménard Committee took up this notion and suggested that this limit be defined by the growth of collective wealth[55].

— Several European countries have adopted analogous targets, and two of them have actually achieved them. Over the past ten years, Germany and the Netherlands have succeeded in limiting the growth of public health spending to the increase in collective wealth[56]. England has formulated a similar objective for its National Health Service.

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54 Commission d'étude sur les services de santé et les services sociaux. *Emerging solutions: report and recommendations*, 2000, p. S.XXI, and recommendation 19, page 149.

55 Comité de travail sur la pérennité du système de santé et de services sociaux du Québec. *Pour sortir de l'impasse: la solidarité entre nos générations*, 2005, p. 101 and recommendation 1, page 48.

56 *Comparaison de l'évolution des dépenses en santé et de la croissance du PIB des pays de l'OCDE*, Ministère des Finances du Québec, note prepared for the Task Force, December 10, 2007.

3.4 Adopting means of achieving the objective

This is a very demanding objective, however, and the Task Force is well aware of this fact. Its achievement requires major efforts.

❑ A qualitative limit: coverage under the public plan

This objective must first be accompanied by a qualitative limit on the coverage under the public health plan.

As we have just mentioned, all over the world, governments are compelled to make choices and identify priorities. First of all, they must see to it that the services insured by the public system are those that best meet the public's needs, at the best possible cost.

What is raised here is the entire question of the delimitation of public coverage, to which we will return in the next chapter[57].

❑ An action plan

The setting of this objective must be accompanied by a realistic and operational action plan. The main lines of the plan proposed to the government are presented in this report.

■ Targeted investments concerning services

The government must review several key elements of the services offered by the health care system. In some cases, the desired results are related to certain targeted investments. International experience shows that any desired improvement to the health care system requires investments.

The Task Force thus has identified the initiatives to be taken regarding services – for example, for first-line and home maintenance services –, so that the right health service is offered by the right person at the right time[58].

[57] See below, Chapter 4, page 57.

[58] See below, Part 4, page 65.

■ Productivity gains

The government will have to utilize the system's resources better, so that our health care system is more productive and more efficient. The Task Force is convinced that Québec can do more with the amounts spent at the present time.

This is the sense of the different recommendations and proposals formulated, particularly to improve the governance of the health care system, the allocation of resources and the work organization[59].

■ Appropriate revenue sources

Finally, the government will have to ensure sustainable and diversified revenue for the public health care system, accounting for the expected effects of the different proposed initiatives on the growth of public health spending, as well as the time necessary to benefit from them.

Here again, the Task Force has identified orientations for this purpose[60].

■ A horizon of five to seven years

The horizon of five to seven years recommended by the Task Force seems realistic. It will take a certain period of time before the identified measures can be implemented efficiently and produce their full effect.

At the same time, it is important to initiate the necessary efforts promptly. For the Task Force, the worst response to the current problems would be to continue to transfer budgets to health care without a significant change of approach.

If public health spending is allowed to continue increasing at the current pace, this could only be achieved to the detriment of the State's other mission – or by increasing the tax burden. Both of these options are dead ends.

We must be clear, however: the Task Force is not proposing that the government implement a plan of budget cuts of the nature of the restrictions applied in the 1990s. There can be no question of subjecting the public network to the difficulties already experienced.

It is precisely to avoid such a situation that the Task Force has identified a coherent set of actions. The purpose of all the proposed efforts is to ensure the sustainability of our public health care system.

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59 See below, Part 5, page 143.

60 See below, Part 6, page 213.

CHAPTER 4 – A QUALITATIVE LIMIT: THE DELIMITATION OF PUBLIC COVERAGE AND SETTING PRIORITIES

The frame of reference proposed by the Task Force is not limited to a quantitative objective. It also involves a qualitative limit, consisting of the delimitation of public coverage on the basis of quality and efficiency criteria. The choices must be based on scientific knowledge and public deliberation.

The quantitative and qualitative limits are complementary: the delimitation of public coverage is one of the components of the frame of reference recommended by the Task Force to government, and one of the means to be implemented to comply with the quantitative limit previously identified.

By proposing a redefinition of the current public coverage, the Task Force is opening up a delicate debate.

— This debate requires that we first note the problems resulting from the public coverage applied by the Québec health care system – incoherent coverage with a rigid definition.

— The Task Force has sketched the main lines of a mechanism allowing this coverage to be modified and redesigned, with the aim of proposing a credible and legitimate approach to the government.

— The application of such a mechanism and the delimitation of public coverage that will result from it can be accomplished successfully only if certain conditions are fulfilled. The Task Force has attempted to identify them.

4.1 The current coverage: incoherent and rigid

The current coverage under the public health care system is both incoherent and rigid.

❑ The basket of services is incoherent

In its report, the Clair Commission emphasized the absence of rationality in the composition of what is also sometimes called the basket of insured services.

The current coverage is the result of a historic process and not of a continuous evaluation of the social, clinical or economic relevance of the services insured or insurable. The basket of services does not account for the evolution of society and its composition is less and less easy for individuals to understand.

There are many examples of incoherence.

— Some care is covered in the hospital but not covered at home. Glasses are not reimbursed for school-age children, certain psychological care is refused to

patients who would need it, and speech therapy services offered in private practice are not covered. However, any visit to the emergency room or to a physician is compulsorily free, regardless of its object and frequency, and regardless of the seriousness of the problem to be examined.

- Recurring flu symptoms are treated free of charge, but not psychotherapy.
- Certain diagnostic services are covered in the hospital but not in a clinic.
- Food services offered in hospital centres absorb over $250 million a year in Québec[61].
  - Why should the public pay for meals for hospitalized patients, regardless of their socioeconomic status?
  - On the other hand, seniors suffering loss of autonomy accommodated in a CHSLD pay substantial amounts for their food. In this specific case, the incoherence is due to the provisions of the *Canada Health Act*. The federal law penalizes provinces which charge for hospital meals, but says nothing about the treatment of seniors in residential care centres.

❑ The taboo of change

This incoherent public coverage is also rigid. Reviewing the basket of insured services is taboo in Québec. It is perceived as a Pandora's box which must not be opened.

- Some prefer not to review the range of services insured by the public plan, fearing that the process will lead to its expansion and increased costs.
- Others oppose the opening of this discussion because they fear a reduction of public services.

The Task Force finds that nobody has formulated a concrete proposal on how it would be possible to proceed in order to review the basket of insured services.

However, the *Health Insurance Act* recognizes vast regulatory powers for the government to identify the services covered by the public sector and to qualify them as insured.

- The Act mentions many factors to be taken into account, such as the frequency of an act, the age of the person who receives the services, the nature of the services or the indications of their provision. It explicitly allows the government to determine the services which must not be considered insured.

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[61] According to an estimate by the Ministère de la Santé et des Services sociaux. For institutions with a hospital centre mission – including institutions with multiple vocations, the CSSS – the costs of food services are estimated at $253 million in 2006-2007. In all of the institutions with a CHSLD mission, the estimated amount of costs rises to $263 million, also for 2006-2007.

— In the past, the Gouvernement du Québec actually used these powers, particularly to limit the age at which vision examinations and dental care are covered. But it hesitates to do so when medical and hospital care are involved, particularly out of fear that the federal government will rely on the *Canada Health Act* to penalize the provinces financially.

The existence of the *Canada Health Act* thus reinforces this taboo against change.

❑ It is difficult to add new services or modulate services

By renouncing the withdrawal from public coverage of services of contestable relevance, the government makes it difficult to take any initiative aimed at replacing them with new services.

It also abandons any idea of modulation in this coverage.

— By relying on principles such as universality and comprehensiveness, Québec up to now has refused to modulate coverage of medical and hospital care according to criteria which nonetheless are set out in the Act, except for medications.

— As a general rule, when a service is insured, it is insured for everyone and it is paid 100% without restriction on the frequency of use.

Distinctions for certain services have been introduced into the system, but very timidly and marginally.

— For example, when a person undergoes cataract surgery, the public system reimburses the price of a normal lens. If a person wishes to obtain a higher quality lens, he must pay the difference.

— This practice could very well be extended by defining how far to go with national solidarity and the point at which the individual should pay a supplement, expressing his preference for services of a higher quality than is medically necessary. Nobody would be deprived of essential services.

The existing examples of modulation are very limited. They confirm the reality that must be noted: the current coverage of the public health care system is essentially considered untouchable, despite its deficiencies and incoherence.

4.2 A credible and legitimate mechanism

The system must escape this dead end, and the only way to achieve this is to adopt a permanent, credible and legitimate mechanism allowing continuous review of the coverage under the public plan.

❑ Defining what is medically required

Currently, services are covered by the public plan if they are considered "medically necessary" and "medically required". The *Regulation respecting the application of the Hospitalization Insurance Act* provides a detailed list of the insured services provided in hospital centres, when these services are medically required. However, neither this Act nor the *Health Insurance Act* defines the notion of what the public plan considers to be "medically necessary" and "medically required". Nor are these notions defined in the *Canada Health Act*.

By adopting a public coverage review mechanism, Québec would simply adopt a means of defining what is medically required.

❑ The questions that are asked

It is not easy to determine how to set limits justly, equitably and efficiently, that is, to make choices that will produce the most health care for the greatest number at the best possible cost.

How can the boundary line be drawn between what must be covered by the public plan and what should no longer be covered, without abandoning the requirement of solidarity?

The simplest method would be to establish principles and adhere to them firmly. But no democratic society has achieved consensus on these principles, which inevitably give rise to ethical controversies.

The questions multiply. Who should be given absolute priority? People who are the most gravely ill, even if the chances of success of the costly treatments administered to them are low? Seniors suffering loss of autonomy or children suffering from degenerative diseases? New technologies, from which miracles are expected, or prevention programs in disadvantaged urban neighbourhoods or devitalized rural areas?

❑ The European experience

In several European countries, and particularly in the Scandinavian countries, priorities have been established and the basket of insured services has been revised for nearly twenty years. These countries looked for an approach in the mid-1980s. Since 1987, first in Norway and then in Denmark, governments have sought to establish principles and stick to them.

The reflection undertaken recently in the Netherlands, Denmark and Norway has some lessons for us.

The adoption of criteria

In the Netherlands, in 1992, the authorities adopted four criteria seen as filters to determine what services to include in the basket of services and what services should be excluded from it.

The following criteria were adopted:

- First criterion: is this care required from the community's point of view?
- Second criterion: can it be shown that this service is effective?
- Third criterion: is the service efficient, meaning that it offers the best quality-price ratio?
- Fourth criterion: can the service be left to individual responsibility?

On this basis, the committee in charge of defining health care priorities suggested that in vitro fertilization was unnecessary from a community perspective, regardless of its benefits on an individual basis.

On the other hand, the committee considered that sports injuries should be treated in the public system because they result from an activity which is normally beneficial for health.

Needless to say, these lists of criteria sowed controversy.

The search for equitable and legitimate processes

Starting in 1996 in Denmark and then in 1997 in Norway, the authorities wanted to move away from this method, which they considered simplistic. They no longer seek to establish absolute principles. Instead they look for equitable and legitimate processes.

The decisions made within the context of these processes must be perceived as reasonable by the average citizen.

- The Danish Council of Ethics thus suggested that openness, transparency and public dialogue are essential conditions for the success of any health services planning process, including processes intended to establish an order of priority of insured services.
- Decision-makers must always be clearly informed of the social consequences of their choices.
- On the other hand, the public has a right to all the information available to understand and influence the decision-making process.

■ Scientific knowledge and public deliberation

The reflections undertaken in Europe offer at least two lessons:

— The decisions concerning public coverage undeniably depend on political power.

— These political decisions must be based on public deliberation and scientific knowledge.

In fact, the ultimate criterion is as follows: decisions that have the effect of excluding certain care and certain services from public coverage must be considered legitimate by the people who are affected by the decision. The decision-makers must put themselves in the shoes of a patient who is refused care.

❑ A two-level approach

Based on foreign experiences, the Task Force proposes to the government that public coverage be defined according to a two-level approach. The First level would determine general coverage and the second level would concern the modalities of managing the risks insured by the public plan.

■ Defining the contours of general coverage

The first level involves a redefinition of the contours of coverage of the risks assumed by the public plan and covered on the grounds of national solidarity.

We are not starting from zero in this regard. We have already decided, as a society, that certain risks would be excluded from general coverage to be assumed by distinct plans. This is the case for industrial accidents and road accidents.

Québec thus could decide to exclude specific risks from public coverage or to include others.

■ Modulating the modalities of managing the risks insured by the public plan

The second level involves management of the risks covered by national solidarity.

The issue is to determine as clearly and as equitably as possible the limits of public coverage of the risks assumed by society.

Thus, for a given condition, we would have to determine what is medically necessary through the establishment of care protocols. It would be specified that the public plan reimburses a specified number of medical visits or a maximum frequency for certain treatments.

Needless to say, the limits set in this manner would have to be justified by conclusive scientific data, in addition to being the subject of open deliberation by experts, practitioners and citizens. It would be important, of course, for the decision-making mechanisms to include the flexibility required by the efficient operation of the system.

But there is nothing reprehensible about setting limits and ensuring that they are observed.

On the contrary, the current refusal to set limits means that health services are excluded outright from public coverage when they are more necessary or essential than services currently covered.

4.3 The conditions for success

The process adopted will have to fulfill certain conditions to be considered legitimate and equitable. Such conditions have been identified in the scientific literature[62].

❑ The four conditions proposed

These conditions are as follows.

■ Transparency

The decision-making process must be public and transparent.

— The decisions rendered by the organization mandated for this purpose must be public.

— The grounds and the reasoning that led to the decision to include or exclude a service or a technology from the basket of insured services also – and above all – must be public.

— The procedure must provide for participation by the public and experts.

■ Relevance of the decision-making criteria

The grounds invoked in supporting the decision must be perceived by impartial persons as relevant to determine the best ways to meet the needs for health services, in a context of reasonably limited resources.

These criteria must correspond to a shared objective.

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[62] For example, Daniels, Norman and James E. Sabin, *Setting Limits Fairly*, Oxford University Press, 2002.

■ The possibility of contesting the decisions

It is necessary that the decision-making process includes review and appeal modalities, and the appeal procedure must respect the first two conditions stated above.

It must also be possible to review the decisions periodically in the light of new information, scientific progress or social judgments that would justify them.

■ A regulating mechanism

The entire process must be governed by clear rules and be placed under the responsibility of a credible, legitimate and efficient organization. As we will see later, the Task Force proposes the establishment of such a body[63].

Neither market rules nor the will of the majority are of any assistance in establishing the limits of the care system. Neither of these two logics is appropriate to decide among various scientific or ethical considerations.

The Task Force thus makes the following recommendation.

Recommendation

The Task Force recommends that the government proceed with a systematic, structured and ongoing review of public coverage, adopting a permanent, credible and legitimate mechanism for this purpose.

❑ A profound change

With its recommendation regarding public coverage, the Task Force is aware that it is proposing a profound change.

The Task Force is convinced that this change is necessary, if we want to set realistic and equitable limits to public health spending, and thereby ensure the sustainability of our health care system.

Far from calling the very idea of public coverage into question, the limits we propose to define would ensure its relevance.

[63] See below, le chapter 13 devoted to the creation of an Institut national d'excellence en santé (National Institute for Health Excellence), page 195.

PART 4
Services: the right health service offered by the right person at the right time

Reducing the growth of public health spending while improving the quality of care and access to services assumes an effort and initiatives that concern several key components of these different services. In some cases, the government will have to proceed with targeted investments, knowing that the investments thus granted involve major potential for long-term gains.

The Task Force has identified a set of recommendations, proposals and suggestions concerning the main services offered by the health care system, to ensure that in our system, the right health service is offered by the right person at the right time.

These recommendations, proposals and suggestions and the reflections that led to it are articulated in five chapters.

- **Chapter 5** is devoted to prevention: the purpose is to propose that Quebecers adopt a healthy lifestyle and thereby limit the system's costs.
- In **Chapter 6**, the Task Force discusses the entire question of first-line care– a crucial question for the efficient operation of the system as a whole.
- In **Chapter 7**, the Task Force proposes a certain number of initiatives, in order to improve access to care. These improvements include an increased role for the private sector with the aim of making it an ally of the public sector.
- **Chapter 8** consolidates the Task Force's recommendations and proposals with a view to providing a response adapted to aging and loss of autonomy.
- Finally, **Chapter 9** discusses medications, a major therapeutic and economic issue, to identify the best ways to use them and control costs better.

CHAPTER 5 – HEALTHY LIVING AND LIMITING COSTS THROUGH PREVENTION

For the Task Force, it is clear that the reflection on health services must begin with an analysis of what can be done in prevention.

However, society is a long way from consensus on this clarity.

— In financial terms, prevention is synonymous with investment and results that can only be made and evaluated in the long term.

— Moreover, prevention is largely related to each individual's behaviour, which is not easy to move quickly in the right direction.

As a basis for its reflection, the Task Force could rely on the study conducted by Pierre Fortin and Luc Godbout on the initiative of the Lucie and André Chagnon Foundation[64].

This chapter devoted to prevention is divided into three sections.

— The Task Force first wanted to specify what it meant by prevention, by defining the economic dimension of successful prevention.

— In the past few months, the government has undertaken major prevention initiatives. In most of the industrialized countries, questions related to prevention – such as the fight against smoking or obesity – are on the front line of public debate. Taking these concrete examples, it is possible to measure the impact of prevention on the health care system – and on the economy in general.

— Of course, these reflections and analyses lead to several recommendations and proposals, which are all intended to increase individual and collective investment in prevention.

64 Fondation Lucie et André Chagnon, Pierre Fortin and Luc Godbout; *Voir plus loin que le bout de son nez: la contribution de l'investissement en prévention au financement de la santé*, September 28, 2007.

5.1 Prevention and its effects

Prevention often is defined as a set of clinical interventions of an individual nature. For example, such interventions include vaccinations, detection and various prophylaxias performed or proposed in a clinic.

❑ A broad definition

This exclusively clinical definition of prevention is reductive. The Task Force prefers to adopt a broader vision of prevention, including any action with the aim of reducing the risk of occurrence of accident, disease or death.

We should go even farther. The contemporary medical literature and practice in the field today consider prevention in a much vaster perspective. It encompasses not only clinical interventions but legislative, educational or community initiatives which promote health to the general public.

These initiatives include, for example:

— the laws and regulations concerning occupational safety, highway safety, the building code, and provisions concerning tobacco and food;

— educational efforts on food, physical activity, alcohol and drugs;

— community support accompanying parental involvement in the school, recreation and sports, healthy diet and any policy supporting school success;

— any program which seeks to modify environments with the aim of obtaining and maintaining public health, such as programs concerning physical education in the schools, strengthening the identity of boys, stress management and development of children in difficult settings.

❑ The effects of prevention

Prevention first and foremost makes it possible to improve the health status of the people who benefit from it.

However, prevention has an economic dimension which cannot be overemphasized. The fact that a population is healthier thanks to prevention efforts has an impact on employment, productivity and the standard of living.

Prevention thus has both a direct and indirect impact on health funding.

— First, by improving health, prevention reduces or at least defers health spending.

— On the other hand, a population who lives longer in good health is more productive economically and creates more wealth. This indirectly facilitates public and private funding of health care.

In all countries, poor health is a major source of underemployment of the population. Poorer health reduces the proportion of adults who hold a job, increases workplace absenteeism and decreases productivity on the job.

- In 2006 in Québec, full-time employees were absent from work for an average of 9.3 days due to illness (maternity excluded). This is 30% more than in the rest of Canada, where the rate of absence of full-time employees due to illness was 7.1 days.
- There is thus room for a significant increase in attendance at work by Québec employees, if their health can be improved. Lowering their rate of absence to the same level as the rest of Canada would increase Québec's domestic income by $1.1 billion.

Similarly, the extension of life expectancy could have a significant impact on the participation rate of the older population. Again in 2006, only 48% of people in the 55 to 64 age bracket held a job in Québec, compared to 58% in the rest of Canada. We should not underestimate the importance of increasing the employment rate of this age category in Québec over the next two decades.

Up to 2030, it is forecast that the Québec population in the 20 to 54 age bracket will lose 400,000 people, while employment will decline by about 300,000 people. If, in the interim, better health and other measures were to increase the employment rate of the 55-64 age group from 48% to 58% – the same as the Canadian rate –, Québec then could count on an additional 100,000 experienced workers and thus compensate for the one-third education in the workforce that will result from demographic aging.

5.2 Convincing examples

The examples of the fight against smoking, campaigns against obesity or more global battles against poverty or in favour of education convincingly illustrate the positive impacts of prevention on an entire society and the consequences this can have for health funding.

❑ The example of the *Tobacco Act:* an annual gain of one billion dollars

The Québec *Tobacco Act*[65], introduced in 1998 and amended in 2006, is a health promotion measure that offers a good illustration of these realities.

This Act imposed various restrictions on the consumption, sale, display, signage, promotion, advertising and packaging of tobacco products.

[65] R.S.Q., c. T-0.01.

— In 1997, UQAM researchers estimated that these restrictions could reduce the prevalence of smoking in the Québec adult population by half in the long term[66].

— On this basis, they calculated that direct annual savings of $630 million would ensue, resulting from the reduction of health care costs, and that the increased economic productivity would raise Québec's domestic income by $1.1 billion a year.

— The total annual gain for Québec would be $1.8 billion. If we add the direct savings of $630 million and about $400 million in taxes that would be paid to the Québec State on the basis of the increased domestic income, the beneficial impact of the *Tobacco Act* on Québec's public finances can be estimated at $1 billion a year, or the equivalent of 4% of the current health care budget.

❑ The plague of obesity

In 2004, 22% of the adult population were obese in Québec. If we add the 34% who were overweight, we arrive at a percentage of 56% of the population who had excess fat. The obesity rate was 24% in the rest of Canada and 31% in the United States.

Its high obesity rate would have ranked Québec tenth among the 30 OECD member countries[67]. The problems related to obesity are such that the World Health Organization considers obesity to be a worldwide epidemic[68].

❑ Poverty reduction, education, support for early childhood development

Prevention covers a series of actions that go far beyond the health sector. The international literature is unanimous on these questions.

— The evidence is well established that powerful socioeconomic factors are at work, even after accounting for difference in risk factors, such as smoking, obesity and alcohol consumption[69]. Regardless of whether it is measured in terms of income or education, socioeconomic status is very closely related to

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66 P. Ouellette et al., *Étude d'impact du projet de loi sur le tabac*, Report prepared for the Ministère de la Santé et des Services sociaux, Québec, 1997.

67 OECD, *Eco-health OECD 2007*, Paris, 2007.

68 World Health Organization, *Obesity: preventing and managing the global epidemic*, Geneva, 2003.

69 See J.D. Banks et al., "Disease and disadvantage in the United States and England", *Journal of the American Medical Association*, vol. 295, nº 17, May 2006, pp. 2037-2045.

health in every country[70]. The poorer the people, the sicker they are and the more they die young.

Thus, although several causal relationships have yet to be elucidated in this field, researchers are unanimous in affirming that the effort to improve public health does not solely depend on technological progress. It largely is based on the reduction of poverty and inequality.

— The Association des centres jeunesse du Québec drew the Task Force's attention to the data gathered by the Kirby Committee[71]. These data show the economic and social losses of not investing in specialized social services. Canadian economic losses are estimated at $33 billion a year, directly related to absenteeism due to the mental health and addiction disorders of Canadian workers.

— It is clearly shown that the more an individual is educated, the less he is unemployed and the better he is paid. How can this be accomplished? In the long term, school success and perseverance are effective weapons in poverty reduction – and therefore in fighting disease. The more people are educated, the less they are unemployed, the better they are paid and the less they are sick.

— The most recent syntheses of the economic literature imply that investment in early childhood development is the most profitable of all investments in human capital[72]. Needless to say, investment in elementary and secondary education is very profitable in social terms. Its expected benefits are three times greater on the average than its cost.

But investment in good-quality early childhood development programs is even more profitable. Its expected benefits are eight times greater than its cost – even before accounting for its impact on physical and mental health later in adult life[73]. In short, investment in early childhood development is three times more profitable than investment in elementary and secondary education.

— Finally, there is multiple evidence that the family, neighbourhood and community involvement are irreplaceable and that a person who benefits from

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[70] See M.G. Marmot and R.G. Wilkinson, *Social Determinants of Health.*, 2nd edition, Oxford University Press, London, 2005; and G. Paquet, *Partir du bas de l'échelle: des pistes pour atteindre l'égalité sociale en matière de santé*, Presses de l'Université de Montréal, Montréal, 2005.

[71] *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*, Interim Report of the Senate Standing Committee on Social Affairs, Science and Technology, November 2004, page 121.

[72] See F. Cunha et al., "Interpreting the evidence on life cycle skill formation", in E. Hanushek and F. Welch (eds.), *Handbook of the Economics of Education*, North Holland, Amsterdam, 2006, chap. 12; D. Blau, "Pre-school, day care, and after school care: Who's minding the kids?" , chap. 20; and M. Norrie McCain et al., chap. 6.

[73] Certain programs aimed at children from vulnerable families, such as the Perry Preschool program in the United States, achieve benefit-cost ratios over 15 to 1. See Cunha et al., *Op. cit.*

solid family and social support has much better chances of overcoming disease than a person without this support[74].

By extension, it is completely plausible to believe that when a community supports children's progress in school, this also benefits the community. Even in a system where the public sector plays a central role, the private sphere of individuals, families, neighbourhoods and communities retains great importance for the improvement of its members' health and its children's school success.

5.3 Investing in prevention, individually and collectively

By proposing that there be even more investment in prevention, the Task Force draws the logical conclusion from the different analyses available. It also takes up the recommendations forcefully put forward by several commissions and committees.

The Clair Commission, the Ménard Committee and the Perreault Committee[75] all called on the government to adopt a strong and dynamic prevention policy. A consensus thus exists on the question, and the Task Force joins it.

❑ Going farther

This proposal is addressed to the government. In the past few months, as already noted, the government has undertaken several major initiatives in the right direction.

— The government voted measures to ban junk food in school cafeterias.

— The government also obtained the adoption of Bill 1[76], for the promotion of a healthy lifestyle, creating a special Fund of $40 million a year over ten years to support prevention efforts, particularly with youth[77].

However, the proportion of deaths ultimately attributable to these avoidable risk factors is still very high.

The Task Force is persuaded that more conviction, resources and perseverance are required in the commitment to prevention. In the reserved language for which it is known, the OECD made the following explicit recommendation in a recent

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74 See L. Berkman, "The role of social relations in health promotion", *Psychosomatic Medicine*, Vol. 57, No 3, May-June 1995, pp. 245-254.

75 *L'amélioration des saines habitudes de vie chez les jeunes: recommandations*. Rapport submitted to the Minister of Health and Social Services by the Équipe de travail pour mobiliser les efforts en prévention, September 2005.

76 *Act to establish the Fund for the promotion of a healthy lifestyle.*

77 Half of this endowment is funded by the Lucie and André Chagnon Foundation.

document: "A greater focus on prevention might provide opportunities to further improve health while reducing pressure on health care systems[78]".

The urgency of this prescription is especially clear in the current context of rapidly growing health care costs and the impending acceleration of population aging.

❑ Investing and promoting

The Task Force makes the following proposal to the government.

Proposal

The Task Force encourages the government to pursue the efforts undertaken to prevent disease and promote health.

Fundamentally, this proposal meets the urgent need to revolutionize our social standards in prevention so that we work zealously to improve our fellow citizens' welfare. This improvement will not only come from the progress of pharmacochemistry and medical technology, but from the reduction of poverty and inequality at the grassroots. Investment in early childhood development and school success are preferred vectors of this struggle.

❑ Releasing funds for prevention

We now connect with the argument presented previously concerning the limits to be applied to the growth of public health spending[79].

— In a context of limited public financial resources, any increase in public health spending encroaches on the State's other missions.

— The most effective prevention actions are those that concern poverty reduction, education, community support, sports and creation support for early childhood development and the family. To this list we could add housing, environmental protection and public transit support policies.

The importance that must be given to prevention is one more argument in support of the objective of adjusting the growth of public health spending to the growth of collective wealth.

The more the health care system's productivity increases, the more it will be possible to reduce its costs, thus releasing amounts that will boost the level of investment in prevention. In turn, this will reduce the pressure on the health care system.

78 OECD, *Health at a Glance: OECD Indicators 2005*, Paris, 2005, p. 15.

79 See above, page 52.

❑ Individual responsibility and private sector participation

Prevention is not only a collective matter. It depends just as much, if not more, on each individual's behaviour.

We have seen that in the social contract it has outlined, the Task Force emphasizes the role and responsibility of each individual in health[80]. The adoption of a healthy lifestyle ranks first among these responsibilities.

Each person is responsible for his own behaviour. While the State should implement the measures and conditions for this responsibility to be exercise, it cannot take each citizen by the hand to compel him.

Similarly, prevention is the business community's responsibility.

— Companies already contribute to disease prevention, and particularly to prevention of occupational diseases, under mechanisms put in place by the government.

— However, they must go farther.

  — They can support families through rational work-family reconciliation policies.

  — They also have a role to play in protecting the environment and reducing the negative effects of their production on water and air. The food industry certainly has to ask itself questions about the quality of the products it puts on the market.

In fact, prevention concerns the private sector in the broad sense, which includes civil society – particularly foundations and various non-profit organizations, which can combine their efforts with those of the government to favour prevention.

We thus note that prevention is the business of all players in society. It represents the most effective long-term investment to reduce the growth of the costs we allocate to health.

[80] See above, page 11.

CHAPTER 6 – A FIRST-LINE HEALTH CLINIC FOR EVERYONE IN QUÉBEC

First-line care plays a central role in the operation of any health care system.

Analysis of the best health care systems around the world shows unequivocally that the success of these systems is based primarily on a strong and effective first line: the population is healthier, it is satisfied with the services received, and the entire care system costs less.

In the case of Québec, it is certain that the implementation of a system ensuring that the right health services are offered by the right person at the right time depends, first and foremost, on the improvement and development of the first line.

Accessible and effective first-line services will make it possible to reduce the costs of the health care system as a whole, relieve hospital congestion and offer care at a better price. The Task Force is convinced that the development of health clinics will relieve part of the current demand on hospitals and thus increase the productivity of hospital institutions in general.

— We must first recall, at least succinctly, what first line means, what services it encompasses and what practitioners provide these services.

— Steps have been taken in Québec to strengthen the first line. It is important to mention them.

— At the same time, it must be observed that the progress achieved is far from sufficient. Many industrialized countries do much better than we do in this matter. The Task Force has mainly attempted to identify the reasons that explain the delays observed in the organization of first-line care.

— After its analysis of first-line care, the Task Force makes a set of recommendations and proposals to the government with the aim of strengthening effectiveness and accessibility. These recommendations include reflections on the role of the private sector.

— They also include financial involvement of the users, in the form of an annual contribution to health clinics.

6.1 What is the first line?

For the purposes of the report, the Task Force proposes that first-line services be defined as the first level of universally accessible services offered to maintain and improve people's health.

In general, first-line services correspond to general services, intended to respond to usual and varied health or social problems, intended for the population as a whole – such as prevention services, medical services, nursing services, psychosocial services and the Info-Santé Health Line.

First-line services also include services offered to specific vulnerable clienteles – home support services -, available near people's living environment.

First-line services are assured in Québec by various resources. The CLSCs mostly provide social services. Nearly 80% of the first-line services are provided by private practices.

6.2 The path taken to strengthen the first line

As already mentioned, the Clair Commission played a major role in strengthening the first line in Québec[81]. One of the Commission's recommendations, formulated in the report released in 2000, sought the creation of family medicine groups. The deployment of family medicine groups began in 2001.

❑ Family medicine groups and network clinics

In the past few years, the government has accelerated the establishment of family medicine groups, for which it should be congratulated. This concept has been adapted to urban realities to take the form known as "network clinics".

— Seven years after the publication of the Clair Commission report, 135 family medicine groups and more than twenty network clinics are in place. They offer a wide range of services, thus favouring access to health care.

— In March 2007, a little over a million patients, mainly vulnerable persons, were registered with a family medicine group[82]. Everything indicates that these patients thus benefited from a substantial improvement in the accessibility and continuity of services.

81 See above, page 21.

82 Source: Survey conducted by the Direction de l'évaluation of the MSSS on the experience of the FMGs.

Family medicine groups, as described by the Clair Commission

In its report, the Clair Commission described its vision of the first line organization. This vision is more relevant than ever:

"As a citizen, in an improved health care and social services system, I would first choose my family doctor. It doesn't matter where he practises – in a clinic or a CLSC. He is a member of a team of 8 to 10 family doctors practising group medicine.

This team also includes nurses who are involved in health education and promotion activities and in managing problems. They perform tasks which complement those of the doctor and coordinate activities with the other professionals.

My family doctor who collaborates with the team nurse knows when and where to refer me for other medical and social services based on my needs. He is very familiar with the network of professionals, institutions and organizations and is in direct contact with specialists, with whom he can discuss my health condition should it become more complicated. He refers me to these specialists in their clinics or at the hospital if my condition requires diagnostic tests or further treatments. I have access to these tests and treatments within a reasonable period of time.

My family doctor remains in contact with the specialist and continues the follow-up when I return home.

To sum up, in this vision, I choose my family doctor and he chooses me. An agreement is reached together. This partnership agreement determines part of the remuneration paid to my family doctor and his team, an amount which is also defined on the basis of my personal characteristics and health needs"[1].

1 Commission d'étude sur les services de santé et les services sociaux. *Emerging Solutions – Report and Recommendations*, 2000, page 26.

6.3 Still insufficient efforts

The efforts made by the government to accelerate the deployment of family medicine groups are moving in the right direction.

However, they have not allowed Québec to catch up regarding individual access to a family doctor.

❑ Insufficient access to a family doctor

As already mentioned, the proportion of the Québec population with a regular family doctor is the lowest in Canada[83]. In 2005, it was found that 75% of the Québec population benefited from a family doctor, compared to 95% in Nova Scotia and 86% in Canada as a whole.

According to a study produced at the Task Force's request[84], accessibility for Quebecers to health services is one of the lowest levels in Canada for routine care and follow-up of non-urgent surgeries.

83 See above, page 26.

84 *Modes d'organisation des services prometteurs pour le Québec*, Paul A. Lamarche; Raynald Pineault, Yvon Brunelle, October 2007, page 3.

Québec also has the highest proportion in Canada of people who have not visited a doctor in the past year. Québec thus ranks among the provinces where the least detection of breast, cervical and prostate cancer is done.

The problems encountered in Québec regarding use of the first-line seem to concern all of North America. According to the same study conducted at the Task Force's initiative, Canada is contending for last place with the United States in this regard among the industrialized countries analyzed[85].

— Canada and the United States rank last in percentage of the population who have a regular family doctor, and in coordination of care.

— These are also the two countries where the transmission of information between medical specialists, hospitals and first line physicians is the most faulty.

— In Canada and the United States, clinic hours least allow patients to consult a physician outside the patients' normal working hours.

— Finally, Canada has the highest rate of emergency room use for at least the past fifteen years.

❑ A direct impact on the quality of care and the system's costs

The main consequence of insufficient public access to the first line is to reduce the quality of care and increase the system's costs.

All the studies emphasize the central role of first-line services in the effectiveness of the health care system as a whole.

— This explains the importance of the first line in the follow-up of chronic diseases, which are the leading source of costs in the health care sector.

— Canadian researchers have estimated that two thirds of all medical costs are associated with the treatment of chronic patients[86]. These same researchers estimate that 80% of primary care consultations are related to chronic diseases.

A great many foreign and Québec studies and initiatives confirm that follow-up of chronic diseases by a multidisciplinary team is one of the preferred means of improving patient satisfaction, increasing the effectiveness of the health care system and controlling costs better.

— England thus established a policy to improve takeover of chronic patients and reduce hospitalizations, by transferring the takeover from the hospital to the

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85 *Modes d'organisation des services prometteurs pour le Québec*, op. cit., page 5.

86 John Rapoport... [et al.]. "Refining the measurement of the economic burden of chronic diseases in Canada", *Chronic Diseases in Canada,* Vol. 25, Nº 1, 2004.

general practitioner, based on a strong associative approach. Remuneration based on health performance indicators concerning the patients serves as an incentive to upgrade practices.

— Canadian and American studies show that disease management models emphasizing first-line care have beneficial effects on health and on costs. Research performed by Thomas Bodenheimer of the University of California draws the same conclusions.

An exemplary experience: the CSSS des Sommets pilot project

In 2006, CSSS des Sommets, located in the Laurentian region, launched a pilot project with remarkable results.

- Inspired by Shortell's chronic disease management model[1], the CSSS project team integrated different components of the model into its primary care organization, such as the case manager, takeover by the physician, the shared patient record, etc.
- The team identified and followed the 200 CSSS patients with the highest visitation, who were responsible for 5.3% of the emergency visits, 11.5% of the hospitalizations and 9.4% of the CLSC interventions.
- The results obtained after nine months indicate a reduction of emergency visits and hospitalizations and greater reliance on the CLSC, as desired.

	Beginning of the project	After 9 months
Emergency visits	5.3%	1.6%
Hospitalizations	11.5%	3.0%
CLSC interventions	9.4%	11.0%

1 Shortell, S.M. et *al*. *Remaking health care in America*: *The evolution of organized delivery systems.* 2000.

❑ The least affluent citizens are the most affected

Insufficient access to the first line especially affects the least affluent citizens.

— The poorest people have the least access to care, especially in their first contact with the health care system. According to a very recent study by University of Waterloo researchers[87], the most affluent Canadians are 1.7 times more likely to have family doctor than the poorest Canadians.

— The same study and comparative research conducted by the OECD[88] indicate that economically disadvantaged people have more difficulty seeing a general practitioner than those with higher incomes.

87 Lori J. Curtis and William J. MacMinn. *Health-Care Utilization in Canada: 25 Years of Evidence*. Research Paper No. 190 of the Program for Research on Social and Economic Dimensions of an Aging Population (SEDAP), based at McMaster University, May 2007.

88 Eddy Van Doorslaer and Cristina Masseria. "Income-Related Inequality in the Use of Medical Care in 21 OECD Countries", Chapter 3 of *Towards High-Performing Health Systems: Policy Studies*, OECD, 2004.

— Once they have entered the health care system, they resort to general practitioners more often than the most affluent people. Poor people rely more on hospitalization because of their difficulty obtaining access to first-line care. They delay in consulting a physician, their health status worsens and they end up using heavier and more costly services.

❑ The reasons for delay

In Québec, several reasons explain insufficient public access to general practitioners, and thus to effective first-line care. The Task Force attempted to discern the main reasons.

■ Disaffection of physicians with family medicine

First of all, we note the decrease in the number of physicians in first-line practice. In just one year, from 2004 to 2005, the proportion of physicians in private practice declined from 77% to 71%.

The data available regarding training are very disturbing. They show a growing disinterest in medical schools in the practice of family medicine. According to young doctors, the requirements related to specific medical activities and the regional staffing plans seem to add to the constraints of family medical practice and explain this phenomenon.

— In 2007-2008, only 237 of the 300 family medicine resident positions were filled[89] –79% of the positions offered. On the other hand, the proportion of medical specialist positions filled was 94.5% for that same year.

— This change in the 2007-2008 data represents a break in the trend compared to previous years. This is observed despite the substantial increase in medical students authorized by the Gouvernement du Québec in the past few years.

■ Weakened private practices

The situation of private practices is worrying.

The proportion of general practitioners' income from private practice has decreased, since general practitioners have increased their activities in other settings.

Several factors explain this situation.

— The technical component of the physician's remuneration has become insufficient to cover the operating costs of private practice. This deficiency

[89] *Modes d'organisation des services prometteurs pour le Québec...*, op. cit., page 23.

largely explains the growing reliance on incidental expenses charged directly to the patient.

— Takeover of the patient is not recognized in an interdisciplinary context. In general, to be remunerated, the physician must be the person who provides the care. He cannot delegate his task to another professional.

— The first-line medical teams have difficulty accessing technical platforms, diagnostic services and specialties. This difficulty is a major source of delays and inefficiency in the delivery of first-line services. It results in high follow-up costs and has a negative impact on accessibility.

■ Funding oriented mainly to the hospitals

In our health care system, the lion's share of the funding is directed to hospital institutions.

The system is mainly organized around hospitals. Although first-line care should mainly be delivered in health clinics, the hospital centres in fact remain too heavily involved in this care – at a time when medical clinics are underdeveloped.

6.4 Accelerating the deployment of health clinics throughout Québec

The current situation of first-line care in Québec and the importance it represents for the effectiveness of the system as a whole and for satisfaction of the public's needs require vigourous action.

❑ A priority

Everyone agrees on the importance that must be given to the first line. The orientations adopted in the past few years by the Ministère de la Santé et des Services sociaux attest to this. The government has already started to deploy the family medicine groups and the network clinics. This deployment must be accelerated.

The necessary investments for this purpose are fully justified by the gains that will result in the medium and long term.

Recommendation

The Task Force recommends that the government accelerate the deployment of health clinics, in order to ensure that every Quebecer has access to a family doctor.

This deployment should be carried out over a five-year horizon.

The Task Force proposes that we talk about health clinics rather than medical practices to emphasize the fact that the services offered would have to be provided not by lone physicians but by multidisciplinary teams.

For the Task Force, the health clinic concept thus would be a generic term, encompassing a variety of organizations dedicated to first-line care – private practices, family medicine groups, network clinics, health cooperatives and CLSCs.

❑ A flexible and adapted formula

In the Task Force's vision, the deployment of the family medicine groups would be completed, but according to a flexible formula adapted to the different living environments.

— In some settings, it will be preferable to favour the cooperative formula, which is well known to the Québec population and which has already been successful in some locations.

— A lighter family medicine group formula could be obtained by associating several private practices, sharing office hours and nursing staff to ensure greater accessibility and better takeover of patients.

— It is possible that a CLSC could associate with private practices to form a health clinic, in order to establish an organization offering both better accessibility and better takeover of patients.

— According to the study conducted for the Task Force[90], another interesting avenue is emerging in Québec, based on strong involvement by certain municipal authorities in the field of health. This possibility may be more promising in rural communities than in urban settings.

For the organization of first-line care, the Task Force thus recognizes the contribution of private practices and polyclinics. It proposes an effective organization, based on more than one model, provided that the health clinics achieve the objectives laid down by the regional agency and have established an agreement with it.

❑ Special funding

These clinics would benefit from special funding, just as the family medicine groups and the network clinics currently do.

— The funding would allow the health clinic to provide the services of nurses, professionals and support staff.

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90 *Modes d'organisation des services prometteurs...*, op. cit., page 19.

— This funding would include computerization of the clinic, implementation of an electronic medical record and networking with the hospital centre, the radiology services, the laboratories and the other relevant health services.

❑ A contract with the regional agency

These clinics should offer services and pursue objectives defined by contract with the regional agency.

The contracts would clearly specify the services involved, based on health indicators and determining a limited number of parameters of the service offering – such as takeover of patients and guaranteed accessibility with extended service hours.

❑ Conditions of success

The success of the health clinics assumes that the government and all the stakeholders concerned respond to the above-mentioned problems with a certain number of initiatives.

It would thus be necessary to:

— enhance the practice of family medicine during training and adjust the physicians' remuneration level for this purpose;

— give physicians an incentive to practice in the most promising modes of organization of first-line services;

— allow and give financial support to the hatching of new organizational models originating from the community;

— facilitate liaison between the health clinics and the sector's other stakeholders, such as the CSSS and community organizations.

❑ Pondering the rigidities of the current legislative framework

First-line organizations are all the more effective when they have great flexibility in the organization of care. The *Act respecting health services and social services* is a long way from allowing such flexibility, according to the study commissioned by the Task Force[91].

The study finds that: "There are very specific and homogeneous forms of institutions offering health services and social services in Québec. They are stipulated in the *Act respecting health services and social services*. The internal structure of each institution is also specified down to the smallest detail. Their

[91] *Modes d'organisation des services prometteurs pour le Québec…*, op. cit., page 85.

responsibilities and modes of operation are also scrupulously specified in the Act. [...]

Management of the production of services guides the actions and decisions of the Ministère de la Santé et des Services sociaux and the regional agencies. Because of this design, everything in the Act governs the production of services. [...] Québec has possibility reached the limit of this concept of governance"[92].

This finding at least deserves reflection. The government should analyze the current legislative provisions based on the philosophy that seems to have presided in their drafting.

For the Task Force, it is essential that the government adopt more supple and flexible approaches, facilitating adaptation and stimulating innovation[93].

6.5 An annual contribution

The Task Force analyzed the possibilities of additional funding from which the health clinics could benefit, tying this reflection to the links that would have to be established between the clinics and their clients. Inspired by cooperatives, the Task Force suggests an annual contribution.

Recommendation

The Task Force recommends that the government give health clinics which have made an agreement with the regional agency the right to collect an annual contribution from the registered patients.

Such a contribution would help create a sense of affiliation for the registered individuals to their health clinic.

The patient would pay the contribution upon registering with the health clinic.

- A clinic could decide not to ask its registered patients for a contribution, or to request a lower contribution than the permitted ceiling.
- The contribution should not exceed $100 per year per adult.
- Children under 18 and the most disadvantaged clients should not have to pay a contribution.

The contribution could be an eligible expense for personal income tax purposes.

92 *Modes d'organisation des services prometteurs pour le Québec...*, op. cit., page 34.

93 See Chapter 12 below on the work organization, page 181.

❑ Many advantages

For the Task Force, an annual contribution would offer many advantages.

■ A sense of affiliation

The Task Force examined the health cooperative model. One of the advantages of these cooperatives is that they create a sense of affiliation and responsibility for their own health and the health of their fellow citizens among their member consumers.

— The cooperatives have special characteristics which are not limited to this idea alone. The cooperatives function according to democratic rules.

— Affiliation is strengthened by democracy but is formalized by payment by the members of a lifetime social share. In some health cooperatives, members are also asked to pay an annual contribution.

Private medical clinics have instituted a registration system and an annual contribution.

■ A mutual commitment between the individual and his physician

Payment of the contribution upon registration with the health clinic or renewal would have the effect of establishing a mutual commitment between the individual and his physician.

In return for payment, the physician would undertake, with the health clinic, to guarantee this patient:

— follow-up and takeover of the patient's health,

— service 24 hours a day, seven days a week,

— access by appointment within a short time,

— a drop-in clinic,

— varied services,

— a point of access to the other services of the health care system.

The mutual commitment would be reinforced by a concrete gesture, payment of the contribution.

■ The principle of freedom of choice

The annual contribution would be concretized at the same time as the principle of the citizen's freedom of choice.

By the gesture of paying an amount of money, the citizen would very concretely express his choice of one clinic over another.

— With the contribution, citizens would exercise their power as consumers in choosing a clinic.

— If they prefer, citizens could use this mechanism to favour the creation of a health cooperative or a community clinic, unless they opt for the public system by registering with a CLSC.

■ An incentive for productivity and quality

The ability given to citizens to direct funds to one clinic instead of another involves another significant advantage – that of encouraging care providers to be more productive and offer quality service.

Physicians would know that patients henceforth have the possibility of reducing their clinic's revenue by deciding to register elsewhere.

For an equivalent contribution, physicians could offer additional services to stand out from other clinics. They could prefer to set a contribution lower than the authorized ceiling.

■ A conviction

The Task Force is convinced that the emphasis to be put on first-line care is an absolute priority, if we actually want to ensure the sustainability of a health care system that meets the public's needs effectively.

CHAPTER 7 – INITIATIVES FOR ACCESS TO CARE

The Task Force has already noted that it considers a reflection on the organization of care to be inseparable from any analysis of the question of health funding[94]. A more effective organization of care will contribute to the solutions to this question.

For the Task Force, even though the government must give priority to first-line care, this will not be enough to improve the organization of care significantly. Several initiatives must also be introduced into our health care system which have already proven their value abroad.

Steps have been taken in this regard. However, it is necessary to go even further.

There are essentially two kinds of suggested initiatives.

— The Task Force has identified several targeted actions to ensure close collaboration between the first line and the other components of the system.

— The Task Force also wants to help overturn certain taboos by making the private sector an ally of the public sector. The private sector could contribute directly to ensure the sustainability of our system, on condition that it is considered to be a complementary resource.

These different initiatives require clear oversight. The Task Force considers it essential to evaluate their results regularly.

7.1 Ensuring close collaboration between the first-line and the other components of the system

In the previous chapter, a set of conditions were identified to guarantee the success of the health clinics.

To assume their responsibilities, the health clinics must have means of ensuring the continuity of care between their services and the other components of the system.

❑ An essential collaboration

The analysis performed at the Task Force's request confirms that the best performing first-line service organizations are those that are fully geared to collaboration with the community and the integration of their services with the other components of the care system[95].

94 See above, page 65.

95 *Modes d'organisation des services prometteurs pour le Québec…*, op. cit.

— Collaboration among the first-line service organizations in the same territory is required to provide services 24 hours a day, 7 days a week.

— This collaboration guarantees better follow-up of persons with complex health problems, such as chronic diseases, or better follow-up of population groups during mass vaccination or detection campaigns.

— Collaboration must be established with the organizations offering specialty services, in order to facilitate access to these services by the patients who need them.

— Better coordination must be ensured for the services offered by different health professionals or organizations during the same care episode for a given patient. We are referring here to the collaboration which should exist between general practitioners and medical specialists.

  The agreements made recently between the government and the medical federations approach this question through incentives, the effectiveness of which will have to be evaluated.

— Close collaboration must also be established with community organizations to support people faced with complex health problems and close caregivers.

This collaboration is thus an essential condition for obtaining the expected effects from the development of first-line services.

The agreement between the Fédération des médecins spécialistes du Québec and the government: measures to improve access to specialty medical services

The agreement made in 2007 between the Gouvernement du Québec and the Fédération des médecins spécialistes du Québec includes various incentives with the aim of improving access to specialty medical services.

A few examples can be given here:

- Certain measures have the purpose of optimizing use of the operating room and technical platforms, in order to reduce the waiting lists for certain surgical services. The agreement thus provides for an increase in the resources necessary for surgery, and an increase in operating room availability in certain designated institutions.
- Other measures have the purpose of reducing the wait times between referral by the family doctor and consultation of the medical specialist. For example, the agreement provides for the creation of points of access and modulation of the remuneration of certain medical specialists based on the time elapsed since the referral by the general practitioner.

❑ Establishing mechanisms, offering new tools, acting on training

This collaboration corresponds to the basic mandate entrusted to the health and social services centres (CSSS) established in 2004[96].

[96] See above, page 21.

— With their partners, they have a responsibility to the population they serve. They must assure care and services within the framework of clinical and organizational projects. One of their missions is to ensure coordination between the constituent unit and the hospital centres, clinics, community organizations and other institutions located in their territory.

— In fact, the CSSS are care providers. Their mission completely corresponds to the concern for ensuring close collaboration between the first line and the other components of the system. To accomplish this mission effectively, they must be able to benefit from broad autonomy and be fully responsible for their management.

However, it is necessary to go further.

To strengthen the collaboration between the first line and the other components of the system, the institutions must be able to count on new tools and support.

— Thus, liaison officers should be put in place with the responsibility of ensuring relations with other health practitioners, community organizations and sectors other than the health-care sector. In some institutions, this function exists under the name of "liaison nurse", and it produces good results.

— More use should also be made of new information technologies to transmit clinical information between the different practitioners, provided that their content is inspired by common clinical thinking and is the object of consensus. We will return later to the use of new information technologies and the establishment of the electronic patient record[97].

— With the specific aim of strengthening collaboration between general practitioners and medical specialists, it would be appropriate to review the training framework for physicians. This would avoid the establishment of a cleavage between family doctors and medical specialists starting in the years of study and residence, and restore value to family medicine.

— As we have just mentioned, the most recent remuneration agreements made between the government and the medical federations includes incentives intended to favour the reduction of wait times to obtain an appointment with a specialist after visiting a generalist. These agreements also provide for measures – such as lump-sum payments – with the aim of accounting for the responsibilities entrusted to family physicians in follow-up and takeover of patients.

  The Task Force considers that, in the medium term, the remuneration of family physicians should evolve towards a mixed plan, including funding related to the number of patients registered with the physician whose follow-up and takeover he accepts to ensure – this is called "capitation funding"[98].

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97 See below, page 203.

98 *Modes d'organisation des services prometteurs pour le Québec*..., op. cit., page 27.

❑ Strengthening collaboration through funding

There is another way of strengthening collaboration between the first line and the other components of the system, this time by acting on their funding. The Task Force suggests that the funding of health-care organizations become interdependent. Such interdependence would give each organization an incentive to define its actions by accounting for the obligations of the others.

— A portion of the funding granted to the health clinics and family doctors, which would take the form of capitation, could include all or part of the cost of consultations requested from medical specialists.

— In consideration, the first-line service organizations could receive an amount equivalent to the savings realized by a shorter hospital stay resulting from their rapid takeover.

7.2 Making the private sector an ally of the public sector

The second series of initiatives proposed by the Task Force concerns the private sector, its role and the responsibilities that could be entrusted to it.

It has already been mentioned that this vision of the role of the private sector is diametrically opposite to a privatization process[99]. For the Task Force, the goal is to recognize the private sector as an ally of the public sector, through a structured definition of the resulting complementarity.

The private sector is the principal stakeholder for first-line services[100]. The opposition currently presented in Québec between public sector and private sector is unproductive, when attempts are being made to find the best ways of improving the performance of the existing health care system.

This is why the Task Force has analyzed and chosen four innovations it considers relevant and promising. The Task Force thus proposes:

— more transparent relations with the associated medical clinics;

— a limited decompartmentalization of medical practice;

— expansion of the possibility for citizens to contract private insurance;

— increased use of hospital equipment, opening up the possibility for the public hospitals to benefit from private revenue sources.

[99] See above, page 13.

[100] See above, page 75.

7.2.1 More transparent relations with the associated medical clinics

Bill 33[101], adopted at the government's request in December 2006, governs the specialty services offered in private clinics. Its purpose was to define stricter regulations than those that previously existed in order to ensure the quality and safety of care.

Bill 33 also introduced the concept of associated medical clinic. Such a clinic constitutes an extension of the hospital to the premises of a private clinic, a laboratory or a specialized medical clinic.

❑ A law that must be more flexible

With the establishment of associated medical clinics, the government thus has created a situation in which care usually provided in the hospital can be provided by a private organization. However, this care is subject to the same controls as in an institution, and funding of the services remains completely public.

The Task Force considers that the associated medical clinics represent an interesting initiative for the purposes of increasing access to services. The services rendered visibly respond to a demand.

However, the Task Force finds that Bill 33 is complex and that its wording can lead to confusion. It deplores the very heavy regulation surrounding the creation of associated medical clinics and fears that the development of such clinics will be slower than desired.

❑ A call for tenders procedure

A transparent call for tenders' procedure based on a clearly defined need for services should guide the selection of the care provider. This choice thus would essentially be motivated by the possibility of improving public access to the service concerned or, at equal quality, provide the service at a lower cost.

The Task Force proposes that the government institute a transparent procedure for awarding contracts binding the institutions or the regional agencies to the associated medical clinics authorized to provide specialty services.

[101] See above, page 22.

7.2.2 A limited decompartmentalization of medical practice[102]

According to the *Health Insurance Act*, physicians must choose between participation in the public plan or withdrawal. They cannot have a mixed practice, that is, participating in the public plan while treating certain patients outside of this plan.

— The health care systems of most of the industrialized countries allow various degrees of mixed practice. They see the mix of public and private practice as a choice offered to people whose demand for care cannot be covered satisfactorily by the public system.

— In the case of Québec, the compartmentalization of medical practice prohibits such a choice because it limits the number of physicians on whom a patient can call. Individuals subject to excessively long waits and the absence of accessible care in the public system do not have the means or options allowing them to obtain the care their condition requires. In practice, the law forbids them to use their money to obtain medical or hospital care.

❑ The negative effects of the current situation

Eloquent examples of the negative effects resulting from the current situation were brought to the Task Force's attention. The persons in question belong to every income class. These examples illustrate situations in which individuals do not have the possibility of calling on a physician at their own expense, because compartmentalization has severely limited the number of physicians practising outside the public plan.

— Thus, cases have been reported of children who have to wait months for minor surgery.

— Over time, the care not provided is transformed into conditions necessitating much costlier interventions in terms of health impairment, absences from school and work for parents and higher expenditures for hospitals.

Many medical specialists vigorously deplore that they cannot treat their patients on a regular basis, due to unavailability of operating rooms or clinical equipment. This situation is all the more unacceptable in that operating rooms and clinical equipment are far from being used optimally.

— Greater use of this costly equipment, which often has a limited life cycle, would allow faster depreciation of its costs.

[102] This section is the object of a dissenting position by Mr. Michel Venne. see Appendix 3, page 277.

— It would provide an additional source of income to physicians, nurses and other staff – and to the institutions themselves – without encumbering public finances.

❑ The arguments in favour of the status quo

Those who oppose any change do so based on the principle of equal access to care for all.

According to them, the strict enforcement of the law is more important than the negative consequences resulting from the current situation. They ignore the Supreme Court judgment in the Chaoulli case, according to which the delays endanger the life, integrity and safety of patients.

❑ A framework is possible: the proposed rules

A framework for decompartmentalization is possible, and the Task Force proposes three rules, inspired by what is done in developed countries authorizing mixed practice.

— In the first place, opening the system to acceptance of patients on a private basis should not have the effect of draining part of the public sector's staff levels to the private sector in a given territory. There is a general consensus on this point. In a given region or territory, there should be enough physicians to ensure public delivery of care.

— Secondly, opening the system to mixed practice should be governed by an agreement between each physician and his institution to ensure, in particular, that the necessary staff levels are maintained in the institution. For the Task Force, it is preferable to leave it to the administration of the institutions to make the most appropriate decisions in the patients' interest, together with the professional staff.

— Thirdly, to ensure that the physician fulfills his obligation to the public, his income from private sources should be limited to a percentage of the income received under the public plan. This limit could also be calculated in terms of hours devoted to the private service and the public plan.

Recommendation

The Task Force thus recommends that mixed practice by physicians be authorized within prescribed limits and on condition of an agreement with their institution.

7.2.3 Opening the system to private insurance[103]

In the personal insurance sector, insurance is a way to protect oneself against the risks of illness, accident, disability and loss of autonomy.

— The insurance or coverage can take the form of a payment or a reimbursement for care or services received by the insured.

— It may also consist of a lump sum or periodic payments to an insured who is disabled, suffering loss of autonomy or in rehabilitation following an accident. In these cases, it is generally up to the insured to decide how to use the benefits received.

Private insurance essentially is a budgeting tool that allows the insured, generally middle class, to avoid disbursing large amounts without advance warning if they are affected by an event not covered by the public system.

❑ Foreign experiences

Private insurance plays a role in protecting the health of individuals in all OECD countries, except for two of them: Norway and Japan.

— It can take various forms, ranging from primary coverage to parallel or duplicate coverage, and including complementary or supplemental coverage.

— There is no single model. The role of private insurance is adapted to each situation and depends on historical factors and government objectives.

— According to the OECD, private health insurance can help achieve the performance objectives of a health care system, but its impact is limited.

In 2004, the private insurance share of total health costs represented over 5% in ten countries and over 10% in only four countries.

❑ The current system

Our public health care system covers medical and hospital care and medications for persons not covered by group insurance.

It also covers long-term care, subject to eligibility conditions.

Thus, a wide range of services still remains uncovered, such as dental, optometry and paramedical services, ambulance expenses and all other care and services provided by professionals other than physicians.

[103] This section is the object of a dissenting position by Mr. Michel Venne, see Appendix 3, page 277.

In Canada and in Québec, about two thirds of the population is covered and approximately 12% of total health spending comes from private insurance, whether individual or contracted on a group basis.

❑ Freedom of choice

As in the case of decompartmentalization, the question of private insurance raises the whole question of freedom of choice.

Freedom of choice is compatible with a public plan accessible to all. An individual's freedom of choice will not have the effect of limiting the rights and freedoms of other citizens, if it is well governed. On the contrary, it will have the indirect consequence of increasing the overall supply of care, and thus its accessibility.

This is not only a matter of choice for higher-income individuals. The following very real case clearly illustrates the importance of this freedom of choice for everyone. It concerns a truck driver who, instead of having to wait weeks for an operation, decided to pay out of his pocket to return to work faster. On the basis of what principle can he be refused the right to obtain insurance against such a risk, when the public system is unable to meet his needs satisfactorily?

The freedom to obtain insurance against these risks exists in several other Canadian provinces, and nowhere has this had significant negative effects on the public health care system.

❑ Bill 33

Until recently, the *Health Insurance Act* prevented individuals from taking out private insurance for care covered by the public system.

Since the adoption of Bill 33, the situation has changed somewhat.

— When this component of the law takes effect, a person will be able to make an insurance contract covering the cost of insured services to perform knee, hip and cataract operations or other treatments which might be determined by regulation in the future.

— However, the services will have to be provided only in a specialized medical centre where physicians who do not participate in the public health insurance plan practice exclusively.

❑ Removing the existing restrictions

The Task Force believes that within the framework of the very limited decompartmentalization that is recommended, the restrictions defined in Bill 33 would no longer have a reason to exist.

A person should have the right to obtain insurance for all the services that could be offered by physicians authorized to treat patients on a private basis.

To the extent that Bill 33 provides for the possibility that its application will be broadened to include other surgeries – and ultimately any surgery -, it must be asked why the government would not proceed with this expansion immediately.

Proposal

The Task Force proposes that the Act authorize recourse to private insurance for services already covered by the public plan.

With such a change, people would have a real choice of faster access to care when they consider it necessary.

7.2.4 Using hospital equipment more

The authors of the study on the organization of care requested by the Task Force drew its attention to a potentially interesting initiative, aimed at increased use of hospital equipment, opening up the possibility for the public hospitals to benefit from private revenue sources[104].

This would allow the health and social services centres (CSSS) and the hospitals to act as true non-profit organizations and thus be authorized to diversify their funding sources.

American community hospitals and certain British hospitals (Hospital Trusts) have the possibility of being funded simultaneously by public funds (Medicare and Medicaid) and private funds (private insurance). The same principle could apply to Québec hospitals.

Of course, in the same way that it is important to set guidelines for physicians in private practice, it is just as important that the institutions first commit to comply with the public production objectives stated in the contract made with the regional agency. Only once this condition is fulfilled could the institutions offer private services on their premises.

Subject to these conditions, the hospitals could improve their financial profitability. Their status as non-profit organizations would oblige them to use this increased profitability for the benefit of the patients and communities they serve.

Bill 33 already provides for measures allowing institutions to lease technical platforms and benefit from the revenue this generates. The Task Force wants the possibilities opened in this manner to be confirmed and take the form of concrete initiatives.

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[104] *Modes d'organisation des services prometteurs pour le Québec...*, op. cit., page 18.

7.3 Clearly governed initiatives

The innovations which have just been proposed ultimately are all intended to strengthen our health care system and ensure its sustainability. However, they risk raising suspicion and reticence, especially when they involve an increase in the collaboration and contribution of the private sector.

For the Task Force, it is therefore important that these different innovations be clearly governed and guided, remembering the system's foundations, which will continue to be respected, and providing for close evaluation of the results obtained.

Several individuals and organizations have expressed fears regarding some of the initiatives proposed by the Task Force – such as the decompartmentalization of medical practice, reliance on duplicate private insurance or an increased role for the private sector. The implementation of Bill 33, despite the many restrictions that accompany it, also raises some concerns.

In view of these apprehensions, the Task Force considers that the proposed changes and experiments – as well as implementation of Bill 33 – should be evaluated after a reasonable time.

At a not too distant horizon, it will be important to verify:

- whether the care provided is delivered at a competitive cost in relation to the cost of care provided in institutions;
- whether the quality and safety criteria are observed;
- whether these changes have an effect on the availability of competent human resources for public institutions.

Proposal

The Task Force proposes that the initiatives regarding the role of the private sector and those resulting from the actions already taken by the government be evaluated over a five-year horizon.

This is a question of good governance, at the same time as a democratic approach, allowing the change to be accompanied transparently.

CHAPTER 8 – AN ADAPTED RESPONSE TO AGING AND LOSS OF AUTONOMY

In 2008, Québec has slightly over one million persons age 65 and over. This number will not stop growing, and will exceed two million within twenty years.

Population aging already has an effect on health funding, and this effect will increase. Average per capita expenditures are ever higher as people grow older. Considering the impact of population aging on health care costs, some predict that we are heading for an inevitable crisis, jeopardizing the existence of our social programs. On the other hand, others believe that we will be able to deal with population aging without too many problems.

— It is important to provide some nuances concerning the impacts of aging on the individual and on health care costs. These nuances will be specified at the beginning of the chapter.

— For the Task Force, it is essential to discuss the question of aging with a long-term vision, recognizing that the impacts of an aging society go far beyond funding of health services.

— The Task Force focused on the nature and implications of a public insurance plan covering loss of autonomy. It concludes that Québec should not embark on this path.

— The Task Force then concentrated on what awaits us in the years ahead. Based on the experience of the developed countries, an analysis of what is happening in Québec and the formulation of a certain number of findings, the Task Force presents the orientations of what a strategy for the coming decade would involve.

8.1 Some preconceptions about the effects of aging

Before confronting the question of aging and loss of autonomy head on, it is necessary to rectify some preconceptions concerning the impact of this aging on the individual and health care costs.

❑ Old age is not synonymous with dependence

As the Ministère de la Santé et des Services sociaux points out in its 2005-2010 Action Plan Regarding Services Offered to Seniors Who Have Lost Autonomy, "old age is no longer synonymous with illness, poverty and dependence. This former perception should no longer prevail. The vast majority of seniors today are autonomous, healthy, socially active and economically independent"[105].

In fact, in Québec, only 20% of seniors need services due to an incapacity. In most cases, these are very aged people. Only 3.5% of seniors are housed in a residential and long-term care centre (CHSLD) – about 40,000 people.

Old age thus is not synonymous with dependence, but the growth in the number of seniors will lead to an increase in the number of dependents in absolute terms.

■ Aging is not the principal factor in the increasing costs of health care

A second preconception must also be rectified. Despite what is often heard, aging is not the principal cause of rising costs in the health care sector.

It is certain that general population aging has an effect on health care costs, even when people are autonomous. The consumption of health services grows with age. This is particularly the case for people suffering from a chronic illness.

However, according to the outlook for structural growth of health spending established by the Ministère des Finances, the aging factor only accounts for 1.3% in the foreseeable 6% annual growth of public health spending over the next ten years. This percentage would increase subsequently to 1.6% five years later. Thus, it is only in ten years that the effect of the aging factor will gradually become more pronounced.

In the meantime, this means that the effect of aging on health care costs is likely to remain relatively stable during the next decade. In application of a precautionary principle, however, a long-term vision must be adopted as soon as possible concerning aging and its effects.

[105] Ministère de la Santé et des Services sociaux, *Un défi de solidarité – Les services aux aînés en perte d'autonomie*, 2005, page 11.

8.2 The importance of long-term vision

It is now necessary to return to the main demographic data related to aging, before discussing the uncertainties with which we have to deal.

❑ The demographic issue

The shifting of the postwar generation, the baby boomers, through the age pyramid – and particularly its arrival at retirement age – will trigger accelerated aging of the Québec population for a period of fifteen to twenty years.

Since this is a gradual phenomenon that will be spread over a long period, it is important to establish when and at what rhythm aging will occur. To put the question in perspective, it must be remembered that a person born in 1950, at the height of the baby boom, will only reach age 65 in 2015 and age 75 in 2025.

The demographic projections show that the effect of aging consequently will only be felt gradually, over a horizon of about thirty years.

— Over the next ten years, from 2008 to 2018, the population age 65 and over will increase from 14.7% to 19.5% of the total population. This represents an increase in the number of seniors of about 30,000 people a year.

— Within this group, the proportion of seniors turning 75 will increase much more slowly. Over the next ten years, their share will grow from 6.8% to 8.2% of the total population.

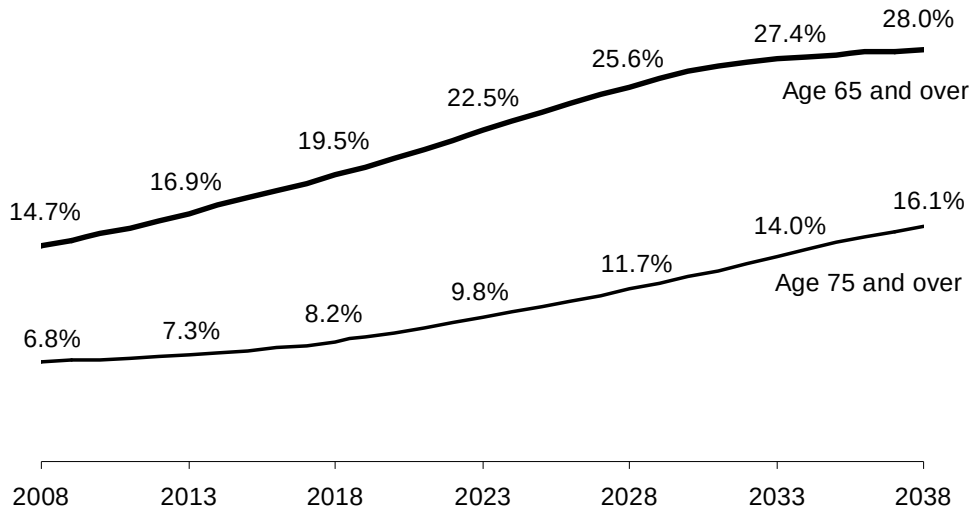
The trends in the number of seniors over the next decade gives reason to believe that it will be possible to deal with the situation. The strategy proposed by the Task Force covers the period.

However, we must have a longer-term vision and start thinking now, as a society, about impacts that become accentuated later.

GRAPH 8

Proportion of persons age 65 and over and age 75 and over in Québec, 2008 to 2038

(percentage)

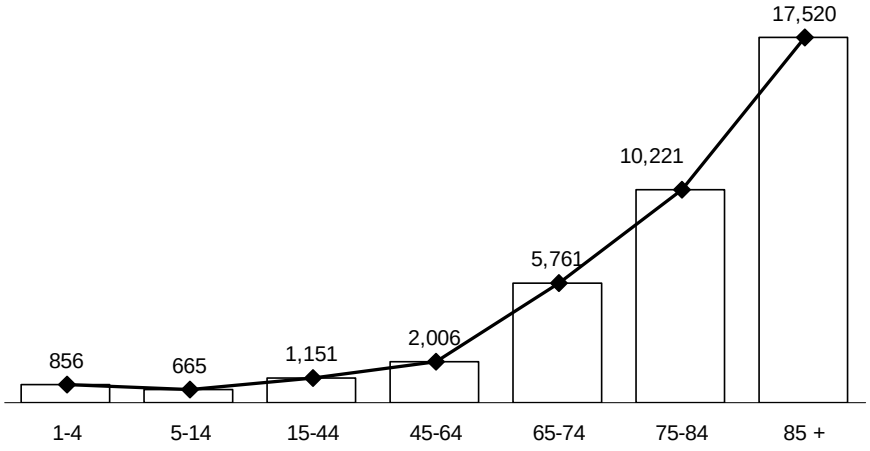


Source: Institut de la statistique du Québec, *Perspectives démographiques, Québec et régions, 2001-2051,* 2003 edition, demographic reference scenario.

GRAPH 9

Government of Québec health spending by age, 2004

(in dollars per capita)



Source: Canadian Institute for Health Information.

❑ A lot of uncertainties

Forecasts of this kind are relatively reliable when they cover a limited period of years.

However, beyond 2018, they become increasingly hypothetical. It is essential to account for the fact that the world in which we live is evolving rapidly, and that many factors, as in the past, can produce highly unpredictable changes.

The history of the past few decades is full of events with major repercussions that nobody could have forecast, even over short horizons. Just in demographic terms, the experts predicted in 1998 that Québec's population would decline in 2008. It was also announced that the pension funds would be dried up, that the unemployment rate would be high and that federal transfers would no longer exist.

It is hazardous to try to forecast how several factors will evolve that will have major medium and long-term repercussions on the social and economic context and more specifically on health funding.

— What will be the job market participation rate of people ages 55 to 65 in the years ahead?

— To what extent will the health status of people ages 65 and over improve, and what will be the impact on the future trend of health spending?

— What income level will baby boomers level obtain at retirement, compared to the current situation?

There would be multiple questions of this kind.

8.2.1 Implications beyond health care

In fact, the implications of aging go far beyond the funding of health services. This is a complex problem with a wide variety of solutions. They must be discussed within the context of a broader study, which singularly exceeds the Task Force's mandate.

— Everyone agrees that one of the keys to the future is to create more wealth, so that society can afford to offer its seniors the services they have a right to expect.

— The idea of extending participation in the job market to people later in their sixties is progressing.

— The idea of reducing debt service more aggressively by reducing the excessive amount of debt is also making progress. The government has created a Generations Fund for this purpose.

— The entire issue of retirement is in question. People currently on the job market undoubtedly should be given incentives to prepare for their retirement, whether by savings or insurance.

— The objective of maintaining seniors at home or in housing modes similar to a home environment calls into question not only residential care programs but housing policies.

In fact, the question of population aging has multiple ramifications. It cannot be studied in isolation or sectorially. Since this phenomenon is more pronounced in Québec than elsewhere, its repercussions for public finances and, indirectly, for the long-term survival of social programs, should be discussed promptly. Given its evolving nature, the question should be re-evaluated periodically.

The more delay there is in establishing priorities and taking the necessary measures, the more difficult and risky the choices will be.

Recommendation

The Task Force recommends that a collective process of reflection be initiated on the medium and long-term repercussions of population aging.

8.3 Comments concerning an insurance plan covering loss of autonomy

The Task Force focused on the nature and implications of a public insurance plan covering loss of autonomy and concludes that Québec should not embark on this path.

— The establishment of a separate insurance plan covering loss of autonomy was a major recommendation of the Clair Commission[106] and the Ménard Committee[107].

— In spring 2006, the consultation document *Guaranteeing access* tabled by the Minister of Health and Social Services proposed that the creation of an insurance plan covering loss of autonomy be one of the avenues to explore to ensure the sustainability of the system's funding[108].

[106] Commission d'étude sur les services de santé et les services sociaux. *Emerging solutions – Report and recommendations*, 2000, page 190.

[107] Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, *Pour sortir de l'impasse: la solidarité entre nos générations – Rapport et recommandations*, July 2005, pages 87 and 104.

[108] Ministère de la Santé et des Services sociaux, *Guaranteeing access: Meeting the challenges of equity, efficiency and quality – Consultation document*, February 2006, page 60.

— Some stakeholders met by the Task Force also proposed the creation of such a plan.

❑ The foreign experience is inconclusive

A review of the prolonged care situation shows that a variety of approaches have been adopted in the OECD countries.

Only five of the thirty member countries – Austria, Germany, Netherlands, Japan and Luxembourg – have established insurance systems against loss of autonomy funded by specific contributions. These plans were all established a number of years ago[109].

The OECD draws the following conclusions from its analysis:

— The countries that introduced contributory social insurance plans have resolved immediate problems.

— On the other hand they find they are faced with significant new commitments to maintain these plans in the future regardless of the economic context.

— It is far from certain that their long-term financial viability is assured.

— Moreover, in each country, reforms are currently being considered.

The other OECD countries preferred to achieve a better balance among equity, quality of care and viability of the system within the existing fiscal envelope. These countries had to make difficult choices on reduction of services and introduce or modify income or asset tests.

❑ Rejection on principle and for financial reasons

Primarily on principle, the Task Force rejects the idea of insurance covering loss of autonomy.

— Currently, all Quebecers are covered by our health insurance plan. This plan is funded to a very large extent by the State's general revenues. It is based on the principle of solidarity among all Quebecers.

— The creation of a distinct plan intended to cover part of the population separately and further would be completely contrary to this fundamental principle of solidarity.

— If this path were chosen, people who retire in the future would benefit from greater coverage than the rest of the population.

[109] Netherlands (1968), Austria (1993), Germany (1995-96), Japan (2000) and Luxembourg (1999).

Moreover, no detailed study exists allowing a conclusion that the proposed plan would be financially viable. None of the stakeholders' proposals to the Task Force is based on an analysis of the financial issues.

Moreover, the participants in the Health Summit held by the Collège des médecins in November 2007 took a position against the creation of a separate insurance plan covering loss of autonomy. Before another plan is created, they affirmed that they initially prefer that the existing plans be reviewed in depth, adapted to the needs not covered and monitored regularly over time.

The Task Force believes that all these grounds are sufficient to reject the creation of an insurance plan covering loss of autonomy.

8.4 Needs related to loss of autonomy: the situation in Québec

In Québec, care related to loss of autonomy includes nursing and professional care, assistance for activities of daily living and home assistance services. Such care and services can be offered at the person's home as well as in residential care centres.

The nature of this care can be defined more precisely:

- Nursing and professional care includes nursing services, rehabilitation and adaptation services (physiotherapy, occupational therapy) and psychosocial services.
- Assistance for activities of daily living includes personal hygiene, dietary assistance and travel assistance.
- Home assistance services encompass meal preparation, housekeeping and laundry.
- "Adapted safe residential care" covers room and board for long-term care.

  As of March 31, 2006, nearly 90% of seniors resided in a conventional domicile and only a little over 3% in a residential and long-term care centre (CHSLD).

TABLE 3

Distribution of seniors by place of residence as of March 31, 2006
(by number and percentage)

Place of residence	Number of persons	Percentage	
Conventional domicile	954,610	88.4%	
Private residences	81,167	7.5%	
Intermediate resources (IR) and Family-type resources (FTR)	6,509	0.6%	
Private CHSLDs not under agreement	2,538	0.23%	4.1%
Public CHSLDs and private CHSLDs under agreement	**35,461**	**3.3%**	

Source: Ministère de la Santé et des Services sociaux.

❑ Costs

In 2005-2006, the costs of the different services offered to persons suffering from loss of autonomy totalled $2.7 billion. Almost all of these (97%) were persons age 65 and over.

TABLE 4

Costs of MSSS programs covering autonomy, 2005-2006
(in millions of dollars)

	Millions of $
Residential care services	
Residential care services (public CHSLDs, private CHSLDs under agreement and not under agreement)	1,474
Administration and support expenses of residential care services	590
Intermediate and family-type resources	116
Other (day centres, nursing and geriatric daycare)	177
Subtotal – Residential care services	**2,357**
Home maintenance	
Home services (Nursing, professional and assistance)	299
PEFSAD (Financial Exemption Program for Home Assistance Services)[1]	21
Subtotal – Home maintenance	**320**
Other services (transport, coordination)	**24**
TOTAL	**2,701**

1 Excluding business consolidation grants.
Source: Ministère de la Santé et des Services sociaux.

❑ Home maintenance

Of this total of $2.7 billion, the expenditures for home services incurred regarding seniors suffering from loss of autonomy are estimated in 2005-2006 at $320 million.

— Services amounting to $267 million are provided by the institutions' internal resources, both for medical services (nurses and specialized professionals) and for social or home assistance services (CLSC family and social auxiliaries).

— Community organizations complete the service offering ($32.4 million, including $7 million for direct allowance), and the social economy sector through the Financial Exemption Program for Home Assistance Services (PEFSAD - Programme d'exonération financière pour les services d'aide domestique) ($21 million). This program seeks to support persons suffering form loss of autonomy who call on social economy enterprises for domestic services.

The number of seniors receiving services in the community was 160,000 in 2003-2004. Less than half of these people, or 70,000, benefited from a home care tax credit in 2003. It is forecast that in 2009-2010, at least 185,000 seniors will need home care.

These services are essential. They meet obvious needs and are appreciated by the individuals concerned and their families.

Financial Exemption Program for Home Assistance Services (PEFSAD)

The Financial Exemption Program for Home Assistance Services (PEFSAD) offers financial assistance to persons who entrust a recognized social economy enterprise with providing the home assistance services they need (housekeeping, clothing maintenance, meal preparation, etc.). These services are intended for any person who requests it regardless of financial position. These may also be people referred by the CLSC. The subsidy is paid directly to the enterprise and reduces the rate charged to the client.

The subsidy takes two forms:

- Fixed basic financial assistance, accessible to anyone (age 15 and over) regardless of family income, corresponding to a subsidy of $4 for each hour of services rendered.
- Supplemental variable financial assistance of $0.40 to $6 for each hour of service, which accounts for the person's family income and family situation. Only persons age 65 and over and persons with support needs referred by a CSSS are eligible.

The financial assistance cannot exceed $10 per hour of services rendered and the person pays the difference between the rate charged by the enterprise ($17 in 2003-2004) and the assistance granted.

Direct assistance to the enterprises involved is also provided and is added to the costs of the program.

❑ Tax credits

The refundable tax credit for home-support services for seniors provides financial support to seniors who choose to remain in their living environment as long as possible.

— Since the 2000 taxation year, the tax system grants individuals age 70 and over a refundable tax credit.

— In 2007, this credit was increased from 23% to 25% of the eligible expenditures to obtain recognized home support services. The amount of eligible expenditures is subject to an annual ceiling of $15,000, which allows an individual to receive a maximum tax credit of $3,750.

— In 2004, seniors benefited from this tax credit for a total amount of $78 million. The projection by the Ministère des Finances for 2007 is $191 million.

— The rapid increase in the cost of this tax credit must be noted.

The refundable tax credit for natural caregivers of adults has the purpose of recognizing the role played by the extended family in the takeover of a person with a severe and prolonged impairment or aging persons.

— The credit consists of a universal basic amount of $561 per person housed, to which is added a supplement of $459, which can be reduced according to the person's income.

— This tax credit has a maximum value of $1,020 per year.

— The cost of this tax credit is estimated at $38 million for 2007.

The refundable tax credit for natural caregivers of adults has the purpose of recognizing the contribution that certain individuals may provide to the natural caregivers of persons with a significant disability, by providing them with volunteer home respite services.

— Since the 2007 taxation year, an individual who provides volunteer respite services to a natural caregiver for a total of no less than 400 hours may benefit from a refundable tax credit.

— The maximum amount per caregiver is $1,000 ($500 per volunteer), which represents $10 million in tax relief in 2008.

❑ Residential care services

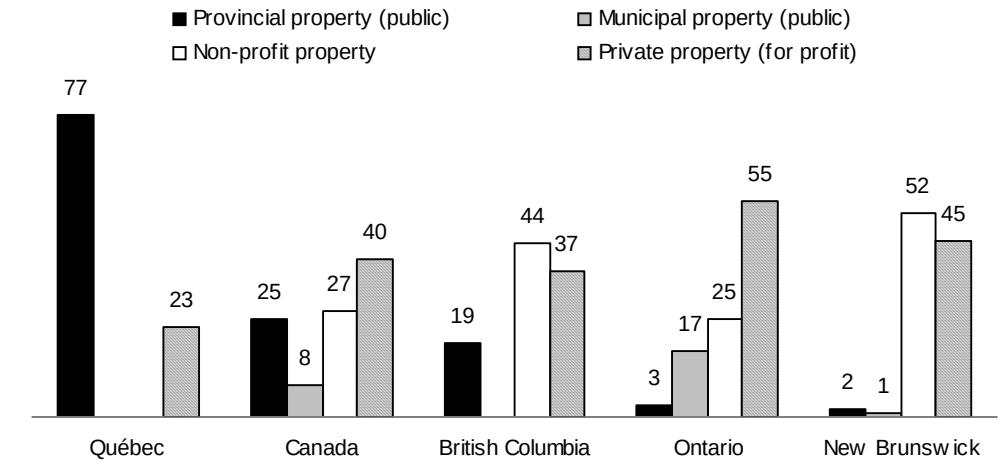
Residential care services represent most (87%) of the costs incurred by the government regarding persons suffering from loss of autonomy – $2.3 billion out of $2.7 billion in 2005-2006).

However, contributions are required of the users, which in principle are supposed to cover the actual costs incurred by the institutions for room and board. Nursing, personal assistance, specialized professional care, medications and recreation expenses are completely covered by the State. The Superior Court recently ruled that even washing the users' clothing was a right. This court decision raises serious questions about the extent of the basket of insured services for people in residential care.

In 2005-2006, the contribution by adults in residential care totalled $515.3 million, reducing the cost for the State to $2.2 billion. However, the contribution which can be charged to individuals is capped and established according to their ability to pay.

GRAPH 10

Trends in the percentage of beds approved for residential care of seniors by category, Québec, Canada and provinces, 2005
(percentage)



Source: Statistics Canada, *Residential Care Facilities*, 2004-2005.

Québec clearly stands out from the other Canadian provinces regarding the mode of ownership of residential care places for long-term care.

— In Québec, three quarters (77% in 2004-2005) of approved beds are under provincial public ownership, and 23% are privately owned.

— On the average in Canada, only 25% of beds are located in provincial public residences, while 8% belong to municipalities, 27% to non-profit organizations and 40% to private enterprises.

— In British Columbia, 44% of the places are in the non-profit sector and 37% in the private sector. In New Brunswick, only 2% of the beds belong to the province, 52% to the non-profit sector and 45% to the private sector.

■ Too few light resources

The vast majority of seniors suffering from loss of autonomy are housed in the heaviest and most costly modes of residential care, public CHSLDs and private CHSLDs under agreement.

— Too small a proportion of cases rely on the formula of intermediate and family-type resources, living environments attached by contract to a public institution (CSSS) or to a public institution identified by an Agency.

— In search of less costly solutions, however, the Ministère de la Santé et des Services sociaux, in its 2005-2010 Action Plan Regarding Services Offered to Seniors Who Have Lost Autonomy, proposed to favour innovative solutions. These would depend on greater reliance on the private sector, when such solutions can ensure an increased supply of services more quickly on advantageous conditions.

As of March 31, 2006, 37,999 persons were housed in public CHSLDs or private CHSLDs under agreement, 2,538 were housed in a private CHSLD not under agreement, and 6,590 persons lived in intermediate and family-type resources.

TABLE 5

CHSLD residential care

CHSLD residential care	
Number of persons in public CHSLDs or private CHSLDs under agreement as of March 31, 2006	37,999
Average total cost per person in a CHSLD	$57,500
Average contribution by residents (room and board)	$10,000
Average net cost	$47,500
Percentage of the persons exempted from contributing due to their low ability to pay	50%
Maximum monthly contribution by users (as of January 1, 2008)	
– Individual room	$1,590.90
– Room with two beds	$1,329.90
– Room with three or more beds	$988.50

Sources: Ministère de la Santé et des Services sociaux et Régie de l'assurance maladie du Québec, *La contribution financière des adultes hébergés*.

8.5 The situation in the OECD countries

As specified from the outset, a distinction must be made from the overall problem of aging and the specific needs related to loss of autonomy.

The Task Force analyzed the situation of the OECD countries, as well as the current state of the services offered in Québec, before drawing a number of conclusions and deducing several orientations.

❑ The major trends

Several major trends emerge from an analysis of the responses provided to loss of autonomy in the OECD countries.

Over the past decade the rates of institutionalization of seniors have decreased in many countries.

— In 2004[110], between 3% and 6% of persons age 65 and over were institutionalized in most of the OECD countries. This proportion was 1% in Korea but rose to 7.5% in Sweden[111].

— On the other hand, also in the past decade, the proportion of institutionalized seniors increased in Austria and Germany. In Luxembourg and Japan, this proportion rose between 2000 and 2004. In these different countries, the

[110] The most recent year available.

[111] *Society at a Glance: OECD Social Indicators*–2006 edition, HE5. Long-term care.

increase in institutionalized seniors coincided with the introduction of a dependence insurance plan, which reduced the costs of long-term care paid directly by individuals[112].

In other places, new housing formulas are being explored. In Denmark, for example, and in the United States, adapted housing is being constructed for seniors instead of institutional and conventional housing. The housing sector is separated from the service sector, with all the care equipment and caregiving staff.

For persons receiving care at home, whole services of cash benefit programs have been developed in many OECD countries over the past ten years.

— The aim is to provide dependent persons and their families with a greater individual choice of care.

— With personal budgets (cash allowance formula) and direct employment by the user of health auxiliaries, seniors can employ a personal care attendant who very often can be a relative.

— Surveys have shown that a greater choice and direct employment by the user can contribute to a better quality of life, for a cost analogous to that of traditional services – subject to these programs being well targeted by the persons who need them the most.

❑ Coverage and funding

In most systems, the care services provided in institutions is usually only partially covered by the public programs. Households may be required to contribute to shelter and meal expenses.

— In most countries, nursing and personal care are also billed to the users under resource conditions.

— Retirees are frequently required to contribute to the funding of long-term care, both by a direct contribution to the public plan and by a substantial participation in the direct costs.

Given the weight of these private expenditures, the role of private complementary insurance could increase in scope in the years ahead.

In short, unless coverage is reduced considerably and unless services are targeted to the sickest and most handicapped individuals, all countries are having difficulty meeting the demand for care, even before the full effects of aging have been manifested.

[112] *Society at a Glance: OECD Social Indicators*–2006 edition, HE5. Long-term care.

❑ Organization and delivery of services

The models for organization and delivery of long-term care services are very diversified in the OECD countries, and it is very interesting to note how much Québec stands out in this regard. Above all, in several OECD countries, it is found that long-term care is placed under the responsibility of the municipal authorities.

— Thus, in the United Kingdom, the local administrations are responsible for care assessment and management.

— In Denmark, the rule is freedom of choice of the personal and practical assistance provider.

  — This means that the municipality organizing the services must ensure that individuals really have a choice among the different providers.

  — Thus, the local council has an agreement with all the providers who wish to provide personal and practical assistance, and they must meet the local price and quality requirements.

— In Sweden, management of long-term health care has been integrated at the municipal level. Some municipalities have introduced a separation between the functions of buyer and provider.

8.6 Main findings

Several findings result from the analysis of the care offered in Québec to persons suffering from loss of autonomy.

— It must first be noted that the vast majority of seniors want to stay at home as long as possible. Moreover, a large proportion of Quebecers affirm that they would be willing to take care of a senior suffering from loss of autonomy in their home instead of finding a place for that person in a residential care centre[113].

— The basket and level of services covered are not the same throughout the territory. They vary according to the place of delivery of the service and they do not always account for the person's ability to pay.

— A person suffering from loss of autonomy has a limited choice of providers. In general, public services are provided in kind (a place in a CHSLD, the services offered by the CSSS at home) and rarely take the form of cash benefits.

[113] Léger Marketing survey conducted for Le Journal de Québec of a sample of 1,000 Quebecers from June 6 to 10, 2007, published on June 18, 2007.

❑ An inadequate partnership with the private sector

In Québec, the Arpin (1999), Clair (2000) and Ménard (2005) reports recommended in turn that substantial partnership possibilities be explored with the private sector. This would not be limited to the market sector but would include the social economy and cooperative sectors.

— The Arpin Report thus states: "Regardless of the adjustments to public services that the government might make in the years ahead, most of the needs of seniors for residential care and home services will find an answer in the private sector"[114].

— Since then, reflection has continued in the living environments and among the different players involved in the delivery of services. The persons met by the Task Force suggest an in-depth review of the ways we do things.

— The CSSS should be freed from their role as direct providers of long-term care services and act as case managers, for example.

— The MSSS should supervise the private sector to assure the population's safety and assure our vulnerable people of decent environments and quality services.

— Québec thus seems to be late in inducing community participation and encouraging cooperative or non-profit organizations and social economy enterprises.

❑ Other observations

The Task Force was made aware of several other situations.

— Due to a lack of appropriate services, many people – mostly seniors suffering from loss of autonomy – end up in a hospital due to a lack of CHSLD places. They occupy about 800 short-term beds.

— A large number of seniors end up in a CHSLD, when their condition requires a number of hours of care per day that could be provided to them in less heavy and less costly substitute environments – such as intermediate or family-type resources or at home.

— Several public and private CHSLDs are obsolete.

— Private resources are insufficiently utilized and mobilized.

  — Seniors' residences complain that they are ignored by the MSSS and the institutions.

[114] Group de travail (Roland Arpin, Chair), *La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec*, Ministère de la Santé et des Services sociaux, Québec, September 1999, page 78.

- Since they constitute an essential resource between home and the long-term care centre, these residences should be included in the assessment of needs and resources.
- Links should also be established with these residences so that they can be integrated into the supply of residential care services.

— The tax credit for home-support services is offered to everyone equally, regardless of income level. Thus, an affluent person is entitled each year to the $3,750 granted under this tax credit, even though he could afford to pay for the services received. On the other hand, the maximum permitted is not enough to meet the needs of a person with modest income.

8.7 Orientations for the next decade

Based on these findings and the trends observed in several OECD countries, the Task Force reflected on a strategy covering the next decade. This strategy would be articulated around six orientations:

— priority to home-support services,

— graduated coverage according to degree of dependence, nature of the service and ability to pay,

— a better defined role for the regional agencies and the CSSS,

— the patient's choice of provider;

— diversification of the residential care supply;

— adjustment of the contributions based on ability to pay.

❑ Priority to home-support services

For seniors, health services and social services must be organized and funded on the basis of home support. Residential care must be delayed as long as possible, reflecting the will of the vast majority of Quebecers to remain in a conventional domicile.

To achieve this objective, it is essential to offer better first-line medical care, improve follow-up and takeover of patients – particularly those suffering from a chronic disease –, and establish effective prevention programs.

The government recognizes this priority. Over the past five years, the amounts granted to home-support services have grown at a faster pace than aggregate public health spending, namely 9% compared to 6.5%.

This effort undeniably must continue.

❑ Graduate coverage according to degree of dependence, nature of the service and ability to pay

The Task Force considers that coverage of home-support services must be defined more clearly and inspired by the following rules:

— The extent of coverage by the public plan must account for the degree of dependence of the persons concerned. The degree of dependence must be established by eligibility tests. The range of services covered should be related to the nature and degree of dependence.

— Medical, nursing and specialized professional services must be insured by public coverage, provided that these services are included in the basket of services.

— Assistance to activities of daily living must be covered by the public plan for the most disadvantaged persons and then, beyond a certain threshold, charged according to ability to pay while being eligible for tax credits.

— It would be preferable that domestic assistance services be at the expense of the individual and his or her family, with a form of exemption for the most disadvantaged persons.

— When a user fee is in force, the services should be charged as close as possible to the actual cost and billed according to the ability to pay established by income tests.

Recommendation

The Task Force recommends:

— that for seniors suffering from loss of autonomy, the government give priority to home-support services and that for this purpose, it support a high level of investment in this sector;

— that medical, nursing and specialized care covered at home be covered universally by the public plan and that the other home-support services, for assistance with activities of daily living and home assistance, be the object of graduated coverage according to degree of dependence, nature of the service and ability to pay (in all cases, the most disadvantaged should be protected);

— that eligibility for a tax credit be the object of an income test.

❑ A better defined role for the regional agencies and the CSSS

According to the proposed approach, the Ministère de la Santé et des Services sociaux and the regional agencies should not be directly involved in the production of services as such.

As suggested by a study on practices and social policies, "the State, in a public policy, can assume its responsibilities by specifying the role of the players by the application of a policy, without thereby being obliged to specify that it itself is the manager and provider of services"[115].

Regarding services to seniors suffering from loss of autonomy, the government should increase mobilization of private resources, without in any way abdicating its responsibility.

— It is up to the Ministère de la Santé et des Services sociaux to determine the contents of the basket of insured services, define the quality standards to be observed by the care providers, the eligibility rules and the modalities of evaluation of the services offered In particular, it is the role of the MSSS to ensure that the eligibility rules are applied uniformly throughout the territory.

— It is up to the regional agencies to proceed with approval and evaluation of the service providers, in order to ensure that the quality standards are observed and that the objectives set for the providers by contract are achieved. They have the obligation to ensure the availability of the services in their territory.

— The CSSS, of which the CLSCs have become a component, have as their primary responsibility case management, evaluation of patient eligibility, referral of patients to the appropriate services, and organization of gateways between home services and the other components of the health and social services system.

— The CLSCs are providers of home services. Gradually the services offered by the CLSCs should be concentrated on nursing and professional care. The CLSCs should be less and less involved in assistance with activities of daily living, and even less with home assistance.

❑ The patient's choice of provider

It is necessary to depart from a system in which services are distributed exclusively by public organizations and continue the current progress towards a system of regulation and management of providers.
The patient henceforth should be able to choose a provider from a list of providers approved by the regional agency.

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[115] *Les passerelles entre l'État, le marché et l'économie sociale dans les services de logement social et d'hébergement pour les personnes âgées*, research report, Laboratoire de recherche sur les pratiques et les politiques sociales, Université du Québec à Montréal, November 2005.

- The patient could receive a cash benefit allowing him to opt for the services of an approved provider of his choice.
- The patient should also have the right to obtain approval of a caregiver close to him – what is known as a natural caregiver –, if this person is able to meet the established standards.

For the past several years, the government has counted on community organizations and social economy enterprises to offer services of this nature. Under the proposed strategy, these providers would have to receive appropriate recognition by the State and be awarded funding modalities that will allow them to maintain and improve their service offering.

❑ Diversification of the residential care supply

The residential care supply is currently concentrated in the public or private CHSLDs, the heaviest and costliest form. However, all over the world, for several years, the organizations responsible for long-term care have opted for lighter formulas, closer to the communities and, on the whole, less costly.

■ Developing lighter resources

The ministerial policy provides for diversification of the residential care supply to intermediate or family-type resources. For the past few years, the MSSS has also supported innovative projects. All these initiatives go in the direction of extending the residential care supply to lighter formulas. The Task Force supports this orientation.

- In its 2005-2010 action plan, the MSSS seeks to reduce the accommodation rate of seniors in CHSLDs to 3.1%.
- To achieve this objective, the supply of lighter resources must be increased.
- Moreover, the funds currently allocated to CHSLD places that are considered to be surplus should be transferred to home services or services in the community.

There is a high level of resistance in the communities and in political and union circles to any closure of CHSLD places.

If we really believe in the shift to home-support services and to lighter resources, corresponding to the wishes of the vast majority of seniors, then change must be accepted.

For the proposed changes to be acceptable, certain conditions are necessary:

— The persons currently housed in CHSLDs and who wish to remain there should have the right to stay there.

— The MSSS, in collaboration with all the stakeholders, must adopt a credible new deployment plan for places in intermediate or family-type resources and home-support services.

— The MSSS must ensure, through approval and evaluation measures, the quality of care and services provided by residential care resources.

— The regional agencies must ensure that functional links are established between the health and social services agencies and the residential care resources.

■ Entrusting residential care to the non-profit, cooperative, private and municipal sectors

In Québec, contrary to the situation on the Canadian and global scale, the vast majority of the residential care supply for seniors suffering from loss of autonomy is provided by public institutions. This situation forces the government to maintain and service a costly real estate inventory.

In other Canadian provinces, the private, community and municipal player have a majority role in residential care to seniors suffering from loss of autonomy. Such a policy has the advantage of mobilizing private capital to develop places quickly and reduce public real estate expenditures in the CHSLDs.

The following principle should apply. Health care must be the responsibility of the public health care system while residential care should be the responsibility of approved community players, non-profit organizations, cooperatives, private enterprises and municipalities. In short, the role of the public health care system is to care and not to house.

— In Québec, the private sector has played a role for many years, but its contribution has been deliberately marginalized. It should be called upon to play a greater role.

— The cooperative sector is already very present in housing for seniors. It is willing to test pilot projects combining housing and home care. In Québec, SSQ Mutual already supports an innovative project with the same inspiration.

— The municipal sector plays a much greater role in this regard in some Canadian provinces but especially in Europe. In Québec, some municipalities have expressed interest. The cities are already responsible for low-cost housing, particularly for seniors. If favourable conditions are put in place, they could play an increased role.

Before proceeding with such a change, the MSSS must give priority to adopting strict rules and approval modalities to ensure the safety of people and the quality of services.

Recommendation

The Task Force recommends that the Ministère de la Santé et des Services sociaux concede the operation of the CHSLDs to the appropriate resources within a five-year horizon.

❑ Adjustment of the contributions based on ability to pay

As they do everywhere outside the province, seniors in Québec pay a contribution for their residential care. The contribution currently asked of people in residential care must be adjusted to their ability to pay.

The level of this contribution should be adjusted so that it better reflects the current actual cost of room and board. Such an adjustment would restore equity in relation to people who remain in their own homes at their own expense.

CHAPTER 9 – BETTER USE OF MEDICATIONS AT A CONTROLLED COST

In the overall problem of the organization of health care, medications are a major therapeutic and economic issue.

It is important to explain the dimensions of this issue clearly, because approaching the two paths by which it is possible to improve the contribution of medications to the health care system:

- by favouring their optimum use;
- by improving the funding rules of the Basic Prescription Drug Insurance Plan.

9.1 A major therapeutic and economic issue

First of all, medications are a major therapeutic issue. Human beings have always employed medicinal substances to improve their state of health. However, drug technologies saw extraordinary progress in the 20th century.

This evolution conferred a central importance on medications in the therapeutic arsenal. Medications are used not only to cure, but to prevent and control the evolution of diseases, reduce symptoms or even improve the comfort and the quality of life of people suffering from chronic diseases.

Medications make it possible to prolong life, and current genetic research gives reason to look forward to possibilities that until recently were in the realm of science fiction.

9.1.1 Access to medications

In all developed countries, governments have taken measures to ensure access by citizens to this essential therapeutic tool.

Medications are covered in most public health plans in Europe. This is not the case in all Canadian provinces, except for specific groups suffering from special pathologies, or for disadvantaged or elderly people.

- In all provinces combined, about 60% of medication expenditures are funded by the patients themselves, either directly at the pharmacist or through private insurance – particularly group insurance contracted through their employer.
- Medications taken in the hospital and in long-term care institutions are free for everyone. The situation is different for medications taken in an ambulatory context.

❑ In Québec: gradually expanded access

In Québec, the first measures aimed at protecting the public against the cost of medications were put in place in the 1970s.

— The first to benefit from free medications were Income Security (employment assistance) recipients and persons age 65 and over receiving the maximum amount of the Guaranteed Income Supplement.

— Free medications were extended to all persons age 65 and over in October 1977. However, this measure was amended in May 1992 by the introduction of an amount of $2 per prescription, which had to be defrayed by persons age 65 and over not receiving the maximum amount of the Guaranteed Income Supplement, up to a maximum contribution of $100 per year.

— In 1973, the *Malades sur pied* circular was adopted to cover the particularly high costs of medications required for six pathologies, namely cancer, cystic fibrosis, diabetes insipidus, tuberculosis, primary hyperproteinemia and severe psychiatric diseases. The distribution of these medications was to be assured by the hospitals and a contribution of $2 per prescription was charged.

— In 1992, a program was established to cover the medications used for most sexually transmitted diseases.

The situation changed radically in the 1990s. Until then, the Health and Welfare Policy published by the MSSS was virtually silent on the subject of medications.

— Several serious diseases were excluded from the *Malades sur pied* circular, which created inequities.

— The shift to ambulatory care, which had just begun, had the effect of reducing the length of hospital stays and thus of transferring the cost of medications to the patients when they returned home.

— Moreover, the price of medications was growing rapidly and it was observed that 1.4 million people, including 317,000 children, were not covered by any private or group insurance plan.

The Basic Prescription Drug Insurance Plan was established to respond to these three difficulties.

❑ The Basic Prescription Drug Insurance Plan

The Basic Prescription Drug Insurance Plan was established in January 1997. It has three main characteristics:

— This is a universal plan, meaning that all Québec citizens benefit from basic coverage for medications and pharmaceutical services.

— The plan is contributory, meaning that it provides for the insured's financial participation in the form of a contribution upon purchase (co-insurance and deductible) and an annual premium. However, certain clienteles of the public plan do not have to pay any contribution: these are children, employment assistance recipients and persons age 65 and over receiving at least 94% of the Guaranteed Income Supplement.

— The plan is a mixed plan, which involves the coexistence of private drug insurance plans with the public plan.

■ The public plan

The public prescription drug insurance plan covers persons age 65 and over, employment assistance recipients and about 1.7 million people who do not have access to a group insurance plan or an employee benefits plan applicable on the basis of a relationship of employment, a profession or any other usual occupation.

In all, in 2006, the public plan covered nearly 3.2 million people, or 41% of the Québec population.

The rest of the population are insured under private plans, particularly group insurance contracted through the employer.

TABLE 6

Public Prescription Drug Insurance Plan
(number of persons insured, 2006)

Employment assistance recipients	511,691
Persons age 65 and over	951,284
Members	1,699,649
TOTAL	**3 ,162,624**

Source: RAMQ, *Statistiques annuelles 2006*, table AM.06.

■ The parameters of the public plan

The persons insured must contribute financially when they purchase a prescription drug. This contribution is calculated on a monthly basis and consists of:

— a monthly deductible;

— co-insurance on the portion of the cost of the medication that exceeds the deductible.

To avoid an excessive burden on the insured due to consumption of medications, monthly contribution ceilings are fixed.

An annual premium, for a maximum amount of $557, is charged for certain classes of insured. This premium is established according to the income of the person insured under the public plan.

The contribution parameters (deductible, co-insurance) and the ceilings vary according to the groups.

TABLE 7

Parameters of the public prescription drug insurance plan
(as of July 1, 2007)

	Deductible ($/month)	Co-insurance (%)	Contribution limit ($/month)	Maximum premium ($/year)
Employment assistance recipients	**0.00**	**0.0%**	**0.00**	**0**
Seniors receiving at least 94% of the GIS	0.00	0.0%	0.00	0
Seniors receiving partial GIS	14.10	30.0%	48.27	557
Seniors with no GIS	14.10	30.0%	75.33	557
Members	14.10	30.0%	75.33	557

Source: Régie de l'assurance maladie du Québec, *Prescription Drug Insurance: Important Information About the Public Plan*.

Employment assistance recipients with severe employment constraints benefit from free medications since 1999. Recipient without severe constraints benefit from free medications since July 1, 2007.

Persons age 65 and over receiving the maximum Guaranteed Income Supplement benefit from free medications since July 1, 2005. Those receiving 94% to 99% of the Guaranteed Income Supplement benefit from free medications since July 1, 2007.

Children under age 18 and students under age 25 are exempted from contributions.

❑ Existing controls

The importance of medications has led the industrialized countries to adopt measures to protect the public.

In Canada, this responsibility is shared between the federal government and the provinces.

— Health Canada is the authority responsible for licensing of pharmaceuticals. To put its product on the market, a manufacturer must provide scientific proof of its safety, effectiveness and quality.

— Also at the federal level, the Patented Medicine Prices Review Board ensures that the prices of medications patented in Canada are not excessive.

In Québec, the Minister of Health and Social Services makes the decision whether to enter medications in the list of the public prescription drug insurance plan and the list of the health care institutions, after consultation with the Conseil du médicament.

■ The Formulary

The *Act respecting prescription drug insurance* stipulates that the Conseil du médicament shall first assess the therapeutic value of each medication. If the Conseil considers that the therapeutic value has been established, it sends the Minister its advisory opinion after assessing the following aspects:

— the reasonableness of the price charged;

— the cost-effectiveness ratio of the medication;

— the consequences of entering the medication on the list will have on the health of the population and on the other components of the health care system;

— the advisability of entering the medication on the list with regard to the purpose of the basic plan.

The decision whether or not to enter a product on the list of medications must be justified by the existence of conclusive data which prove the effectiveness and value added in relation to the existing medications or the ability to influence the consequences of the disease.

■ Exceptional plans which have become more lax

A medication can be entered in the regular section or in the exceptional medications section of the list of medications.

The “Exceptional medications” section is a tool designed to improve control of the costs of the public prescription drug insurance plan. A medication entered in this section is only covered if it is used for recognized clinical indications. To have access to an exceptional medication, the insured must have a form completed by his attending physician.

However, the authorization procedure for exceptional medications has been made more flexible since April 25, 2007, as proposed in the Medication Policy. For half of the exceptional medication, the entry of a code accompanied by the name of the exceptional medication on a prescription corresponds to a payment authorization.

The Régie de l'assurance maladie du Québec manages this program. The Régie must consult the Conseil du médicament, but is not bound to follow its recommendations.

The Régie also manages a second program called "exceptional patient".

— Under this program, a patient may obtain reimbursement from the Régie, with the consent of his physician, for medications not entered on the list, for treatment of a severe medical condition.

— The Régie is not bound to obtain the advisory opinion of the Conseil du médicament when it makes decisions under this program.

9.1.2 An important growth factor for public health spending

Medications are not only a major therapeutic issue. They represent a considerable economic issue, due both to the role played by medications in the growth of public health spending and the role of the pharmaceutical industry in our economy.

The contribution of medications to the growth of health care costs can be summarized in a few statistics.

— According to the Canadian Institute for Health Information, Quebecers spent $288 million on medications in 1975. This amount represented only 9% of total health spending in Québec that year.

— Thirty years later, expenditures for medications exploded to reach $6 billion. In 2006, public and private medication expenditures represent 22% of total health spending in Québec.

— In 1975, two times more was spent on physicians than on medications. The situation has been reversed completely in the past thirty years. Medication expenditures represent nearly double the cost of medical services in 2006 – that is, $6.2 billion for medications compared to $3.4 billion for physicians.

❑ The cost of medications in institutions is relatively controlled

Medications taken in hospitals and long-term care institutions are paid for from public funds.

Between 1998-1999 and 2006-2007, the cost of medications in institutions increased by an average of 10.4% per year, from $246 million to $525 million.

— More than half of the increase in medication costs in institutions is explained by the increase in the number of persons treated in a hospital context in Québec. The number of these persons has grown by 5.5% in the past five years.

— The rest of the increase is due to a combination of the increase in the average number of medications taken per patient and the price increase.

▪ The means mobilized to reduce costs

The hospitals have adopted means to pay for their medications at the lowest possible price.

— The hospitals have formed regional groups to purchase their medications, which has allowed them to realize savings – not only on the price of medications, but on their procurement management costs. Eleven group purchasing organizations have been created in the past thirty years, serving every region of Québec. The groups proceed by block tenders every three years. The supplier is chosen on the basis of the lowest bidder.

— Moreover, as soon as a generic drug – that is, a copy of the patented drug – is put on the market, the purchasing groups generally issue a new call for tenders to put the single drug into competition with the new generic product.

■ Possible improvements

Grouped purchasing of medications has proved to be an effective procedure for reducing institutional costs. It is appropriate to study the amalgamation of purchasing groups to increase their size and optimize savings. One of the options could be to create a single Québec-wide group.

In addition, it is probable that a more efficient organization of care, closer follow-up of medication and the use of new technologies and tools to assist the prescription and distribution of medications would contribute to reduce the costs further.

According to a recent study[116], 44% of institutions have already deployed a unidose medication packaging system and 35% have planned the acquisition of such robots. Only 22% of hospitals use bar codes to manage medications, although 50% of institutions plan to do so in the near future.

The Task Force suggests that the use of these technologies be extended quickly to as many institutions as possible.

[116] Guy PARÉ and Claude SICOTTE. *Intensité du déploiement des technologies de l'information dans les établissements de santé au Québec*. Expert report submitted to the members of the Task Force on Health Funding du Québec, October 24, 2007.

❑ The cost of the public prescription drug insurance plan is increasing twice as fast as aggregate public health spending

The gross cost of the medications purchased by the persons insured under the public prescription drug insurance plan – persons age 65 and over, employment assistance recipients and members – grew by an average annual rate of 12.0% from 1997-1998 to 2007-2008, to reach $3.6 billion.

After a slowdown in 2004-2005 and 2005-2006, the growth of the cost of medications accelerated again in the past two years. It stood at 8.5% in 2006-2007 and is forecast at 10.9% in 2007-2008.

If the user contributions – the premium, the deductible and the co-insurance – are subtracted from the gross cost of medications –, we obtain the net cost for the government of the public prescription drug insurance plan.

TABLE 8

Trend of the costs of the public prescription drug insurance plan
(in millions of dollars)

	Gross cost	Variation (%)	Government cost	Variation (%)
1997-1998	1,161.8		696.2	
1998-1999	1,339.1	15.3	776.8	11.6
1999-2000	1,559.9	16.5	981.8	26.4
2000-2001	1,878.2	20.4	1,139.7	16.1
2001-2002	2,127.7	13.3	1,295.6	13.7
2002-2003	2,375.9	11.7	1,395.7	7.7
2003-2004	2,634.0	10.9	1,543.0	10.5
2004-2005	2,819.1	7.0	1,677.4	8.7
2005-2006	2,992.9	6.1	1,766.1	5.3
2006-2007	3,247.0	8.5	1,945.6	10.2
2007-2008[F]	3,601.5	10.9	2,215.3	13.9
Growth 2007/1997		**12.0**		**12.3**

F: Forecast
Source: Régie de l'assurance maladie du Québec, Annual Reports.

— The cost for the government rose from $696 million in 1997-1998 to $2.2 billion in 2007-2008, for an average annual increase of 12.3%. The rising cost of medications thus continues to impose heavy pressure on public finances.

— In comparison, over the past few years, aggregate public health spending has risen by an average of nearly 6% per year. Medications account for one sixth of that increase.

❑ The main cause of the growth of expenditures: consumption

The growth of the costs of the public prescription drug insurance plan is essentially due to two factors, the increase in consumption and, to a lesser extent, the cost per prescription.

- The increase in consumption, resulting from the rise in the number of participants and the number of prescriptions per participant, accounts for 83% of the increase in the gross cost of medications observed in the 1997-2006 period.
  - The increase in consumption is explained, in particular, by the appearance on the market of medications that allow treatment of diseases for which no treatment previously existed.
  - It is also explained by the increased use of medications for preventive purposes, in particular for cardiovascular incidents.
  - The increase in the number of participants results in part from population aging.
  - The increase in consumption does not depend only on the patient. It also results from the attitude of the prescribing physician.
- The cost per prescription accounts for 17% of the increase in the costs of the public prescription drug insurance plan. The importance of this factor has diminished since 2000. Indeed, the cost per prescription explained about 30% of the increase in the gross price over the 1997-2000 period.
  - The increase in the cost per prescription largely results from the introduction of new medications with a higher average price.
  - Up to last April, no price increase was granted for medications already entered on the list of medications, by virtue of the policy instituted in 1994 of no increase in medication prices.
  - Indexation of medication prices is authorized henceforth on certain conditions. In particular, the annual indexation must be limited to the Consumer Price Index, which could have an impact on the increase in the cost of the plan.

❑ Strong growth forecast over the next few years

Over the next few years, the annual growth of the cost of the public prescription drug insurance plan could range between 9.5% and 11.0%.

— In the latest forecast of the Régie de l'assurance maladie du Québec, the average annual growth rate is 9.5%.

— However, if consumption – the number of prescriptions multiplied by the number of participants – were to increase at the level of the last two years for which data are available (2005 and 2006), the growth rate could reach 11.0%, in view of the effect of population aging and the price increases which are henceforth permitted. This is the growth forecast retained by the Task Force, as we have already seen[117].

TABLE 9

Projection of the growth of the cost of medications
(% for each factor)

Demographic (growth of clientele and aging)	1.6
Prices and/or inflation	2.0
Increase in consumption	7.4
AVERAGE ANNUAL GROWTH	**11.0**

Source: Secrétariat du Conseil du trésor.

The increase in consumption was calculated on a differentiated basis for the three clienteles of the public plan, on the basis of the growth of consumption by each clientele over the past two years. The results obtained are as follows:

— 9.0% for employment assistance recipients,

— 6.7% for persons age 65 and over, and

— 3.8% for members.

On this basis, the cost of medications for the participants in the public plan could reach over $6 billion in five years.

Assuming that medication cost sharing will be maintained at the level forecast for 2007-2008, the cost for the government would reach $3.7 billion in 2012-2013.

[117] See Table 2 above, page 36.

9.1.3 A major economic sector

Another economic issue is that the pharmaceutical industry represents one of Québec's major sectors of activity, contributing directly to our prosperity and to wealth creation.

It is thus understood that the government has adopted an industrial policy intended to favour the implementation and maintenance of pharmaceutical companies in its territory.

There are many reasons justifying such support.

— This economic sector is growing worldwide.

— Québec accounts for 35% of the jobs related to the pharmaceutical industry in Canada. Its territory hosts six of the seven fundamental research centres or groups of the innovative multinational pharmaceutical companies in Canada, while 68% of Canadian prescription drug patents are held by companies established in Québec.

— Over 40% of this sector's research and development expenditures are incurred in Québec, which represented half a billion dollars in 2005.

❑ The 15-year rule

The government confers certain tax benefits on this sector. It has also decided to grant an additional benefit to companies that market innovative drugs. This is a measure known as the 15-year rule, which has been in force since 1994.

— Under the lowest price method, the government only reimburses for the least expensive medication under the public plan, when there is more than one manufacturer offering the same product on the market.

— Québec makes an exception for innovative drugs, which are entered within the past fifteen years on the list of medications of the Basic Prescription Drug Insurance Plan.

— During this 15-year period, the innovative drugs continue to be reimbursed at their price even if a generic drug is also entered on the list of medications at a lower price. This rule allows the innovative manufacturer to retain a considerable market share, even when a generic drug is offered at a lower price.

This measure obviously involves a cost for the public plan. To account for this, the government annually pays an amount to the Prescription Drug Insurance Fund, into which the premiums paid by the participants in the public plan are also deposited. For the year 2007-2008, this compensation represents $41 million.

By way of comparison, in Sweden, the substitution of a generic drug for the original product is compulsory since 2000 for medications of equivalent medical value. If the patient nonetheless chooses the original drug, he pays the difference. This practice generated savings of 700 million euros between 2002 and 2005.

❑ A finding

The study of this policy is not part of the Task Force's mandate – nor is a study of the commercial practices of pharmaceutical companies.

However, the Task Force notes this policy's impact on the costs of the health care system. The government, under its new Medication Policy, has just implemented a series of measures to govern these practices. The Task Force suggests that the government continuously evaluate its real impacts on public health and on the costs of the public plan.

9.2 Making optimal use of medications

Faced with this major therapeutic and economic issue, it is essential both to make optimal use of medications and to improve the funding rules of the Basic Prescription Drug Insurance Plan.

Regarding optimal use of medications, the initiatives in this sense have barely begun in Western countries. In general, the governments of the developed countries are only starting to be concerned about limiting consumption of medications when this is abusive.

It is true that in several situations, the appropriate use of medications makes it possible to avoid more complex and more costly treatments or to reduce or even avoid prolonged hospital stays. In the mental health field, resorting to medication makes it possible to avoid institutionalization.

However, when consumed abusively or inappropriately, these same medications can cause irreparable harm and result, on the contrary, in major costs for the individual and for the health care system.

Moreover, new products regularly arrive on the market, with real therapeutic value but excessive cost in relation to their effect.

While it is important to ensure that the patients can benefit from the progress of pharmaceutical research when this progress is real and scientifically well established, it is just as necessary to set limits on consumption of medications, so as to ensure their optimum use for the individual and for society.

9.2.1 The Medication Policy

To control consumption of medications, the Ministère de la Santé et des Service sociaux relies on various mechanisms for their optimum use.

❑ The responsibilities entrusted to the Conseil du médicament

Under the Medication Policy presented on February 1, 2007, the Conseil du médicament was mandated to see to the implementation of this program.

— The mechanisms for entry on the list of insured medications are a first measure favouring their optimum use. For 2006-2007, 62% of applications for entry of new products on the list of medications were rejected by the Conseil. In at least half of the cases, these refusals are justified by an insufficient therapeutic value in relation to the cost of the medication.

— The other measures proposed by the Medication Policy concern drug use reviews, training and information strategies for professionals and the public, review of medication at home, transmittal to the pharmacist of the prescriber's therapeutic intention, study of physicians' prescription profiles to detect deviant situations, and use of information technology to help physicians choose the most appropriate medication.

The Task Force fully supports these measures and wants them to be applied vigorously and speedily. They have been discussed for years.

The Task Force is also persuaded that the full deployment of first-line health clinics, the registration of patients with these clinics, and the follow-up and takeover of chronic patients recommended previously are all means that will contribute to optimum use of medication.

❑ Limits related to the nature of the Conseil du médicament

However, this will not be enough. There are several limits on the proposed program in the Medication Policy, the first of which stems from the nature of the Conseil du médicament.

— The Conseil du médicament only has a limited power of initiative. The Conseil essentially acts at the request of the Minister or when a pharmaceutical company wants to have a new product entered or change the classification of a medication on the list.

— The Conseil du médicament is not independent. The Conseil's staff is integrated with the staff of the MSSS. Yet this independence is crucial.

Québec has decided to rely on the pharmaceutical industry to develop its economy, which the Task Force does not call into question. There are strong

pressures on the government for the medications produced by the companies present in its territory to be entered on the list.

Moreover, as is the case throughout Canada, the industry exerts pressure so that the prices of medications are revised upwards and aligned with the higher prices applied in the United States. Even generic drugs are more expensive in Canada than in the rest of the world.

— The studies used by the Conseil du médicament are produced and funded by the pharmaceutical companies themselves. Contrary to the equivalent British body, the National Institute for Health and Clinical Excellence, the Québec Conseil du médicament does not have sufficient resources to perform independent studies on the pharmacoeconomic value of the medications it reviews.

  The data from these studies are not public because they are considered to belong to the companies concerned.

— The Conseil du médicament does not include any economist. One of the major issues related to medications is economic. The Conseil must give advisory opinions to the Minister on the prices of medications and account for this factor in the decision whether or not to enter a medication on the list.

  Although several pharmacists employed by the Conseil have pharmacoeconomic training, only one person is trained as an economist. The Comité scientifique de l'inscription does not have any.

— There is not systematic review of the list of medications. The list of medications insured under the Basic Prescription Drug Insurance Plan includes over 5,000 products. It is rare for any of them to be withdrawn. Moreover, the Conseil does not have the mandate to review systematically the relevance of maintaining all the medications entered on the list.

❑ Incoherence in the system

The MSSS has allowed specialized committees and bodies to deploy in the health care system, in the cancer field for example, which have mandated themselves to study the optimum use of medications in their field.

— These organizations issue advisory opinions, published by the MSSS, which have authority in the medical profession.

— Yet these advisory opinions, generally prepared without accounting for the financial impact of a medication, sometimes contradict the advisory opinions of the Conseil.

The professional orders also publish advisory opinions concerning the use of medications. Sometimes the Conseil mandates the Collège des médecins or other professional orders to product practice guides.

The Act also confers the mandate on the Régie de l'assurance maladie to manage two exceptional programs, which are increasingly lax, granting patients the privilege to obtain medications free of charge when they are not on the list or are entered on the list of exceptional medications.

— These two plans are managed independently of the Conseil's advisory opinions.

— The Régie manages them based on financial risks. It is not bound by the same rigour as the Conseil regarding the application of the clinical criteria, the actual therapeutic value or the cost-effectiveness ratio of the medication.

While it is appropriate for any system to provide for exceptional situations and ways of dealing with them, the proliferation of these exceptions risks undermining the credibility of the basic plan. Moreover, this situation creates inequity between patients who know the exceptional mechanisms and those who do not know them.

Proposal

The Task Force proposes that the government tighten the rules regarding the application of the exceptional measures provided in the Basic Prescription Drug Insurance Plan, imperatively accounting for the advisory opinions of the Conseil du médicament.

The Task Force also proposes that a single body be given the authority over all advisory opinions issued in the health care system on the therapeutic value and the cost-effectiveness ratio of medications.

9.2.2 Creating a new body

Another body exists within the health care system with a role similar to that of the Conseil du médicament. This is the Agence d'évaluation des technologies et des modes d'intervention en santé. The mandates of the two bodies overlap in some regards.

As we will see later[118], the Task Force recommends the creation of a new body, which could be called the Institut national d'excellence en santé.

— The Task Force proposes that the functions of the Conseil du médicament and the Agence d'évaluation des technologies et des modes d'intervention en santé be merged with those of the Health and Welfare Commissioner.

— This consolidation would strengthen the position of the three bodies and utilize their resources more effectively.

[118] See Chapter 13, page 195, on the establishment of an Institut national d'excellence en santé.

— Their authority would be strengthened. The new Institute would be independent of the Minister. Its mandate would extend far beyond the advisory function.

9.3 Improving the funding rules of the Basic Prescription Drug Insurance Plan

Independently of the measures for optimum use of medications, the Task Force has identified a number of initiatives which would allow improvement of the funding rules of the existing plan.

9.3.1 Respecting the principle of indexation

In 2002, the *Act respecting prescription drug insurance* was amended to introduce the principle of annual indexation of the premium and the other parameters of the plan, so as to account for the increase in costs.

— The parameters are modified on July 1 of each year to account for the previous year's experience and the cost increase outlook related to changes in the plan's coverage, the addition of new products to the list of insured medications, the anticipated price increases and any other factor which may influence the cost of the plan.

— The Régie de l'assurance maladie du Québec has the mandate to determine the parameters.

— Legally, the Régie makes the decision independently and informs the government subsequently. Since 2003, the Régie's decisions have been applied in their entirety. The annual premium was indexed by 9% in 2003, 7.4% in 2004, 5.5% in 2005 and 3.2% in 2006.

❑ The decision made in 2007

However, the government intervened in 2007 to fix the premium increase at 3.5% instead of the 7.8% rate determined by the Régie. This decision was made within the context of the Medication Policy. The government's intention was to counterbalance the authorization decided to increase the price of medications.

This decision, combined with the free medications granted to 280,000 additional people effective July 1, 2007, led to an additional cost of nearly $50 million in 2007-2008.

Even though it may be justified in its context, the decision made by the government deviates from the policy it had established and observed itself in previous years. For the plan to remain equitable and so that it can be funded suitably, the

government must respect the structure and the principles – including the principle of annual indexation of the parameters.

For this reason, the Task Force wants the government to respect the principle whereby indexation of the public plan falls under the authority of the Régie de l'assurance maladie du Québec and that, for this purpose, it abstains from intervening to modify the decisions of the Régie in this regard.

9.3.2 Repairing an inequity against workers insured in the private sector

As recalled at the beginning of this chapter[119], the public prescription drug insurance plan provides for free medications for the most disadvantaged groups and a discount on the premium for certain classes of persons age 65 and over. The Task Force does not call this principle into question.

The plan also covers 1.7 million members, workers and their dependent ages 18 to 64, not covered by a private plan.

- Since the creation of the plan, these workers have benefited from an advantage over those who are insured in the private sector. In fact, their contribution to the public plan is lower than the actual cost of the plan for this group.
- This situation has two unjustified effects:
  - Granting the workers insured under the public system a financial advantage over the workers insured under private group insurance plans.
  - Shifting the cost of this advantage to all taxpayers.
- Moreover, this situation may encourage workers, who sometimes are well paid, to switch from the more costly private plans to the subsidized public plan.

  For 2007-2008, the advantage granted to members ages 18 to 64 represents 25% of the cost of medications in this category, an amount of $211 million.

[119] See above, page 124.

TABLE 10

Cost sharing– Public plan, 2007-2008
(forecasts, in millions of dollars)

	Gross cost	User contributions	Premiums paid by the users	Net government cost	
				(millions of $)	(%)
Employment assistance recipients	649.8	4.2	0.0	645.6	99.4
Persons age 65 and over	2,119.2	437.2	323.3	1,358.7	64.1
Members	832.5	226.3	395.2	211.0	25.3
TOTAL	**3,601.5**	**667.7**	**718.5**	**2,215.3**	**61.5**

Source: RAMQ forecasts, June 2007.

For the Task Force, this is an inequity to the detriment of the workers covered by the private plans. There is no valid reason for the taxpayers to assume this cost.

Recommendation

The Task Force recommends that the parameters of the public prescription drug insurance plan be amended so that the members assume the entire cost of the plan for their insured group.

This measure would have the effect of clearly establishing the insurance principle for this group, in opposition to the insurance principle that applies to the most disadvantaged people and to persons age 65 and over.

9.3.3 A warning from the private group insurance plans

The Task Force's mandate concerns funding of the public system. But the representatives of the employers and of the major central labour organizations both drew the Task Force's attention to the pressures exerted for some time on the group insurance plans jointly funded by the workers and their employers.

— Over the past twenty years, the premiums of the group health and dental insurance plans have grown rapidly. While inflation rose by 3% a year from 1987 to 1997 and 2% a year from 1997 to 2007 in Québec, the premiums of these plans increased by 8% per year for the twenty years considered.

— The progression of the prescription drug insurance premium, which was around 8% for the first ten years considered, averaged about 13% in the ten years after the Basic Prescription Drug Insurance Plan came into force.

❑ Worrying information

The information provided to the Task Force is worrying.

— If the situation continues to deteriorate, it is possible that many workers will abandon the coverage from which they currently benefit, due to their inability to bear the cost of the premiums.

— Workers who no longer have access to a private group plan are obliged by law to insure themselves in another way. Most of them would do so by enrolling as members of the public plan.

— Employers have the legal obligation to include prescription drug insurance, if the company has a complementary health insurance plan. To escape this obligation, companies could decide, together with the unions, to terminate the complementary plans.

— The consequence would be a reduction of the number of persons insured in Québec for care not covered by the public plan, such as dental care or care offered by optometrists. This would have a negative impact on the health status of these persons and would risk increasing the pressure on the public system.

❑ The Task Force's suggestions

For these reasons, the Task Force considers that the government should consider the warnings of the employer and union organizations and proceed, in concert with the employer and employee representatives, with a detailed review of the situation of the private group insurance plans.

It was also brought to the Task Force's attention that the private insurance companies in Québec do not exercise control of the list of medications they cover as tight as the control exercised over the public plan.

— The private companies of course have full latitude to determine their basket of insured services.

— In a context in which the private insurance plans are subject to major pressures which, in some cases, even threaten the viability of certain group plans, the private insurance companies would have to adopt measures to favour optimum use of medications.

— The private insurance industry should collaborate with the public authorities in studying this question.

PART 5
Mobilization of means: a productive and effective health care system

In formulating the central objective around which this report is constructed, the Task Force gave top ranking to the establishment of a productive and effective health care system[120].

To ensure the sustainability of the public health care system, we must increase its productivity, which means that we must mobilize the necessary means to offer the required services to the public.

These means are discussed in five chapters.

— **Chapter 10** is devoted to governance of the health care system: it is essential to embark on a new path and implement a new culture.

— In **Chapter 11**, the Task Force discusses the questions related to allocation of resources, identifying the means to make this an incentive-based and strategic tool favouring performance.

— **Chapter 12** puts the emphasis on human resources and their management, emphasizing the current difficulties and laying the foundations of a dynamic and effective work organization.

— **Chapter 13** presents the new body that the Task Force recommends be created, the Institut national d'excellence en santé – a credible and independent body, called upon to play a strategic role in the efficient operation of our health care system.

— Finally, **Chapter 14** proposes a set of initiatives to make new information technologies serve patients and managers.

[120] See above, page 3.

CHAPTER 10 – GOVERNANCE: A NEW CULTURE TO IMPLEMENT

Our health care system, by far, is the biggest and most complex organization in Québec. This organization operates 24 hours a day, 365 days a year, and affects every citizen without exception, in what is most fundamental to them and quite often when they are the most vulnerable.

Governance of such a system is extremely complex and constitutes a formidable challenge. The Task Force is aware of the efforts made to improve things. At the same time, it is convinced that many initiatives can be taken to improve this governance, and that this is a strategic means to increase the system's productivity significantly.

— We must begin by producing a portrait of this system from the perspective of its governance and operation. Positive changes have been implemented, but it must be agreed that our system's performance is still well below what it could be.

— Based on its findings, the Task Force concludes that a cultural change is necessary to build a coherent system of governance, all the components of which are oriented to satisfying the public's needs.

— Concretely, the Task Force formulates a set of recommendations and proposals concerning most of the aspects of the system's governance and management.

— Finally, the Task Force wishes to emphasize the necessity of evaluating performance and proposes that there be no hesitation about testing new management approaches.

What does governance mean?

The term governance ("gouvernance") is defined in Le Petit Robert, as "the manner of governing, the exercise of power to manage national affairs or the method of management of an enterprise".

Applied to the health care system, governance encompasses all the questions concerning the government and management of the different organizations composing this sector, from the Ministère de la Santé et des Services sociaux to the smallest care units composing the network and offering services to the public.

The concept of governance thus covers the definition of the missions and roles of each organization in the sector, the responsibilities assigned to them, the mode of appointment of their officers, their accountability, the preferred accountability approaches and the evaluation of the results obtained.

10.1 Our health care system from the perspective of its governance

The Québec health care sector is composed of an immense and complex network present throughout its territory. It is animated by thousands of doctors, nurses and workers whose tasks are never easy. The network consists of an aggregation of institutions of widely varied sizes and missions, specialty care, teaching and research institutes and hundreds of clinics and professional practices. It includes close to 250,000 workers, a great many of whom are highly skilled.

The health care network includes multiple activities of prevention, information and education, curative and palliative care, rehabilitation, residential care, training and research. It also mobilizes nearly half of the government's program spending. No other sector of public or private activity is close to health care in importance and complexity.

❑ Changes to be pursued vigorously

Over the past few years, many changes have been made to improve access and the quality of care and respond to the crises that have arisen here and there in the system. The CLSCs, CHSLDs and hospitals have been combined into 95 health and social services centres, the CSSS[121].

Other transformations have been made in the system's operation.

— The system's level of funding has been increased considerably.

— Agreements with the physicians have allowed the necessary catch-up in remuneration levels.

— The agreements include provisions intended to improve the quality, nature and follow-up of care.

— A substantial part of the collective agreements with the network's employees can now be negotiated at the local level.

Despite all these positive changes, the improvement of the effectiveness of the system and its components must be pursued vigorously. The priority must now focus on administration in the broad sense of the system, its governance, the funding modes, performance evaluation, development of best practices and effective utilization of information technologies.

Physicians, nurses and other health care workers told the Task Force about their fatigue, and the weariness and lack of motivation that are appearing disturbingly throughout their ranks. They want to regain their legitimate pride of being part of the big health care team, as they put it.

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[121] See above, page 21.

The question of governance was discussed with most of the individuals and bodies consulted. It resulted in a plethora of ideas and suggestions, most often pointing in the same direction. These ideas are largely recapitulated in this report. It is essential to continue the changes undertaken, but in many cases we must go much farther and not hesitate to implement a new management culture.

10.1.1 Basic findings not to be forgotten

At the beginning of this portrait of our health care system, from the perspective of its governance and operation, several extremely positive fundamental points must be recalled.

- A general agreement exists in Québec on the fact that the core values and foundations of our health care system remain valid and solid.
- In general, the health status of Quebecers stands up well to comparison with the outside world.
- For several years, our health care system has succeeded in operating, on the whole, with a lower level of funding than in the other provinces.
- As we have emphasized, several measures aimed at improving the system's performance have been adopted in the past few years. The priority given to the development of first-line care goes in this direction.
- On another level, the opening to negotiation of collective agreements at the local level and the reduction of the number of union bargaining units have opened up new perspectives in labour relations.

10.1.2 Governance compared to what is happening elsewhere

To better qualify the governance of the Québec health care system, the Task Force wanted to analyze what was happening elsewhere. The Task Force benefited for this purpose from an analysis of the governance of health care systems, based on the experience of the OECD countries, and produced at the government's request[122]. The Task Force also commissioned two studies on certain aspects of governance[123, 124].

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[122] Joanne Castonguay, Claude Montmarquette, Iain Scott, *Analyse comparée des mécanismes de gouvernance des systèmes de santé de l'OCDE*, Centre interuniversitaire de recherche en analyse des organisations (CIRANO), September 2007.

[123] *Le choix des priorités du "panier de services", la pertinence-efficacité-efficience des soins: des enjeux de financement*, Léonard Aucoin, InfoVeille Santé Ltée, October 2007.

[124] *Efficience et budgétisation des hôpitaux et autres institutions de santé au Québec*, Pierre Ouellette, Département des sciences économiques, Université du Québec à Montréal, November 2007.

❑ The OECD countries

From the outset, it is necessary to point out that all countries, except the United States, have the objective of ensuring universal and equitable coverage of health services.

— The literature on the reforms undertaken in the OECD countries emphasizes the importance of creating a coherent system of governance based on the objectives sought.

— All countries are faced with the same concerns, namely to control the growth of health care costs in a context of population aging, and to maintain or improve the universality of access to health services. There is no doubt that improvement of performance depends on improvement of the governance systems.

— All countries also have the objective of improving their system's reactivity. Many of them rely on the improvement of accountability, decentralization of responsibilities and incentives for greater empowerment, including the empowerment of service providers, patients and managers.

— The initiatives most often cited as indispensable to the improvement of productivity concern better knowledge of the costs, circulation of information, greater empowerment of the players through economic and administrative incentives, separation of responsibilities for funding and organization of the system and decentralization of the organization of services.

— In countries where contractual relations between the players are already developed, the reforms have sought to improve the effectiveness of the contracts.

— Where the systems are highly integrated, monopolistic and automatic, countries have reacted by developing market mechanisms, releasing information, creating incentives for the achievement of objectives, establishing control mechanisms and continuously improving their institutions and their contractual relations.

— Finally, the countries which have succeeded in slowing the growth of the costs of public health care plans have tackled the governance mechanisms of their system.

❑ The situation in Canada and Québec

Canada is included in a group of a few countries where the productivity of physicians and the health care systems has diminished regularly over the past ten years.

— The principal characteristic that differentiates this group of countries from those which have improved or maintained the performance of their health care system is centralization of funding and organization of services.

— In fact, all the countries with a decentralized health care system have improved or maintained the productivity of their health care system over the past decade.

— Canada is the only case – along with Australia – out of a sample of seventeen countries, where the hospital budget is established according to historical budgets and where the funding and organization of health services are assumed by the Ministry of Health.

In proportion to population, Québec ranks second in Canada in terms of physicians and 7th in terms of the number of nurses and nursing assistants[125].

In Québec, the productivity of all of the network's employees seems relatively low compared to the rest of Canada[126].

— The number of hours worked per health care network employee in Québec is the lowest in Canada.

— Productivity at work is constantly declining.

— Finally, full-time employees in the health care sector work an average of 41 weeks a year, which corresponds to 11 weeks of time off per year, including statutory holidays, vacations and sick leave – which is cumulative and does not have to be taken due to illness. These data are difficult to reconcile with the perception of the shortage of human resources in the network.

In Québec, a large proportion of the growth of public health spending in the past few years has been allocated to human resources – mainly in remuneration – and to medication[127].

This effort has resulted in a small increase in human resources, no growth in the number of visits to physicians or the number of hours worked, and an inability to limit the movement of nurses to the private sector. Despite major efforts and the improvement of the material conditions of health care workers, the public has derived few benefits.

Several structural measures put in place in Québec are relatively recent and must be given time to take effect. However, we are far short of the target, if we compare the situation in Québec to that of systems where clinical activities are really integrated.

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[125] See Table 11 below, page 182.

[126] Joanne Castonguay, Claude Montmarquette, Iain Scott, *Analyse comparée des mécanismes de governance*..., op.cit.

[127] See above, page 33.

— The structural changes made in Québec did not really affect the central function constituted by clinical activities.

— Several factors risk limiting the implementation of projects to measure clinical performance and the value of care.

  — The principal generators of clinical activities, the general practitioners and specialists, are not integrated into the governance and management of the health care system.

  — Even though there are integration efforts at the local level (CSSS), it nonetheless remains that the Québec care system, at the national level, is not really integrated into systemic management. There is a major problem of central governance. The roles and responsibilities, and especially the decision-making mechanisms among departments, agencies and institutions, are unclear.

  — In budgetary terms, the emphasis is placed on a balanced budget in the short term. Centrally determined budgetary silos do not favour the movement of funds between the budgetary envelopes for medications, physicians, hospitals and home care.

10.1.3 Management findings that are far from positive

The assessment of the management of our health care system is far from positive.

— The Ministère de la Santé et des Services sociaux is actively engaged in micromanaging the system. The decision-making process is highly centralized. For example, the Minister's approval is required to open a family medicine group or a specialized medical centre.

— All processes are instilled with a top-down culture. The legislation and regulations impose a rigid and detailed framework on managers at all levels. The *Act respecting health services and social services,* which originally included 160 sections in 1970, now has over 650.

— Strict and short-sighted cost control is added to this framework, with the consequence that there is scarcely any room for initiative in the management of care.

The system's administrative structures are heavy and restrictive.

— Our system has an imposing central structure, to which a regional structure of 18 agencies is added. This structure is expensive, mobilizing no less than $190 million a year – to which $100 million must be added for the administration of the Régie de l'assurance maladie du Québec. The mission of this costly structure is poorly defined.

— In general, the OECD countries have opted for a strong ministry and light regional structures or for the opposite, a more elaborate regional structure and a lighter ministry. For example, Great Britain only has ten regions, despite its population of close to sixty million.

— Budgets are allocated to the regional agencies by the MSSS according to a "historical" method, which fortunately is evolving towards a modulated populational approach.

— Budgets are distributed to the institutions by the agencies. They consist of a set of envelopes and indicators, which determine the purposes for which the budgets must be spent.

  Budgets are allocated on a historical basis – however, new approaches are beginning to appear[128]. According to the historical method, the relative performance of the CSSS and the hospitals in terms of productivity is not taken into account. Regardless of their performance – with certain exceptions –, the CSSS and the hospitals are all treated on an equal footing from the budgetary standpoint.

  The action priorities are established centrally, at the Ministère de la Santé et des Services sociaux, with little regard for the characteristics of the communities. Moreover, the institutions are overseen by the agencies by means of very detailed management agreements.

— The persons responsible for the institutions are thus subject to omnipresent constraints and their leeway is limited considerably. As if this were not enough, in many cases the budgets are only established late in the year.

In this system, the missions of the organizations at each level are not clearly defined, which reflects on the authority of the persons responsible for these organizations. The chain of accountability itself is not determined precisely. A situation is thus created where, from top to bottom, each person in the structure has a share of responsibility but nobody is ever fully responsible. Each is only partially responsible or accountable for the activities in his or her sector of activity.

This situation, which has heavy consequences, is also the cause of excessive politicization of our health care system for partisan ends.

— In the absence of clear empowerment rules, the inevitable incidents in such a complex system tend to be blamed on the person ultimately responsible. Very often, when there is a regrettable incident, the Minister of Health is required to explain himself to the National Assembly.

[128] Reference is made to the budget allocation for surgery. See above, page 24 and below, page 173.

— This deplorable situation has the effect of diverting attention from the real issues and pushing the MSSS even further towards micromanagement of the system.

Several stakeholders – including the renowned Henry Mintzberg[129] – warned against changing structures too frequently. These changes always necessitate adjustments and adaptation. In fact, they can be avoided, because it is often possible to modify the modes of governance without structural upheaval.

Finally, the performance of the institutions in terms of achievement of health or disease reduction objectives is not evaluated. All institutions are treated on the same footing regardless of their performance.

Finally, there is nothing in the system that gives managers an incentive to look continuously for the highest possible level of performance in terms of administration and health objectives.

If the manager wishes to improve his institution's performance, he does not have the necessary leverage for this purpose: everyone does not have the necessary information, the physicians do not have contracts with the hospitals, the collective agreements largely are negotiated at the central level, the professional corporations and the unions impose their professional qualification standards, and the priorities are established by the MSSS.

10.1.4 Repeated findings

The findings we have just presented are not new.

— In 1996, the Deschênes Committee was mandated by the Minister at the time to study the respective responsibilities of the MSSS, the regional boards – which since then have become regional agencies – and the institutions.

  Its report[130], deposited at the end of 1996, recommended the renewal of the MSSS in order to prioritize its strategic role, eliminate duplications with the rules, develop key indicators and generally organize performance and accountability.

— In turn, the Clair Commission, in its report deposited in December 2000, recalled that the principal recommendations of the Deschênes Committee still remained relevant[131], and implied that they had not resulted in action.

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[129] Professor and Cleghorn Chairholder with the McGill University Faculty of Management in Montréal.

[130] Deschênes, Jean-Claude... [et al.], *Examen des responsabilités respectives du ministère de la Santé et des Services sociaux, des régies régionales et des établissements, réflexions et propositions*, December 1996.

[131] Commission d'étude sur les services de santé et les services sociaux. *Emerging solutions– Report and recommendations*, 2000, page 213.

The Commission recommended in turn that the role of the MSSS be revised to put the emphasis on development of strategic orientations, health and social services policies and evaluation of results.

It also formulated a series of recommendations on governance, which are in the same spirit as those of the Deschênes Committee.

10.1.5 More general conclusions

More generally, the Task Force draws four conclusions from this portrait of our health care system, from the standpoint of its governance and operation.

These conclusions pertain to:

- transposition of policies,
- responsibility and accountability,
- structural changes,
- the existence of a two-headed management structure.

❑ Transposition of policies

In Québec, we produce excellent policy documents, but we are a long way from being as effective in implementing them. We know what to do, but we do not know very well how to do it.

- We have a tendency to believe that the essential has been accomplished when a law or a policy is adopted.
- Often, we do not pay enough attention to their concrete application, which nonetheless is just as important. It is necessary for this purpose that the persons responsible for the system ensure that the managers and professionals at the care level have the required latitude and access to adequate financial resources. This is the level where the action occurs, not at the level of the administrative structures.

Regarding care, which is the system's reason for existence, conditions must be created so that the persons responsible, managers and professionals can adopt the most appropriate means to meet the public's needs. Solutions must be provided where the action is, instead of waiting for instructions from the MSSS.

❑ Responsibility and accountability

Our health care system is based on solidarity and recognition of rights, but also on the obligations of everyone. These rights and obligations must be established

clearly and, when appropriate, must be covered by agreements clearly establishing the responsibilities of each party.

Managers must be in a position to manage the matters falling under their responsibility. Otherwise they cannot be held responsible for their actions. This criterion, too often ignored, applies to all levels of the organization.

The principle of accountability corresponds to the obligation to account for one's intervention and the results of one's actions. Accountability is the corollary of responsibility and must apply on the basis of results. The Task Force cannot overemphasize the importance of responsibility and accountability at all levels.

❑ Structural changes

The frequent structural changes over the years have sown uncertainty and disarray in the personnel of many institutions. The need for stability is manifest.

At this stage of our system's evolution, it is best to learn to operate with the structures in place at the service production level, despite their deficiencies, instead of replacing them. The Task Force thus has limited its proposals concerning structural changes to the highest levels of the pyramid.

❑ The existence of a two-headed management structure

In any organization, there generally is a chain of authority headed by a president or a general manager whose decisions are applied at all levels.

In our health care system, a two-headed management structure exists – that of the administration and that of the physicians. According to the old system of privileges that persists in our institutions, there are no contractual relationships between physicians and institutions – except in certain specific cases.

— The physicians, who are the principal generators of activities and costs at the institutional level, have full autonomy in relation to the administration. They exclusively decide what examinations are administered and what care is provided.

— The staff and equipment of the institutions are resources at the physicians' disposal, to some extent. The physicians' remuneration, established under centrally negotiated agreements, does not create any contractual relationship between them and the institutions. It is even transmitted through an external channel, the Régie de l'assurance maladie.

The result of this modus operandi is that the managers have little say in the organization of the clinical activities taking place in their institutions.

10.2 A cultural change based on principles

These findings do not mean that our health care system is in crisis. In fact, it is the administration of our system that is sick, as Henry Mintzberg affirms[132].

Very fortunately, the experience of the OECD countries shows that it is possible to reverse this situation.

— Our health care system is a monopoly installed at every level with the culture inherent to monopolies, whether public or private. This culture is based on regulation and budgetary controls, closed to the outside world, impermeable to real change, adaptation and innovation. It is a culture that favours inefficiency.

— The Task Force is convinced that a real cultural change is necessary. This change must depend on a coherence system of governance, in which all of the components are oriented to satisfying the public's needs.

❑ Four principles of governance

The term "cultural change" is very often overused. It takes on its full meaning in this instance, based on four principles of governance which should be applied to the health care sector and to its various component organizations.

— First, the culture of governance proposed by the Task Force supposes a clarification of the missions assigned to each of the organizations of the health care system. The missions entrusted to the system's different plays must be clearly defined, with the resulting authority – which is not currently the case.

— Secondly, this culture of governance implies a differentiation of the roles assumed by these same organizations. This means avoiding confusions and overlaps, with the repercussions this can have on the chain of accountability.

— Thirdly, it is important that the rights and obligations of each participant be specified under contractual agreements, made between the different organizations and players of the health care system – including the physicians.

— Finally and fourthly, the culture of governance desired by the Task Force supposes a certain number of orientations, such as decentralization and autonomy, and requirements regarding accountability, responsibility and evaluation.

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[132] In an interview published in the La Presse newspaper on May 12, 2007, Henry Mintzberg declared: "Health care systems are not in crisis … Their administration is in crisis… A differently designed management, more oriented to what is happening in the field, is one of the remedies to the problems of health care systems" (La Presse affaires, *Henry Mintzberg sur la gestion de la santé*, Montréal, Saturday, May 12, 2007).

For the Task Force, there is nothing abstract about these principles. They are very concretely embodied in a number of recommendations and proposals addressed to all the bodies and stakeholders constituting the health care sector.

10.3 Recommendations and proposals

The recommendations and proposals formulated by the Task Force apply at several levels:

- They address the governance structures of the health care network – essentially the Ministère de la Santé et des Services sociaux and the regional agencies.
- They challenge the service providers – the CSSS, but also the health clinics and the other institutions providing care to the public.
- They concern the nature of the contractual agreements established within the system among the various bodies and stakeholders that compose it.
- They apply to the boards of directors and the general managements of the different bodies and institutions.
- They seek participation by citizens, which should be understood as participation by patients and within the framework of the different decision-making processes concerning health.

10.3.1 Governance structures

One of the Task Force's essential recommendations is to distinguish clearly between the system's governance structures – the Ministère de la Santé et des Services sociaux and the regional agencies – and the service providers, that is, all of the institutions offering care to the public.

Two specific bodies should be associated with these governance structures: the Régie de l'assurance maladie du Québec and the new Institute the Task Force recommends be established, the Institut national d'excellence en santé.

❑ The path of decentralization

Eleven years after the Deschênes Report and seven years after the Clair Report, it must be noted that in terms of governance structures, the replacement of the regional boards with the regional agencies has further accentuated centralization of decision-making power at the level of the MSSS.

Most countries whose systems are funded by general taxation have, on the contrary, taken the path of decentralization to regional and local entities. Some of

these countries have populations similar in size to Québec's. We are referring to Denmark, Finland, Ireland, Norway and Sweden.

Even more significantly, Great Britain, whose health care system served as a model for Canada, has made a resolute commitment to regional decentralization.

❑ The Ministère de la Santé et des Services sociaux

In the past few years, several government departments and agencies have concluded that they were unable to provide their services effectively. The public domain introduces bureaucratic burdens and rigidities that render them ineffective in this regard. The search for gains in efficiency has led them to withdraw from providing services, so that they can concentrate on their real mission.

Similarly, it would be necessary for the Ministère de la Santé et des Services sociaux to concentrate on strategic planning and the achievement of health objectives.

To this effect, it should establish the health policy and objectives, define the list of insured services, establish national standards, allocate resources for capital and operating budgets to the regional agencies, establish performance indicators and proceed with evaluation and approval through designated bodies.

To initiate the process of decentralization and empowerment in our system, which is so necessary, the path to follow is clearly indicated.

— It would be essential to restore the primary mission of the Ministère de la Santé et des Services sociaux.

— This implies that day-to-day management of care delivery should be taken away from the MSSS and that it clearly withdraw from providing care.

— Despite the difficulties inherent in such an operation, this should result in a substantial reduction of MSSS staff levels and operating costs.

■ Capital expenditures in the network

The necessity of rational and justified development of institutions and their equipment no longer needs to be shown.

To avoid conflicts between the regional bodies and the Ministère de la Santé et des Services sociaux regarding the capital expenditures for certain major projects, each project should be the object of a strict evaluation before any decision or announcement.

— An evaluation must not only cover the needs and investments regarding the existing resources. Just as importantly, it must also integrate the impact on the future costs and operating expenditures.

— The planning and decisions regarding this important function must be clearly and exclusively under the authority of the Ministère de la Santé et des Services sociaux.

The assignment of this function to the Ministère de la Santé et des Services sociaux means that the institutions do not have the mission to make capital investment decisions in their territory. However, needless to say, the institutions should be consulted as part of the evaluation process.

Recommendations

The Task Force recommends that the mission of the Ministère de la Santé et des Services sociaux be refocused on the establishment of the health policy and objectives, the definition of insured services, the establishment of national standards, the allocation of resources for the purposes of capital and operating budgets to the regional agencies, the establishment of performance indicators, and evaluation and approval through the designated bodies.

The Task Force recommends that the Ministère de la Santé et des Services sociaux withdraw from providing care as such.

■ CHUM and MUHC

It was not part of the Task Force's mandate to evaluate the deployment of resources according to care, teaching and research needs. The Task Force did not have the means or the necessary time to proceed with such an evaluation. The Task Force made one exception to this rule, without calling the MSSS policy into question, by proposing that the development of first-line care be accelerated.

Stakeholders informed the Task Force of their reservations regarding the CHUM and MUHC construction projects. The Task Force considers that these two projects should be explained further, so that their rationale is better understood by Quebecers.

■ La Régie de l'assurance maladie du Québec

The Régie de l'assurance maladie du Québec is a central governance structure of the health care system.

There is no reason to modify its mission as payor under agreement with the professional associations. However, it is possible that, under agreements between the regional agencies and the care providers, funds intended for the remuneration of physicians can pass through other channels.

■ The Institut national d'excellence en santé

The Task Force devotes a specific chapter to the creation of a new body, which it proposes to call the Institut national d'excellence en santé[133].

This institute would be called upon to play a strategic role of the utmost importance. Like bodies of a similar nature, it should enjoy a broad degree of independence. It is only on this condition that it would have the credibility and impartiality necessary for the performance of its important mission.

In the accomplishment of its mission, the Institut national d'excellence en santé would have to account for the clinical, technological, economic and ethical dimensions of the questions on which it would be asked to give its opinion. In particular, it would have to evaluate the cost-effectiveness ratio of current and new technologies and medications.

Regarding governance, we will later see the suggestions formulated by the Task Force concerning the composition of the board of directors of the new Institute, the recruiting of its staff and the relations it should establish and develop with bodies of a similar nature located outside Québec.

❑ The regional agencies

All the health care systems analyzed have regional structures. The rationale of these structures generally is to allow the organization of care to adapt to the realities of the different environments, while decentralizing the system.

In Québec, given the immensity of the territory and the marked differences between major regions, there is no doubt as to the necessity of regional structures.

However, the mission and status of the regional agencies are not clearly defined.

— The agencies do not have the necessary autonomy to constitute decentralized entities.

— They are not regional offices of the MSSS, because they are governed by boards of directors.

— In several cases, the size of the agencies does not allow them to be effective in assuming the responsibilities of a true regional entity.

[133] See below Chapter 13, page 195.

■ Purchasers of services

For the Task Force, the regional agencies must have a precisely defined mission:

— The regional agencies should be the bodies mandated to translate the national policy and priorities into implementation strategies in their territory.

— They should do so as purchasers of services from all of the institutions likely to meet the health care needs.

To fulfill this mission, the regional agencies should benefit from broad autonomy:

— The regional agencies should be responsible for management of the financial resources that would be allocated to them by the MSSS under contractual agreements with the MSSS.

— As purchasers of services, the regional agencies would make agreements with all the service providers on which they would call– CSSS, health clinics, community organizations and other existing institutions.

— These agreements should include health objectives and clinical and financial performance objectives.

— In the agreements made with the CSSS, the regional agencies would ensure that the deployment of the national policy and priorities do no suffer from domination by the hospitals.

— The regional agencies would particularly have the responsibility of ensuring the deployment of health clinics in their territory.

— The regional agencies should publish each year, at the time considered most appropriate, an annual report that accounts, in particular, for the results obtained in relation to the objectives and indicators established under the agreement made with the MSSS.

Recommendation

The Task Force recommends to the government that the regional agencies have the mission to translate the national policy and priorities into implementation strategies in their territories, as purchasers of services from care and service providers, and that they benefit from broad autonomy for this purpose.

■ A limited number of agencies

The Task Force suggests that the regional agencies, currently eighteen in number, be combined into six to eight entities.

— Such a number would allow each entity to cover a fairly large population, with reasonably homogeneous characteristics.

— Each entity thus would have a size allowing it to have the staff levels necessary to accomplish its mission and would have real negotiating capacity.

— The agencies should be combined by accounting for geographic proximity, common service pools, established service corridors, population size and habits of interregional collaboration.

10.3.2 Service providers

Clearly distinct from the governance structures of the health care system, the service providers would include all institutions, health clinics and other providers called upon to provide care for the benefit of public.

The Task Force specified the rules of governance that should be observed by the principal service providers – the CSSS and the health clinics –, while mentioning the various other institutions contributing to provide care to the public.

❑ The health and social services centres (CSSS)

The CSSS were created in 2004.

— With their partners, and in their respective territories, they assume responsibility for care and services under clinical and organizational projects.

— The CSSS must also ensure coordination among the hospital centres, CHSLDs, clinics and community organizations in their territories.

■ Broader autonomy, accompanied by increased accountability

Essentially, the CSSS are care providers. To perform their mission effectively, they must be able to benefit from a large degree of autonomy. In consideration of this increased autonomy, they must be fully responsible and accountable for their management.

■ Empowerment and accountability

The CSSS are responsible for the allocation of resources among the entities under their governance. In this task, it would be necessary to avoid favouring hospital

activity to the detriment of the other institutions and clinics placed under their jurisdiction.

The contractual agreements made between the regional agencies and the CSSS should specify that the allocation of resources will not suffer from hospital domination.

For the entities under CSSS responsibility to be able to play their role fully, a new organizational dynamic will have to be developed. The management agreement, administrative restrictions and directives must be replaced with contractual agreements and economic incentives based on the achievement of health and disease reduction objectives.

As a responsible entity, each CSSS should publish an annual report each year, at the time it considers most appropriate, illustrating, in particular, the results obtained on the basis of the established objectives and health indictors. Moreover, the relative performance of the institutions should be widely publicized.

❑ Other institutions

Along with the CSSS, a number of institutions are also major service providers within the health care system.

These institutions[134] have special statuses, due to certain components of their mission which are inherent to them. Reference is made, in particular, to the university hospital centres (CHU), affiliated hospital centres (CHA), youth centres, rehabilitation centres, and all institutions supporting the supply of services.

The governance rules defined above must be applied to them. These institutions must be fully responsible for their financial resources and their professional and technical staff and must account for the results obtained.

Recommendation

The Task Force recommends that the CSSS and the other institutions benefit from a large degree of autonomy and the means to assume their responsibilities, and that in exchange, they be fully responsible for their management.

❑ Health clinics

The Task Force emphasized the central role of first-line services in the effectiveness of the health care system as a whole.

[134] On the concept of institution in the Québec health care system, see above, page 20.

— The main consequence of insufficient access by the public to first-line care is to reduce the quality of care and increase the costs of the system[135].

— The care systems that base the delivery of services on strong first-line organizations are also those in which the population is healthier and often the most satisfied with the services received[136].

To strengthen the first line, the Task Force recommends that the priority be given to accelerated deployment of health clinics[137]. The Task Force wanted to specify the rules of governance that the health clinics should observe, in accordance with the principles formulated above.

— The health clinics should be fully responsible for management of their financial resources and their professional and technical staff. To this effect, it would be necessary that their mission and their health and disease reduction objectives be established under contractual agreements with the regional agency in their territory.

— Improvement of takeover of patients depends on collaboration between the hospital centres and the medical clinics. A contractual relationship between the two entities should be established to this effect, so that the hospitals can download the first-line activities they still perform. Moreover, financial incentives would have to be established to encourage collaboration between the hospitals and the clinics and between the different professions.

— The clinics should be released from bureaucratic restrictions and have the necessary leeway to develop dynamically, according to the model that suits them best. However, it is essential to the efficient operation of the system that they be able to evaluate their performance on the basis of their health and disease reduction objectives.

— Like the regional agencies and the CSSS, the health clinics should produce a report once a year on their utilization of public funds.

The same principles of governance must apply to the specialized medical clinics and the associated medical clinics[138].

Recommendation

The Task Force recommends that the health clinics be fully responsible for their financial resources and their professional and technical staff and that, in exchange, they be fully accountable for their management.

135 See above, page 78.

136 *Modes d'organisation des services prometteurs*..., op. cit.

137 See above, page 81.

138 On the associated medical clinics and the specialized medical clinics, see above, page 91.

10.3.3 Contractual agreements within the system

Regarding governance, the Task Force recommends a health care system based on recognition of the rights and obligations of each person, as indicated in the social contract outlined at the beginning of the report[139].

This recognition of the rights and obligations of each person should take the form of contractual agreements made between the different partners. Such a generalized system of contractual agreements exists in the European countries.

❑ Contractual agreements between the physicians and the clinical institutions

This principle must also apply to the physicians. The current situation is an obstacle to good governance: since physicians have full autonomy within their institutions, the persons responsible for the institutions have to manage complex care and service organizations, without having any say in the organization of clinical activities.

Such a situation must be corrected.

— The rights and obligations of physicians should be established in contractual agreements between them and the institutions and the clinics.

— While respecting the physician's professional freedom, these agreements should establish the physician's obligations to his institution, and the modalities of his remuneration for everything that is not fee-for-service.

Recommendation

The Task Force recommends that the health care system be based on the rights and obligations of all stakeholders, including physicians, by means of contractual agreements.

10.3.4 The boards of directors and executive directors of the regional agencies and the institutions

The consultations allowed the Task Force to observe that the boards of directors of the regional agencies and the institutions do not play a significant role in the system. There is confusion regarding their role.

— Some of the members of the boards of directors are both judge and party, resulting in a conflict of interest.

[139] See above, page 7.

— According to a report by the Auditor General[140], good governance practices are not applied by these bodies.

— Finally, accountability regarding their activities is almost nonexistent.

Each regional agency and each institution should be governed by a board of directors whose primary responsibility is to ensure effective management of the resources allocated to them.

— The notion of representatives in the appointment of the members of the board of directors must be abandoned. On the contrary, the members of the boards of directors must be independent persons, chosen according to their competence and good judgment – and on the basis of their ability to ensure effective management of resources.

— The boards should be composed of a limited number of members. The Task Force suggests that the boards of directors be composed of five to seven members, which seems optimal for the discussions to run smoothly.

— The Task Force also recommends that the members of the boards of directors be remunerated, in view of their responsibilities –and to ensure quality recruiting. The Task Force here reiterates one of the reforms introduced by the government in its policy on governance of government corporations[141].

The Task Force thus makes the following recommendations.

Recommendations

The Task Force recommends that each regional agency and each institution be governed by a board of directors, whose responsibility is to ensure effective management of the resources entrusted to them.

For this purpose, the Task Force recommends that the boards of directors be composed of a limited number of independent members, chosen on the basis of their competence, and that they be remunerated.

[140] Rapport du Vérificateur général du Québec à l'Assemblée nationale pour l'année 2007-2008, tome I, chapitre 4, *Gouvernance dans les agences et les établissements publics du réseau de la santé et des services sociaux*, page 84.

[141] Ministère des Finances du Québec, *Modernizing the Governance of Government Corporations: Policy Statement*, April 2006 and *Act respecting the governance of state-owned enterprises and amending various legislative provisions* (Bill 53).

❑ The executive directors

In the performance of its duties, it is the board of directors which should be responsible for the appointment and, if necessary, the dismissal of the executive director of the regional agency or the institution.

— In view of the importance of his functions, the board of directors must have responsibility for appointing the most competent person to hold the position of executive director.

— It must be recognized in this regard that the executive directors are called upon to manage complex institutions and budgets amounting to tens and even hundreds of millions of dollars. The Task Force is convinced that the pay scales should be increased, so that they compare more closely to comparable positions in organizations of the same size.

— Finally, the executive director and his team should receive a monetary incentive if the agency or the institution achieves the health and disease reduction objectives within the budgetary envelope allocated for the territory.

10.3.5 Citizen participation

In formulating its recommendations and proposals on governance, the Task Force ensured that citizens will be heard and have a say – both as patients and within the context of the different decision-making processes concerning health care.

The analysis of foreign experiences – particularly that of Catalonia – indicates the importance and interest of ensuring citizen participation.

❑ Patients

A structure and a process for handling user complaints already exits in the health care network. This structure is probably perfectible but it seems to function well.

The Task Force does not recommend any change to this mechanism. Within the context of the evaluation of the institutions' performance, however, the report suggests that user satisfaction be measured systematically[142].

❑ Citizens

Citizen participation in decision-making processes involves several advantages, which the Ministère de la Santé et des Services sociaux has explicitly recognized[143].

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[142] The evaluation of the institutions' performance is discussed below, page 167.

[143] Ministère de la Santé et des Services sociaux, *La participation citoyenne au cœur de la responsabilité populationnelle*, 2006, page 11.

— Citizen participation allows gathering of valuable information on their preferences.

— It contributes to better informed decision-making.

— It institutes a dialogue between the population of the territory served and the health services.

— It also constitutes a factor of social cohesion and individual empowerment.

The Task Force is convinced that citizen participation must be concretized at various times in the decision-making processes concerning health care.

— When the Minister establishes general objectives under a health or welfare policy, he must ensure that his orientations are the object of consultations.

— For the Task Force, it is important that some seats be reserved for the general public on the board of directors of the Institut national d'excellence en santé – the institute that it recommends be established[144].

  The Task Force also asks that this institute create citizen participation bodies within the context of the review of public coverage and the adoption of the care protocols. One of these bodies could be a permanent public forum, such as the one constituted by the Health and Welfare Commissioner.

— The regional agencies already each have the responsibility of establishing a public forum in each region of Québec to consult the public. It is important that these forums be established quickly, wherever this has not already been done, and that they have the necessary means to play their role effectively.

— Major decisions are made at the CSSS, and they have a significant impact on all health services provided in the territories concerned. The Task Force suggests that the CSSS be required to provide for permanent public information and consultation mechanisms in order to discuss the orientations adopted and the services provided.

These different citizen participation mechanisms must be complementary and coherent. It is up to the Ministère de la Santé et des Services sociaux to see to this.

10.4 Evaluating performance, testing new paths

In matters of governance, it is absolutely essential to evaluate the results obtained and thus measure the performance of organizations regularly.

It is also essential to be permanently open to innovations in management, and the best way to qualify them is to provide for pilot projects.

144 See below, page 198.

10.4.1 Performance evaluation programs

Several health care systems have engaged in performance evaluation programs. These programs have the purpose of verifying the extent to which the different objectives are achieved. Thanks to evaluation programs, citizens and taxpayers can find out the effectiveness of the care providers and know whether the dollars allocated to health care are well spent or invested.

Several objectives of different natures are generally pursued:

— The evaluation serves to compare the productivity of the system as a whole with the systems of other jurisdictions. The system's productivity is evaluated to recognize the positive or negative progress from year to year.

— The objectives of the health policy are also evaluated. In particular, we are thinking of the reduction of mortality or disease by certain causes, and the achievement of the objectives of the public health programs – such as vaccination and obesity reduction.

— The goal is to inform the public about the level of performance of the care providers.

— The performance evaluation seeks to identify particularly productive programs or management modes. Information about them can create healthy emulation and positive spin-off.

The evaluation programs also constitute an essential element of performance improvement incentives, from the clinical and economic points of view. Since these mechanisms all have the purpose of motivating the stakeholders, they can take varied forms.

— Institutions with good performance, for example, can retain the margins they generate and invest them locally for purposes they consider useful.

— As another example, institutions which have maintained a high performance level for a period of time will be granted greater autonomy.

— The programs developed particularly in Great Britain, the Scandinavian countries and Catalonia, and by organizations like Kaiser Permanente in the United States, can serve as excellent models from which we should draw inspiration.

The network of Québec institutions and clinicians have not developed a culture of measuring the quality of care and organizational performance.

— Over the past few years, the emphasis has primarily been placed on accounting and cost control – which, among other results, arouses clinicians' suspicion regarding the notion of performance.

- Québec physicians and other clinicians to date have shown little interest, if not resistance, to measurement of the quality of care and clinical performance.
- Comparisons between institutions often have focused only on unit costs and volumes of activities.
- The notion of value in the sense of the relationship between the result achieved and the costs is relatively absent.

Québec is very far behind several countries in terms of performance evaluation.

As in the case of these countries, it is absolutely essential to engage in the evaluation of clinical and financial performance and the degree of patient satisfaction[145].

- The Ministère de la Santé et des Services sociaux should be responsible for the policy of evaluation of the system as a whole.
- It should also ensure that the regional agencies effectively perform their responsibilities to the institutions, first-line care providers and home care providers.
- The development of indicators could be entrusted to the Institut national d'excellence en santé.

Recommendations

The Task Force recommends that a well-structured, complete and systematic program be established to evaluate institutional performance in relation to the health objectives and the clinical and economic points of view, and to evaluate patient satisfaction.

The Task Force also recommends that the results of the evaluations be publicized periodically.

The Health Council of Canada reports on the health of Canadians and inventories the changes in Canada that improve the performance of the health care systems in terms of quality, health objectives and costs.

Québec has chosen not to participate in this initiative. It is not up to the Task Force to call this decision into question. However, the Task Force considers that it would be advantageous to establish an exchange of information with this Council. A useful scale of comparison could thus be established.

[145] See above, page 161.

10.4.2 Testing other management modes[146]

In our health care system, the hospitals are all structured and administered according to the same mode.

- They are held by non-profit corporations.
- They are governed by a board of directors, the composition of which is fixed by law.
- Their two-headed management is shared between the executive director and the director of professional services.
- They are funded by budgets which favour the status quo instead of encouraging innovation and performance.

The introduction of the changes proposed by the Task Force inevitably will encounter tenacious resistance. In the majority of hospitals, a culture has developed of submission to regulation and the directives of the Ministère de la Santé et des Services sociaux, in which there is little room for dynamism and innovation.

Moreover, as already mentioned, we cannot lose sight of the fact that the hospitals absorb the lion's share of public health spending: the aggregate expenditures of all institutions represented no less than $14 billion in 2008. The hospitals, without contradiction, present the greatest potential for productivity gains.

However, there is more than one way to structure and manage hospitals.

- The European countries and the United States offer interesting examples to this effect.
- In Great Britain, the opening of the system to new ways of doing things allowed the creation of about 85 new hospitals over the past few years.

Proposal

The Task Force considers that the implementation of demonstration projects with the aim of testing other hospital management modes could identify fruitful new paths and make interesting comparisons of effectiveness and performance at different levels.

[146] This section is the object of a dissenting position by Mr. Michel Venne, see Appendix 3, page 277.

The administration of a non-profit hospital could be contracted to a specialized management company or a health foundation.

- The mission and the necessary requirements regarding safety and the quality of care would be established in the contract.
- Care would either be purchased by the public system or paid for by the patients who would choose this option within the context of a controlled decompartmentalization of medical practice.

The performance of one or two hospital projects constructed in public-private partnership and administered according to a new model would introduce a refreshing element of dynamism and emulation into the health care system, in addition to meeting needs that otherwise risk remaining largely unsatisfied.

Montréal's northern and southern suburbs offer interesting potential for the launch of one or two projects of this nature. This is where the population is growing fastest in Québec, and there is a real deficit of acute care beds.

CHAPTER 11 – AN INCENTIVE-BASED AND STRATEGIC ALLOCATION OF RESOURCES

The importance of public health spending and its extremely rapid growth threaten the system's sustainability.

These expenditures can be used as a management tool to improve the effectiveness of our system, increase its productivity – and thus ensure that its increase adjusts to the growth rate of collective wealth.

The World Health Organization says nothing different in its report published in 2000, when it points out that a "health care funding policy can and must establish mechanisms and incentives to favour objectives of quality, relevance, efficiency and equity, both in the allocation and utilization of resources"[147].

❑ Allocation of resources: a tool for performance

The Task Force focused specifically on allocation of resources, namely the way public resources are utilized in our health care system.

The modalities whereby resources are allocated within the system represent a powerful tool for performance and effectiveness. It clearly seems that this tool is not really exploited in the case of Québec.

11.1 The current resource allocation system

According to the budgetary system, the Ministère de la Santé et des Services sociaux initially allocates resources among the regions. Each agency in turn distributes its regional budget among the institutions and agencies located in its territory.

These two major stages of the current budgetary system must be clearly understood before identifying the improvements that could be made to them.

11.1.1 Regional allocation

The proposals on governance presented above imply that the regional agencies have the mission to translate the policy and the national policies into implementation strategies in their territory[148]. They would be allocated the necessary financial resources to accomplish their mission under agreements with the Ministère de la Santé et des Services sociaux.

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[147] *The World Health Report 2000…*, op. cit., page 54.

[148] See above, page 160.

To perform its mission, each agency should receive its fair share of resources, according to a mode of allocation that recognizes the needs of each region's population. In other words, the allocation of resources at this level should be based on the principle of regional equity.

In 2004-2005, the Ministère de la Santé et des Services sociaux introduced a new mode of populational sharing of resources among the regions.

— The aim of this approach is to share the available envelope equitably among the regions.

— The envelope is reviewed periodically to make it more sensitive to variations in regional characteristics.

The new mode of allocation revealed the existence of inequities in the distribution between regions. These inequalities, which resulted from the budgets established on a historical basis, are in the process of being eliminated.

The populational approach appears to the Task Force to be both appropriate and equitable. According to the testimony gathered, it seems to be well accepted.

Moreover, the MSSS allocates amounts annually to the regional agencies determined according to additional production objectives, in order to favour access to surgery. These amounts are defined on the basis of a cost per case, and they depend on the production level achieved.

11.1.2 Institutional budgeting

Almost without exception, the individuals and bodies consulted severely judged the budgetary process at the institutional level. Their remarks agree with the findings of the various studies performed at the Task Force's request.

❑ A historical approach

The institutional budgets are established according to a historical approach.

— According to this approach, the budgetary envelope for a given year is very largely established on the basis of the previous year's envelope[149].

— It is indexed mainly according to salary adjustments, without real consideration of institutional performance, evolution of volume and the burden of care.

— In this essentially historical-based budgeting system, the hospitals' performance is not evaluated and the managers know it. The system primarily aims at close control of the institutions' activities.

[149] However, incipient progress is noted since 2004 with the resource allocation modalities related to "surgical production" - see above, page 24.

In its report, the Clair Commission emphasized the necessity of a fundamental change of approach to funding. According to the Commission, resources must no longer be allocated on a historical basis, but according to the desired organization of services, the needs of the population and each entity's performance.

❑ Budgeting that is no longer adapted to reality

Historical-based budgeting is no longer adapted to the reality of today's institutions.

— It encourages them to continue along the same path, without requiring them to take advantage of the possibilities available to them to provide services to patients more effectively. The people who are most familiar with the situation in the field end up farthest from the decision-making.

— Moreover, the institutional budgets are fixed regardless of their performance levels.

In fact, this method does not allow the hospitals to adapt and has the effect of disempowering administrations.

Thus, it would be unfortunate for the Ministère de la Santé et des Services sociaux to act on its project to accentuate its controls even further, by the introduction of a more restrictive method – such as the one proposed in the report on reassessment of the mode of budgeting of general and specialty hospital centres[150].

❑ A management framework that does not encourage efficiency

The current management framework is also far from a model of encouraging efficiency.

— In many cases, the hospital administrations have become bureaucracies mandated to manage the network's resources according to the budgetary framework imposed by the government. For managers, following the rules is a source of job security. However, an innovation that is costly in time and effort could eventually reduce the budget.

— Superimposed on this regulatory framework is the fact that the MSSS is unable to compare what is happening in the field, due to a lack of valid information and method accepted by the institutions. This is the result of the typical bureaucratization of a system.

[150] *La budgétisation et la performance financière des centres hospitaliers*, rapport du Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés. Ministère de la Santé et des Services sociaux, 2002.

❑ A conclusion is necessary

The day-to-day behaviour of hospital administrations has been defined in very great detail, by imposing a framework intended to define exactly what each must do.

Since accountability is deficient, due to a lack of relevant information, seeking efficiency is not a priority.

It must be added that nothing in the accountability system encourages innovation. We must also add that any change in the established rules could become a source of conflict with the unions.

Over the years, the emphasis has been placed primarily on accounting and cost control, which can only arouse clinicians' suspicion of the notion of performance. This situation has the effect of pitting managers and clinicians against each other: any additional expenditure can be perceived as a threat to the balanced budget, and any attempt at savings as a threat to the quality of care.

11.2 A new approach: purchase of services

All industrialized countries have proceeded to modify their institutional budgeting mode more or less profoundly, with the aim of better controlling the increase in health care costs.

— These modifications result from one common finding: the former budgeting modes lack any incentive for efficiency.

— To counter this deficiency, the new modes essentially are based on funding of services rendered.

❑ A new budgeting mode

In the British system, with which our system has many affinities, a new mode of activity-based budgeting, or purchase of services, was introduced. In the regions where this mode is implemented, the results are convincing. France and many other countries have embarked on this path.

However, it is emphasized that this type of change involves modifications throughout the system and requires time. In Great Britain and France, the introduction of the new mode is being spread over several years. This requirement is explained by the need to train the existing managers in the new reality.

In its 2000 report, the World Health Organization confirms the potential of this mode of funding. According to the WHO, purchase of services is an effective way to improve the performance of health care systems. When a passive model is in place, the system should switch to a form of strategic purchasing, under which

proactive decisions are made regarding the types of services that must be purchased, from whom and on what terms[151].

❑ Purchase of services mode

According to the purchase of services mode, the regional agencies would become the buyers for the population in their territories.

— They would be responsible for negotiating the agreements with the service providers, namely the institutions and the health clinics.

— In other words, the purchasing and care providing functions would be clearly separated from each other, as we saw in the previous chapter[152].

The care providers – the CSSS, hospitals, clinics, and long-term care institutions – in fact, all of the health care institutions, would then have the necessary latitude to organize the production of their services as effectively as possible.

— They would receive, not predetermined budgets, but revenues according to the services rendered to their patients.

— The institutions thus would have a financial interest in serving their patients well, because the money would follow the patients instead of preceding them.

— In accordance with the purchasing method, the patient would be considered a revenue source, instead of being perceived as an expense. This change would mean that the hospital would be patient-oriented. It would no longer consider the patient as an expense factor. The hospital would be given the incentive to adopt the most effective management methods, including subcontracting.

❑ The way to determine the amounts paid

The way to determine the amount paid is important. Several countries have decided to innovate on this question, in order to bring the purchasing mode into line with their needs and philosophy.

Most of the industrialized countries have adopted a DRG (Diagnosis Related Group) system[153].

— This system makes it possible to define the groups of patients who require nearly the same intensity of care, and thus the same costs. The general idea is to link the reimbursement paid by the government to the intensity of the resources used.

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151 *The World Health Report 2000...*, op. cit., page 54.

152 See above, page 156.

153 See above, page 24.

— This system presents another major advantage: it largely eliminates negotiations, because the government is no longer involved in micromanaging the hospitals. Its introduction in Québec thus could result in a reduction of the administrative staff levels in the health care sector.

❑ Impact on the quality of care

It must be asked whether the purchase of services mode and the way the amounts would be paid are compatible with maintenance of the quality of care. In other words, is it possible to trust the hospitals in this regard?

In practice, the answer to this question is positive, provided that the level of payments allows the hospitals to cover their costs and that they can keep the profit if they do their job well enough.

Moreover, the purchase of services method requires an effective system for accreditation and periodic evaluation of institutions.

❑ Asking the real question

The purchase of services and the determination of the amount paid that accompany it present the additional advantage of inducing the system's various players to ask themselves the real question – namely what institution provides the best services at the best cost, for a given need.

With the purchase of services method, what is most important is that the services be provided. The debate pitting the public sector against the private sector would become partly devoid of meaning, because the level of payments would remain the same, regardless of which sector provides the service.

❑ A mode applicable everywhere

Finally, the introduction of a purchase of services mode is possible both in the regions and in the urban centres. The objective is not to introduce local competition, as some may think. In any case, such competition is impossible in the absence of more than one hospital in a given territory.

The objective is to orient the hospital to the patient, free the managers from excessive restrictions, set objectives, favour the search for efficiency and measure performance.

The recommendation made by the Task Force thus is very clear.

Recommendation

The Task Force recommends that for institutional funding, the historical-based budgeting method be replaced with the purchase of services method.

❑ A condition: availability of a good information system

The Task Force is convinced that a purchase of services mode could and should be implemented in our system.

— The information and databases necessary to implement the new mode exist.

— The information system or the software making it possible to obtain the cost per care episode in the institutions also exists. According to a very recent study performed for the Task Force, the proportion of institutions that have computerized systems allowing costing of treatment of disease more than doubled between 2000 and 2007, from 20% to 42%[154].

  This software is an integrator of clinical and administrative data of different information systems existing within the institutions. In particular, it validates the quality of information and establishes costing per care episode.

  The information thus is available in real time, which constitutes an enormous advantage over the current administrative systems of the Ministère de la Santé et des Services sociaux, which require a two-year delay.

Having information on the costs per care episode is crucial, because this information can improve institutional performance. It becomes possible to know the factors that determine the costs and explain the variances, and to compare performance year after year and between institutions. This information helps establish budget forecasts in relation to the actual activities of the institutions.

❑ Gradual implementation

The preparation and training of all the stakeholders involved in such a program are just as important as the technological aspects.

— Indeed, a negative attitude exists at all levels in our health care system regarding any measurement of institutional performance.

[154] *Intensité du déploiement des technologies de l'information dans les établissements de santé au Québec*, Guy Paré and Claude Sicotte, HEC Montréal, Canada Research Chair in Information Technology in Health Care, Expert report submitted to the members of the Castonguay Committee, October 24, 2007.

— A phased implementation program should be put in place, the first phase being debugging and demonstration. A region recognized for its openness to innovation could be chosen for this purpose.

Proposal

The Task Force proposes that the purchase of services method be implemented gradually, starting with a pilot region, to allow enough time for training and acquisition of the necessary information tools.

❑ Incentive budgeting: a cultural change in the institutions

As previously mentioned, the slowdown in the growth of public health spending, coupled with an improvement of the accessibility and quality of care, cannot be obtained without a cultural change[155].

Cultural change is a very difficult challenge for an organization. Such a transformation is possible, however. In Europe, incentive-based budgeting has emerged as the only solution, despite the many instances of reluctance in the health-care networks.

Based on various European experiences, it is found that the budgets allocated to hospitals must be linked to what they produce, and not to the amount of past expenditures. What is paid for a health care service must be fairly identical, regardless of the producer.

In the current system, the managers and the professionals, including physicians, nurses and others, operate according to the incentives or messages transmitted to them by budgets established on a historical basis.

Their work methods and the collaboration established between them can allow them to perform below the average cost. It will then be up to them to benefit from the leeway thus released.

These messages or incentives must be modified, and this can be achieved by using the purchase of services mode. Instead of managing expenditures, the managers and professionals work as a team to produce health and reduce disease. It must be in their interest to pursue the new orientation. Otherwise, the expected changes will not happen.

[155] See above, page 145.

CHAPTER 12 – A DYNAMIC AND EFFECTIVE WORK ORGANIZATION

The health care sector is a service sector, in which human resources constitute the basis and foundation of the care offered to the public.

As has been emphasized since the first pages of this report, the Task Force considers that the sustainability of the public health care system will only be assured to the extent that we are able to increase its productivity – to adjust the growth of public health spending to the growth rate of collective wealth, while improving access to care and the quality of services.[156].

This demanding objective cannot be achieved without skilled human resources, meeting the public's needs, whose work is planned and supported by a dynamic and effective work organization.

The Task Force is convinced that the work organization in the health care sector is one of the keys to solving the current challenges.

— The persons and bodies consulted by the Task Force presented a critical picture of the situation in the institutions, characterized by bureaucratism and confrontation. These findings are not new. They must be analyzed lucidly.

— New work organization models are at our disposal, and some of them have begun to prove themselves, even in Québec.

  The Task Force has highlighted the principal characteristics of these models with a view to formulating recommendations and proposals to allow their implementation. These recommendations and proposals are based on the conviction that it is possible to provide solutions to labour relations problems through the work organization.

[156] See above, page 3.

12.1 The current situation: bureaucratism and confrontation

The importance of human resources in the health care sector can be measured in a few statistics. In the 300 institutional establishments and the 2,000 medical clinics of the network there are nearly 8,000 general practitioners, over 8,000 medical specialists and 2,400 medical residents at work. On the whole, the network relies on nearly 240,000 employees, including 100,000 nurses, nursing assistants and patient attendants[157].

TABLE 11

Number of nurses and physicians, Canada and provinces, 2006

	Population	Nurses		Nursing assistants		Physicians	
		Number	Nbr / 100,000 h	Number	Nbr / 100,000 h	Number	Nbr / 100,000 h
Newfoundland and Labrador	508,713	5,515	1,084	2,639	519	1,018	200
Prince Edward Island	138,164	1 428	1,034	599	434	207	150
Nova Scotia	934,562	8,790	941	3,174	340	2,049	219
New Brunswick	748,622	7,680	1,026	2,646	353	1,325	177
Québec	7,674,632	64,014	834	17,104	223	16,533	215
Ontario	12,740,721	90,061	707	25,084	197	22,141	174
Manitoba	1,180,479	10,902	924	2,652	225	2,125	180
Saskatchewan	990,152	8,480	856	2,224	225	1,571	159
Alberta	3,430,221	25,881	754	5,614	164	6,574	192
British Columbia	4,348,583	28,840	663	5,412	124	8,635	199
Yukon	30,980	324	1,046	60	194	70	226
NWT and Nunavut	72,855	1,033	1,418	92	126	59	81
TOTAL	**32,798,684**	**252,948**	**771**	**67,300**	**205**	**62,307**	**190**

Note: Data as of December 31, 2006.
Sources: Statistics Canada (population) and Canadian Institute for Health Information (number of nurses and physicians).

The data available for 2006 concerning the number of physicians and nurses in Canada show that in quantitative terms, the situation varies fairly significantly from one province to another.

[157] See above, page 20.

— Among the provinces, Québec is exceeded only by Nova Scotia for the number of physicians in relation to population – 215 physicians per 100,000 inhabitants, compared to 174 physicians in Ontario and 190 physicians in Canada as a whole.

— However, Québec is one of the Canadian provinces with the fewest nurses and nursing assistants in relation to population. In 2006, Québec ranked seventh, ahead of Ontario, Alberta and British Columbia.

12.1.1 The reforms

In the past few years, many efforts have been made to reform the structures and bargaining units in the health care sector.

— Despite their different missions – the institutions – hospital, CLSC and CHSLD –, were merged to constitute health and social services centres (CSSS).

— A new budgeting mode based on service programs was introduced.

— Bill 90 now allows expansion of the field of practice of some professionals and ensures that each makes the most of his or her competencies.

However, it must be noted that in this context of administrative and budgetary changes, the work organization has not received the attention it deserves.

— Despite the merger of the bargaining units, it is still difficult to make the work organization more flexible. The provisions of the collective agreements, particularly regarding job descriptions and the mechanisms used to account for seniority when positions are eliminated – known as "bumping" – remain a rigid and outmoded framework, constituting an impediment to initiative and creativity.

— The implementation of Bill 90 is encountering resistance with a corporatist stamp. According to the Association québécoise d'établissements de santé et de services sociaux, "this narrow vision of professional practice and relations with the other professions hinders the optimization of services, whether by limiting the delegation of professional acts or by preventing a more effective hierarchization of care"[158].

[158] *Financement adéquat du système de santé québécois: Cette fois-ci doit être la bonne.* Brief presented to the Task Force on Health Funding by the Association québécoise d'établissements de santé et de services sociaux, Montréal, October 9, 2007, page 13.

Bill 90

Bill 90 (*Act to amend the Professional Code and other legislative provisions as regards the health sector*) was adopted by the National Assembly in June 2002. Its implementation marked a major step in the professional organization of the health care sector.

The health care sector includes over half of the regulated professions in Québec. Their fields of practice, for the most part, were fixed in the early 1970s, with little evolution until 2003.

In 2003, Bill 90 revised the fields of practice of eleven professions including over 120,000 health professionals, in order to

- eliminate the useless barriers and constraints related to their definition,
- favour healthy interprofessional collaboration,
- account for the considerable evolution of knowledge, technology and methods.

This Act provides for a new sharing of fields of professional practice in the health care field and the activities reserved for physicians, pharmacists, nurses, radiology technologists, dietitians, speech therapists and audiologists, physiotherapists, occupational therapists, nursing assistants, medical technologists and respiratory therapists.

This Act also establishes a framework that can authorize professionals other than physicians, particularly nurses, to perform certain medical activities. For example, nurses are assigned an expanded role in emergency assessment by allowing them to initiate diagnostic and therapeutic measures, according to a prescription.

Moreover, this Act allows non-professionals, in some circumstances, to perform certain activities so as to meet the needs of individuals better while ensuring public safety.

Finally, various measures are introduced to ensure proper supervision of medical activities engaged in by non-physicians in institutions.

12.1.2 Three conflicting powers

In our health care system, it would be expected that the patient be at the heart of the work organization. On the contrary, many stakeholders described the environment in which they perform their activities as an environment where three powers coexist:

— First, managerial power is exercised by the management team, primarily concerned with compliance with the instructions and regulations of the Ministère de la Santé et des Services sociaux and controlling expenditures.

— Secondly, medical power operates with its own rules and too often keeps its distance – or is kept at a distance – from the management team.

— Thirdly, union and corporatist power is exercised by the professional corporations and unions.

The work environment is described as a place where divergent interests of managers, physicians and unions coexist.

— The players feel like pawns in a system beyond their reach and over which they have no control.

— The executive director of the institution is placed in a situation that is difficult, to say the least: he must deal with the medical administration of the institution and has little autonomy.

— In some institutions, the executive director's relations with the physicians practising in the institution he manages are delicate.

The result of the coexistence of these three powers is an atmosphere of confrontation and a work environment which some try to bypass as best they can.

Several symptoms betray a profound malaise among the caregiving staff in our health care system's institutions.

— This situation is confirmed by a recent opinion of the Direction générale du personnel réseau et ministériel of the Ministère de la Santé et des Services sociaux[159].

— The MSSS opinion thus targets the pronounced staff shortage in certain specific sectors, the difficulty the network's institutions are experiencing in filling their vacant positions, the increase in overtime and the reliance on private agencies.

Some teams of surgeons have opted to practice outside the hospital, which is another symptom of the current malaise. These surgeons prefer private clinics, which reflect their management philosophy and in which they are in charge.

The departure of nurses for clinics and private agencies stems from the same malaise, and illustrates the tensions existing in a great many institutions.

12.1.3 A bureaucratized and centralized work organization

This work organization shared among three conflicting powers is also an excessively hierarchical work organization. The system is managed bureaucratically, a phenomenon that seems to be less present in the English-speaking institutions.

— Decision-making on the organization of services, budgeting, allocation of funds and negotiations with the unions and the medical federations are all centralized tasks.

— The senior executives, managers and workers all feel isolated from each other. They are too caught up in gathering information and writing reports.

The frustrations felt in the nursing community are directly related to this bureaucratization and centralization.

[159] Direction générale du personnel réseau et ministériel, MSSS, October 2007, *Enjeux des ressources humaines en regard de la pénurie de main-d'œuvre en soins infirmiers dans le réseau de la santé et des services sociaux.*

— The nurses' work schedules are often established according to seniority, especially in the French-speaking institutions. The younger nurses are thus subject to demanding work schedules not adapted to their situation as young mothers. They often are the only nurses on call at night and on weekends.

— New nurses are not offered job stability in the hospitals. Mentoring and training activities are not developed enough.

— Many nurses opt for private agencies where they obtain not only higher salaries but more suitable work schedules.

While the executive personnel of the institutions should emphasize results rather than the means of achieving them, the approach of "management agreements" between the MSSS and the institutions has led to an increase in bureaucratic requirements.

— The targets are too precise and uniformly applied, regardless of the reality of the different environments.

— They are often accompanied by detailed directives regarding the means of achieving them.

This is a contradiction: it is not possible to increase the responsibilities of institutions to their territory's population while at the same time reducing the leeway of the people responsible.

12.2 Improving labour relations by means of the work organization

A response can be provided to the labour relations problems by taking action on the work organization.

— A dynamic work organization geared to teamwork and complementary competences will help increase staff motivation.

— Such a work organization thus will have the effect of improving the performance of physicians, nurses, nursing assistants, patient attendants and all personnel – while making them happier in their professional environment.

The current hierarchical and rigid approach must be replaced with a more flexible work organization, based on respect of every individual, which ultimately will have the effect of improving performance and results.

12.2.1 Adopting a dynamic approach

What some specialists call the "organic approach" – the Task Force prefers the term "dynamic approach" – responds to this idea of organizing work flexibly, openly and effectively. The dynamic approach is the opposite of a bureaucratic approach.

- In a bureaucratic or hierarchical system, the emphasis is placed on control, explicitly defined expectations and observance of the operating rules, norms and standards that determine work activity and govern the relations between stakeholders.
- In a dynamic system, the emphasis is placed on the objectives to be achieved, by relying on the stakeholders' problem-solving capacity.

A convincing example of a dynamic approach in work organization – and the results obtained – was presented to the Task Force. This is the project implemented by CSSS Les Sommets.

At the instigation of the de Gaspé Beaubien Foundation, this project was created to invigorate the work organization by involving all the stakeholders.

❑ The findings

The experiment has already resulted in findings that confirm the rationale of the orientations proposed by the Task Force.

In clear and concrete terms, there are three such orientations:

- The staff must be mobilized by involving them in what the organization is seeking to achieve. In particular, it is essential to involve the nurses, nursing assistants and patient attendants, who are responsible for caring for the patients on a continuous basis.
- The managers must be empowered so that they focus their efforts and energies on supporting clinical activities.
- Finally, the physicians must be associated with the change: no significant reform can be achieved if the physicians themselves are not committed to it.

❑ A forum for exchanges

The management teams must change paradigms, moving from a world of regulations and prohibitions to a world in which the best possible solution is sought to serve the patient better.

Opportunities must be created for health professionals to exchange experiences and ideas outside of struggles based on power and interests. The Task Force

suggests that financial encouragement be provided for the creation of a forum for constructive exchanges on therapeutic protocols and best practices, where the discussions would be attended by specialists in work organization and health economics.

❑ A path to follow

In the final analysis, those who perform the work are the people who know it best and who are most qualified to organize it effectively.

The Task Force is convinced that the government should take its inspiration from the experiment accomplished by CSSS Les Sommets and encourage the foundations, and the workers' investment funds, to get involved in initiatives of a similar nature. A path is open to make our health care system more innovative and more productive for the greater good of Quebecers. This path must be exploited.

More generally, the Task Force makes the following recommendations.

Recommendations

The Task Force recommends that the government induce and encourage the health care sector's institutions to replace the current bureaucratic and centralized culture with a dynamic work organization.

The Task Force recommends that the government grant a dedicated budget to every institution that presents a work organization renewal program.

The implementation of this new work organization could be supported by the foundations and investment funds intervening in the health care field.

The dynamic approach in the field: CSSS des Sommet

The CSSS des Sommets pilot project, located in the Laurentides region, was launched in 2006 with the support of the de Gaspé Beaubien Foundation.

The people responsible for the project wondered whether it was possible to design a health care system that ensures the level of professionalism and integrity of the current system, while empowering the players regarding the costs generated and allowing them enough decision-making leeway to adjust the normative framework to their specific context.

Their hypothesis was that it is possible to design an effective public system, provided that the work organization presents sometimes paradoxical characteristics, supporting high performance and controlled costs at the same time.

Three main conclusions emerge from this interesting project.

The dynamic approach in the field: CSSS des Sommets (continued)

Mobilization of the staff

This experiment quickly showed all the players that any improvement in the system could not be achieved without accentuated mobilization of the staff.

- Discussion groups were formed and the Foundation was able to initiate exchanges directly with the staff to identify possible improvements.
- Instead of looking for scapegoats, people tried to solve problems.
- The main lesson from these efforts concerns the positive effect within the CSSS of the initiatives to engage in a dialogue with a social respondent and account to someone who is interested in what is being done, who has a face and is present and recognized.
- According to the person jointly responsible for the project, such an exercise necessitates an open, confident, humble management, ready to let itself be questioned and sometimes to hear difficult things – a flexible management ready to act.

The presence of a social respondent does not mean that the accountability already provided for in the system is obsolete. The process of continuous exchanges with an interested interlocutor forces a sustained dialogue between the system's players to some extent, which creates a moral commitment to achieve results that the players themselves have identified as important.

Empowerment of the managers

Another major finding concerns the perceived powerlessness of managers to translate the multiple functional directives to which they are subject into clinical activities.

The managers must constantly comply with requirements that disrupt the operation of the care teams. They are asked incessantly to meet objectives, comply with directives and achieve performance indicators that are perceived as nitpicking controls, with little relation to the clinical activity they are trying to deploy.

Faced with this finding, the people responsible for the project and the CSSS administration agree that it is important to train managers so that they are better able to direct the clinical teams. A codevelopment program was established based on solving problems confronting the managers. This training accentuates communication between senior and middle management.

The principal finding concerns the importance of managing the system as a whole and not on a piecemeal basis.

- Clinical activity must be repositioned at the heart of the system and not distracted by multiple functional restrictions.
- The managers are not there to apply rules, standards or restrictions stubbornly, but rather to exercise their better clinical judgment constantly regarding their management responsibilities.

Involvement of the physicians

The last finding is that although the physicians are at the heart of the system, they benefit from a status that has the result of marginalizing them in the work organization.

- The physicians have their own remuneration system.
- They have no relationship of employment with the institution where they practice.
- To paraphrase a manager heard by the Task Force, the result is that in a health care institution, the people who control the resources have little say in the decision to spend and those who spend are not responsible for utilization of the resources.

The Foundation's frank and direct exchanges with the representatives of the medical profession led to an unexpected result: it is found that the physicians want to develop a dialogue and accept to espouse the common cause in the system where they perform their activities. They want to share what can improve the quality of clinical acts.

12.2.2 Supporting the managers

It must be noted that, in our system, marked differences exist between institutions in terms of work organization effectiveness. With the same collective agreements and the same budgets, some executive directors find ways to manage their institutions more effectively and recruit and retain motivated professional and technical staff who perform well, while others do not accomplish this.

It is up to the executive director, supported by the board of directors, to take the work organization in hand. It is the executive director who must manage this essential function. The new possibilities of local negotiation of collective agreements would allow provisions to be included in this regard.

For the executive directors to fulfill their responsibilities, they and their teams must be assured of sufficient leeway in decision-making and granted discretionary financial resources.

— The application of the medical staffing plans should account more for special situations in the institutions. Overly targeted funding covering limited periods and too historically based do not make a dynamic institution possible.

— The teams should have the necessary latitude to review their work process.

Our universities should develop health care management training programs inspired by the most dynamic management philosophies. Despite the social and economic importance of the health care sector, much still has to be done in this regard. Such development would be most advisable when a great many managers are heading rapidly toward retirement.

A Ministère de la Santé et des Services sociaux oriented to strategic planning should give high priority to a dynamic work organization and the establishment of positive labour relations.

Staffing plans: the regional medical staffing plan

The purpose of the medical staffing plan is to ensure more equitable access to medical services in the different regions of Québec, by allocating medical staff levels among the different regions.

Medical specialists

The regional medical staffing plan consists of medical staffing plans per institution for all specialties. This plan sets growth objectives. The plan is accompanied by a whole set of management rules. These rules particularly concern accounting for physicians in the medical staffing plans, obtaining notices of compliance, physicians leaving for additional training, physicians returning from remote regions and physicians holding restrictive permits.

Family physicians

For general practitioners, the regional medical staffing plans contain targets, which are reviewed each year according to the existing staff levels and the needs to be met in each region. They account for the mobility of the physicians already in place and the expected number of new physicians. A special agreement made between the Ministère de la Santé et des Services sociaux and the Federation of General Practitioners of Québec came into force in 2004. It ensures compliance with the regional medical staffing plans.

12.2.3 Improving labour relations

According to the testimony received, our health care system does not really recognize the importance of positive labour relations.

Our health care system is not distinguished for a high level of job satisfaction on the part of its workers. However, it is increasingly recognized that the quality of care, client satisfaction and cost control are closely related to the quality of labour relations. It is especially worrying to find that there seems to have been little progress since the unfortunate assessment outlined in the Clair Report.

❑ A climate of confrontation

In our health care system, labour relations, to all intents and purposes, still bear the stamp of a climate of confrontation throughout the pyramid from top to bottom. This climate has an impact in the institutions.

Labour relations continue to be based on bargaining power, which should not have a reason to exist in institutions with the mission of treating patients.

— In the absence of care protocols, as is generally the case at present, the professional orders and the unions in fact dictate the qualifications of the professional and other staff. The trend is clearly a constant increase in the qualifications required. In this process, acquired experience and proven competence have scarcely any weight.

— Adding to this initial rigidity are the seniority rules, the effects of which are well known. In particular, they are one of the causes of the difficulties of recruiting nurses in the public sector. In this regard, the importance of the objective instrument represented by the care protocols becomes fully apparent.

❑ A new unionism

In the health and social services sector, unionism has mainly emphasized monetary questions and job descriptions.

Such a philosophy, specific to the industrial sector of the past, no longer has a reason to exist in a service sector like health care, where union members benefit from good conditions in terms of remuneration, pensions, benefits, work schedules, sick leave and vacations.

A new unionism is necessary. The problems should be solved by work organization processes. The staff must be involved in solving problems.

In a society that has evolved greatly over the past forty years, we need a unionism that encourages its members to participate in the renewal of the work organization, in a healthy search for performance and improvement of the health care system.

❑ The judgment on Bill 30: an opportunity to seize

As previously indicated, in December 2003 the government obtained the adoption of Bill 30, drafted to reduce the number of union bargaining units and decentralize the negotiation of certain provisions of the collective agreements to the local level[160].

— The goal pursued was to allow a more effective work organization and respond more directly to the institutions' specific needs.

— Some of the provisions of Bill 30 were invalidated by a Québec Superior Court judgment on November 30, 2007.

— This judgment is based on the fact that, in obtaining the adoption of Bill 30, the government contravened the freedom of association recognized in the Canadian and Québec Charters.

— In her judgment, however, Justice Claudine Roy specified that she was not ordering a return to the status quo. The judgment provides for a period of eighteen months before its execution, this period being offered to both parties to allow them to reach a negotiated solution.

[160] See above, page 23.

Thus, the Superior Court judgment on Bill 30 perhaps opens the door to the resumption of a more constructive dialogue between the government and the union organizations representing health care workers.

As we know, the government has decided to appeal this judgment[161]. The Task Force recognizes, however, that the government and the union organizations have declared that they are open to dialogue, since the unions recognize the rationale for a reduction in the number of union bargaining units and for local negotiation.

It must be hoped that these intentions are confirmed in reality and that the Superior Court judgment is seized as an opportunity by everyone to establish positive dynamics in health care sector labour relations.

Recommendation

The Task Force recommends that despite the appeal recently filed against the Superior Court judgment on Bill 30, the government and the unions engage in a dialogue with the aim of creating positive dynamics in labour relations, based on mutual respect by the parties involved.

[161] The government appealed the Superior Court judgment on December 21, 2007.

CHAPTER 13 – A CREDIBLE AND INDEPENDENT BODY TO PLAY A STRATEGIC ROLE: THE INSTITUT NATIONAL D'EXCELLENCE EN SANTÉ

We have already mentioned the necessity for Québec to benefit from a credible body, rigorously and effectively assuming functions which currently are only partially fulfilled by several organizations. The Task Force is referring to strategic functions for the health care sector as a whole, such as the definition of public coverage of care, the determination of performance indicators or the periodic review of the list of insured medications.

In this section of the report devoted to the means to be mobilized to build a productive and effective health care system, there is an obvious need for the Task Force to explain more precisely the nature of such a body and the reasons favouring its creation.

13.1 Foreign examples

Sweden, Norway and Denmark were the first countries to adopt mechanisms seeking two objectives:

- establish priorities in the coverage of care by the public health services;
- adopt mechanisms for supervision of medical practice favouring best practices.

They are no longer alone. New Zealand has established similar mechanisms, particularly with Pharmac in the field of medication.

The British have created an organization now cited as an example around the world, the National Institute for Health and Clinical Excellence (NICE).

❑ The British NICE

NICE was created in 1999. It is an independent body, with the responsibility to provide advice and expertise in the field of health promotion and the prevention and treatment of disease.

- NICE intervenes in three fields: public health, health technologies (including medications) and clinical practices.
- NICE offers advice and know-how on the appropriate treatments for specific diseases, based on the best scientific knowledge available.
- NICE develops clinical protocols, which sometimes are also called practice guides, with the aim of improving the quality of health care.

— NICE also has the mandate to ensure implementation of its recommendations. It offers advice and tools for this purpose, and ensures follow-up with hospitals and medical clinics.

Several mechanisms ensure that constant questioning accompanies NICE and its productions. A special space is reserved for a Citizens Council and an appeal system for the guides dictated by NICE.

— The Citizens Council, composed of 30 persons representative of British society, contributes to the development of the principles which must guide the Institute in the preparation of its practice guides.

— A structural appeal system, composed of formal panels, allows the developers of a technology, the professionals concerned, patient associations or medical clinic representatives to present their opposition to orientations proposed by the Institute.

A Board of Directors and regular evaluations also contribute to maintain the Institute's integrity. All these mechanisms assure the British government that this body continually adapts to respond correctly to the public's expectations while making the most of the knowledge allowing the delivery of quality services.

Nothing as important can be found in Canada. At the federal level, the Canadian Agency for Drugs and Technology in Health provides conclusive data which can be used by decision-makers. Québec has withdrawn from its governance and does not participate in its funding.

In addition, a Health Care System Improvement Council exists in Ontario and, since 2002, a Health Quality Council is established in Saskatchewan. Their mission is to report and recommend innovative ways of improving the quality of care. But this is a long way from the scope of the British NICE.

13.2 The situation in Québec

In Québec, three bodies have mandates similar to those devolving on the British NICE or on the Swedish, Danish or New Zealand bodies with similar functions[162].

❑ The bodies

The three bodies are as follows.

— The Conseil du médicament du Québec is mandated to advise the Minister on the composition of the list of insured medications and implement policies to ensure optimum use of medication[163].

[162] There is a fourth body, the Institut national de santé publique du Québec, which the Task Force does not recommend be merged into the Institut national d'excellence en santé. The Institut national de santé publique du Québec is an operational body, with a mission specifically oriented to questions of interest to public health and the related knowledge.

— The Agence d'évaluation des technologies et des modes d'intervention en santé has the mission of promoting and supporting informed decision-making on health technologies[164]. The agency formulates recommendations to the Minister for the acquisition of certain technologies. It publishes advisory opinions on the best practices in this field, intended for institutions and practitioners.

— The Health and Welfare Commissioner, created in 2006, has the mandate to release information relevant to public debate and government decision-making with the aim of contributing to the improvement of the population's health and welfare. The Commissioner assesses the system's results and evaluates all of its elements. He consults the public.

Up to now, the Conseil du médicament du Québec and the Agence d'évaluation des technologies et des modes d'intervention en santé have mainly evaluated the clinical effectiveness of medications, technologies and modes of intervention. The approach of the Health and Welfare Commissioner, whose work is very recent, mainly seems to be oriented to ethics.

❑ Deficiencies

Compared to similar bodies in the rest of the world, the Québec structure has several deficiencies.

— None of these three bodies has developed a frame of reference or know-how in health economics.

— None of them has the explicit mandate to publish or enforce protocols or practice guides.

— The three organizations are small. They are independent, but their influence is limited within the health care system.

  The results of their work depend on the Minister's willingness to consider them.

The evaluations performed by the Conseil du médicament du Québec and the Agence d'évaluation des technologies et des modes d'intervention en santé conform to generally accepted scientific criteria.

But their work is generally performed at the request of the Minister or, in the case of the Conseil du médicament, of drug manufacturers who want to enter their product on the list.

Their attitude is scarcely proactive.

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163 See above, page 135.

164 See above, page 137.

— They do not have very sophisticated technology watch services.

— They are not granted the resources or latitude necessary to accomplish a more extensive mission more in accordance with today's needs.

13.3 Merging the existing bodies to create the Institut national d'excellence en santé

To improve the coherence of public coverage and increase the effectiveness of our health care system, the Task Force believes it is necessary to create an independent and credible organization in Québec.

Recommendation

The Task Force recommends the combination within an Institut national d'excellence en santé of the Conseil du médicament du Québec, the Agence d'évaluation des technologies et des modes d'intervention en santé and the Health and Welfare Commissioner, in order to entrust an independent and credible body with a strategic role regarding the relevance and quality of health services.

❑ An independent body with a broad mandate

According to the proposal formulated by the Task Force, the Institut national d'excellence en santé would be formed from the merger of the Conseil du médicament du Québec, the Agence d'évaluation des technologies et des modes d'intervention en santé and the Health and Welfare Commissioner.

The Institute would be an independent body. It would have the status of a legal person and mandatory of the State[165].

Its mandate would incorporate the current functions of the three merged bodies.

[165] This is the legal status of the Institut national de santé publique du Québec (INSPQ).

In particular, the Institute should:

- Make recommendations periodically on the composition of the basket of services insured by the public plan.
- Evaluate new health technologies, including medications, to recommend their inclusion on the list of medications or in the basket of insured services.
- Review the relevance of retaining the technologies and medications currently covered on the list and in the basket of insured services.
- Ensure a watch of new technologies and new modes of intervention appearing on the market to identify the most relevant.
- Produce clinical protocols and practice guides.

Integrating the economic dimension

The Institute's Board of Directors should be composed of a small number of persons, appointed on the basis of their competencies.

- It should include a sufficient number of health economists, as well as ethicists or health technology experts.
- Representatives of the public should occupy a few seats.

The Institute's staff should reflect the same diversity of competencies. The Institute should establish the necessary working and remuneration conditions to attract and retain the most competent people.

The Institut national d'excellence en santé should not only analyze the clinical relevance of the technologies, medications and services it would evaluate, but also analyze them in economic terms.

In this regard, several stakeholders drew the Task Force's attention to the difficulty of recruiting health economists in Québec.

Proposal

The Task Force proposes that the government take the appropriate measures to favour the emergence of the discipline of health economics, by supporting specialized research centres or chairs in this field.

❑ Transparency, public participation and research

The Institut national d'excellence en santé should create a Citizens Forum and implement various public information and consultation mechanisms[166]. Consultations would be mandatory within the framework of periodic review of the basket of insured services.

The Institute's deliberative process would be transparent and public. It should include appeal mechanisms and account for the most up-to-date scientific knowledge on the questions brought to its attention.

The Institut national d'excellence en santé would have to collaborate with similar bodies existing in the rest of Canada and foreign countries. For the Task Force, it is essential that the Institut be strongly encouraged to exchange information systematically with the other bodies of a similar nature existing outside Québec.

The new institute would develop a research function. It would have to be provided with mechanisms to identify emerging new health problems and inventory the original experiments conducted throughout Québec and in the rest of he world, while favouring the sharing of knowledge on these experiments.

In collaboration with the Québec research funds, the Institut national d'excellence en santé should favour research in specific fields and demonstration projects on solutions to health problems or social problems.

The Institute would have to collaborate with the Institut national de santé publique du Québec

❑ Adopting best practices

The interventions of the Institut national d'excellence en santé could be differentiated according to four graduated levels:

— public information;

— dissemination of research results;

— recommendation of best practices to practitioners;

— directives to practitioners, taking the form of clinical protocols.

Within the context of the most recent reforms, several OECD countries have adopted various incentives and means of action with the aim of directly influencing the behaviour of health professionals.

— Different provisions seek to orient physicians and pharmacists to choose products from the basket of services presenting the best cost-value ratio.

[166] See above, page 167.

Professional freedom remains, but it is influenced by the definition of medical references that physicians and pharmacists are bound to observe.

— Individual analysis of physicians' activity thanks to statistical profiles is used in some countries, including Germany, as a tool for modifying practices. Practice guides, protocols, parameters, prescription profiles and clinical controls are all measures with which many countries have experimented to varying degrees.

These experiments should inspire the new Institute. The Institut national d'excellence en santé would ensure collaboration by practitioners, professional orders, the Conseil d'agrément du Québec, the various university research centres concerned and any other players whose collaboration would be useful to the development of recommendations and the practice guides adopted.

❑ Arming decision-makers against influence games

Needless to say, the work of the Institut national d'excellence en santé would have the purpose of informing the decisions of the Minister of Health and Social Services, as well as guiding the other persons responsible for the health and social services system.

To some extent, the decision-makers would be "armed" with conclusive data based on the best scientific research available, while accounting for the tacit and informal knowledge of patients, citizens and practitioners.

The idea of creating the Institut national d'excellence en santé is consistent with a will to break with a certain tradition, whereby decision-makers too often "make up their minds" on an aspect of the health care system based on the noise level of public opinion or as a result of influence games, instead of making decisions based on the quality or relevance of scientific evidence.

The Institut national d'excellence en santé would not prevent the stakeholders from playing their role, but it itself would be a more powerful player in the health care system. It would be legitimate and influential.

CHAPTER 14 – NEW INFORMATION TECHNOLOGIES TO SERVE PATIENTS AND MANAGERS

The last quarter of the 20th century was marked by a new technological revolution, with the dissemination of microprocessors and the explosion of new information technologies.

The health care sector, like all sectors of human activity, increasingly uses these new technologies to improve the services provided, offer new approaches or achieve productivity gains often unimaginable twenty-five years ago.

New information technologies are thus an essential tool to make our health care system more productive and effective. For the Task Force, it was important to provide an update on this question, especially since the government embarked on an ambitious plan in 2005, with the aim that by 2010, each Québec patient will benefit from an electronic health record – the Québec Health Record (DSQ, or Dossier de santé du Québec).

- The computerization of each patient's record is intended both to improve the quality of care and increase management effectiveness. For both of these reasons, new information technologies have become a tool that the health care sector, like many other fields, cannot do without. The Task Force wanted to recall this.

- The Task Force then sought to produce a status report on the computerization process currently under way in the health care network. Some risks must be emphasized, justifying why the Québec Health Record (DSQ) is the object of a pilot project. Regarding the utilization of new information technologies in the health care sector, the Task Force finds that progress has been made but that a lot still has to be done.

- Based on this status report and the findings drawn from it, the Task Force proposes a slightly different approach than the one favoured to date. This approach is based on two priorities:

  - It is essential to ensure computerization of the institutions and health clinics, which is a prerequisite;

  - Better planning and coordination of all future developments is essential.

14.1 Computerizing each patient's record: for the quality of care and effective management

New information technologies take a concrete form in the health care sector – the collection in a computerized record of all the relevant information concerning a patient.

In fact, computerization of each patient's record has become an indispensable means of improving the quality of care, while achieving substantial productivity gains.

14.1.1 Quality of care

The practice of medicine is based on the exchange of information. The quality of care depends on the quality of the information shared between the patient and the many health professionals who combine their efforts to provide the most appropriate treatments. The doctor's office, the hospital care platform and the pharmacy thus form a real chain of communication, and any error in this chain can have harmful consequences for an individual's health – and even cause him irreparable harm.

The quality of the information exchanged is especially important now that care is provided to a diminishing degree by a lone physician or continuously within the same hospital. The patient has become mobile. The information concerning his health status and the care prescribed for him must follow him and be easily accessible and transferable, while remaining reliable and relevant.

To ensure the quality and continuity of care in an increasingly complex universe, information technology has an essential role to play.

— Thanks to information technology, it is now easier to record, store, update and transfer the relevant information on a patient's health status, and to do this while reducing the risk of error.

  For example, it is possible to avoid the sale of a contraindicated drug to a patient whose prescription is improperly written.

— Of course, this exchange of information must be subject to rules of ethics and confidentiality.

By making information more accessible, multidisciplinary teamwork, which is becoming the rule in the health care field, is easier.

Information technology makes the contents of the patient's record available by remote access.

— Information technology facilitates the continuity of care when the patient returns home after surgery, or when the patient suffers from chronic diseases requiring frequent care.

— Information systems accelerate the transmission of the results of laboratory tests or radiology examinations. These results henceforth travel on secure networks using Internet technology.

— For example, thanks to telemedicine, it is possible for a cardiologist located in Québec City to study the echogram of an infant's heart on screen by remote access and save his life by guiding the attending physician on site in Sept-Îles or Chibougamau.

14.1.2 Better management performance

Information technology is also indispensable for various management functions of the health care system and improves its effectiveness.

— The availability of reliable information on care makes it possible to measure the system's productivity, track cost trends and account to the population for the use of public funds.

— Computerization makes it possible to perform research on vast databases and thus identify the best practices. The relevance of the acts performed by professionals can be evaluated by establishing comparisons between individuals and between institutions.

— In the health care sector, as in the other sectors of activity, information technology greatly facilitates management of services, billing by physicians and administrative control.

14.2 Status report

It is thus understood that the information technology revolution affects the health care sector and that major computerization projects have been undertaken in all the developed countries.

14.2.1 The Québec Health Record

In 2005, the Gouvernement du Québec embarked on an ambitious project by committing to the deployment by 2010 of the Québec Health Record – a computerized record for each Québec patient.

❑ An ambitious project

The objective is to ensure that this record can be consulted by 95,000 health professionals across Québec.

— In particular, the Québec Health Record will contain information on each patient's pharmaceutical profile, laboratory test results, X-rays, medical history and allergies.

— The patients' pharmaceutical profiles will be stored at the Régie de l'assurance-maladie du Québec, while the other data will be archived in secure regional data stores.

— The patients will have to give their consent for the information concerning them to be shared in this way. Strict security rules will be applied.

The project provides for the creation of interfaces, so that the computer hardware already deployed in the hospitals can communicate with the Québec Health Record system.

❑ Major investments

Major investments will have to be made to:

— increase the capacity of the health care system's telecommunications network,

— standardize clinical data,

— collect the users' consent,

— deploy the radiography digital archiving systems where they do not yet exist.

$562 million has been budgeted for this project, including $303 million from Canada Health Infoway and $259 million from the Ministère de la Santé et des Services sociaux du Québec.

Several "indirect" expenses - the Ministère de la Santé et des Services sociaux refers to "complementary costs" – were not integrated into the budget originally forecast. These expenses are estimated at $250 million.

14.2.2 Risks to be managed

However, it is essential to be well aware of the different risks that must be managed, when a project on such a scale is undertaken.

A project on this scale requires massive investments and takes time. In the United Kingdom, the implementation strategy is spread over ten years. The same time frame is observed in Australia.

The analysis of previous experiences with shareable patient records led specialists consulted by the Task Force to develop a model including several types of risks, including the following main risks[167].

— The first type of risk is technological: it is related to selection of hardware or software, specially in the context where all the institutions connected to the system have not achieved the same development level.

— There is a human risk resulting from the users' reactions to technology. The introduction of a new technology provokes major transformations in the users' work habits. The adoption of a record such as the Québec Health Record is directly influenced by the level of perceived usefulness of this technology by the physicians and their degree of mastery of the new technology.

— There is also a managerial risk, associated with the quality of the project's management.

— Finally, it is essential to account for a legal risk, depending on the values and rules in force regarding the dissemination, security and confidentiality of data.

14.2.3 Proceeding with a pilot project

For the Task Force, it is important that the risks be minimized in pursuing the Québec Health Record implementation project.

The pilot project foreseen in a region of Québec must be designed so as to test all of the modalities related to this project, not only between institutions, but between the network and the health clinics, including private practices.

Deployment in the other regions of Québec must be initiated only when the pilot project has been evaluated.

— This should reveal the benefits of the system and the conditions for the project's success.

— If the pilot project is a success, it can be reproduced throughout Québec. Alberta took the same approach: a similar system was deployed in the Edmonton region and then adapted and extended to the rest of the province.

[167] Claude SICOTTE, Guy PARÉ, André PACCIONI, Pascale LEHOUX, *Analyse du risque associé au déploiement d'un Dossier Patient Partageable*, Département d'administration de la santé & Groupe de recherche interdisciplinaire en santé Université de Montréal, Canada Research Chair in Information Technology in Health Care, HEC Montréal, September 2004.

❑ Change management

Within the framework of the pilot project, and for the project as a whole, major efforts must be applied to manage change. This seems to have been neglected to date, particularly with future user physicians.

The project's success largely depends on the capacity of those responsible for it to ensure the support and participation of physicians.

— In Ontario and British Columbia, the project is being tested with groups of volunteer physicians, organized in peer networks. Nurses and other health professionals called upon to use the system are also invited to test it.

— User participation in designing the system is necessary. In general, a consultation process may lead to the design of an inadequately defined technological solution that does not meet the needs.

— Since the local electronic patient record or the Québec Health Record will not contain all the clinical information necessary for the organization of care, the paper record will remain necessary. The articulation between the two information systems, paper and electronic, must therefore be planned.

Recommendation

The Task Force recommends that the Québec Health Record be deployed only once the pilot project has been completed in a region of Québec and once its results are analyzed. It is important that change management be given special attention.

14.2.4 Unequal development in the use of new information technologies

To pass judgment on the implementation of this program, the Task Force first wanted to have an evaluation of the use of new information technologies in the Québec health care sector[168].

The Québec health care system is not deprived in this regard.

— Over the past few years, a telecommunications network links the institutions to each other and connects the institutions to the regional agencies and the MSSS.

[168] Guy PARÉ and Claude SICOTTE, *Intensité du déploiement des technologies de l'information dans les établissements de santé au Québec*, Expert report presented to the members of the Task Force, October 24, 2007

— Information systems have been deployed, particularly to manage home care, services to seniors and care in CLSCs.

— Many hospitals have deployed local electronic patient record systems.

— In some regions, private practices are linked to the hospital.

The report presented to the Task Force shows that the Québec health care system has made definite progress in this regard, at least in the institutions.

— Most institutions have the most classical computerized administrative systems. Over 40% of them use a costing system.

— Management of laboratories, the pharmacy, radiology and outpatient clinic appointments is computerized almost everywhere.

— Over 90% of institutions using digital radiology have initiated deployment plans.

— Progress is less substantial in support for clinical activities. Only 16% of institutions use local electronic patient records. The good news is that 65% have begun to invest in such a system or are planning its deployment.

But the development of these systems is relatively uneven.

— The responsibilities are scattered.

— The technologies are distributed throughout Québec based on each entity's initiatives.

— Not all systems are compatible.

The electronic patient record (EPR) and the Québec Health Record (DSQ)

Electronic patient record

The patient's local computerized record is called the electronic patient record. It is also sometimes called the "computerized clinical record". This record brings together all of the essential clinical information concerning the patient. Its existence allows a clinic's professionals to access all of a patient's clinical information.

Québec Health Record

The Québec Health Record is the computerized record making certain information necessary for follow-up and takeover of patients accessible to health professionals by remote access, regardless of the place in Québec where the patient receives health services. For example, this information consists of the patient's laboratory test and radiology results or pharmaceutical profile. The objective of the plan launched by the government is to ensure that by 2010, each Québec patient has such a record.

14.2.5 Conditions for success not fulfilled

Specifically regarding the implementation of the Québec Health Record project, the Task Force is not convinced that all the conditions for success are fulfilled.

- The computerization rate of medical clinics is low. It is estimated at 20%, and the rhythm of development of information technology in the institutions is uneven, depending on the region.
- The principal potential users – physicians – are showing some skepticism regarding this technology. Some of them are disappointed with the existing systems. Most of them do not see how the Québec Health Record will be useful to them.
- The Québec Health Record involves the exchange of information about patients throughout Québec, while the majority of institutions and almost all medical clinics do not even have a computerized patient record for their own internal use.
- The Act provides for the obligation to obtain the patient's explicit consent – called "opting in"» – before the information concerning the patient can be entered in his electronic record.

  Yet everywhere else, the technique employed is to allow individuals who do not want to participate in the project to "opt out". "Opting in" is viewed by the vast majority of specialists as an obstacle to the deployment of the Québec Health Record.

  In December 2007, the government tabled Bill 70[169]. This bill seeks to replace the "opting in" system with an "opting out" system.

Recommendation

The Task Force supports the approach initiated by the government to cease to require the patient's explicit consent ("opting in") and to replace it with an "opting out" mechanism. It recommends that this approach be carried out.

[169] *Act to amend the act respecting health services and social services, Health Insurance Act* and *Act respecting the Régie de l'assurance maladie du Québec.*

14.3 Starting from the base and improving coordination of the entire system

The Task Force proposes that the government modify the initial approach somewhat, by introducing two essential elements.

- It is essential to start from the base, by ensuring that the maximum number of institutions is computerized – which in fact is an indispensable prerequisite for a project like the Québec Health Record.
- All of the efforts concerning the introduction and use of information technologies must be planned and coordinated better.

14.3.1 A prerequisite: continue computerization of the institutions and health clinics

Despite the interest aroused by the Québec Health Record, the priority must be to continue and accelerate the deployment of information technology tools, and particularly the local electronic patient record in all Québec institutions.

❑ More orderly development

However, this development must be more orderly.

- The Ministère de la Santé et des Services sociaux must further specify the technological orientations and standards that the institutions and agencies will have to observe in deployment of information systems at the local and regional level.
- These orientations will have to account for compatibility with the Québec Health Record.

❑ Equip the health clinics with the necessary information systems

While deployment of the electronic patient record must be completed in the institutions, it is first necessary to equip the health clinics with appropriate information systems.

These systems will make it possible to:

- ensure follow-up and takeover of patients,
- guarantee the continuity of care with the other components of the health and social services system.

The question of funding of these information systems must be discussed within the framework of the contractual agreements[170] between the regional agencies and the clinics.

Recommendation

The Task Force recommends that the priority be placed on deployment of the electronic patient record in each of the institutions and in the health clinics.

14.3.2 Better planning and coordination of the system as a whole

More generally, the MSSS must combine the information systems planning function under a single authority and proceed with a clear distribution of functions among the government departments, agencies and institutions.

In any organization of a certain size in which information technology plays a significant role, a senior executive generally holds the position of chief information technology officer. He is responsible for the essential function of information technology management, on the same basis, for example, as the director of finance or development.

This key function does not exist at the Ministère de la Santé et des Services sociaux. The responsibilities are assumed by several public servants, without central management.

This result is uneven development of systems in the institutions and health clinics. This is a serious deficiency, which can only delay and complicate the essential deployment of information technology and the Québec Health Record.

Recommendation

The Task Force recommends the creation, within the Ministère de la Santé et des Services sociaux, of the position of a person responsible for planning, establishment of norms and standards and deployment of information technology throughout the health care system, including the Régie de l'assurance maladie du Québec and the institutions.

[170] See above, page 163.

PART 6
Funding: adopting a long-term vision, sharing responsibilities

The question of funding is at the very centre of the mandate assigned to the Task Force by the government. The Task Force's name clearly emphasizes this.

At the beginning of this report, the Task Force specified that it was approaching health funding in its broadest sense: to respond to the different points of the mandate defined by the government, it is necessary to act on revenues and expenditures and reflect on public coverage, improvement of services, governance of the system, and the work organization.

For funding in the strict sense of the term, several solutions have already been proposed in the preceding chapters. It is now important to discuss directly all of the revenue sources on which the health care system will have to rely, if we want to correct the imbalance of public finances created by the growth of health spending.

The Task Force has identified equitable and sustainable solutions, with the twofold concern of adopting a long-term vision and defining an equitable sharing of responsibilities.

- **Chapter 15** proposes sustainable and diversified revenue sources and the creation of a Dedicated Health Stabilization Fund, for what specifically involves public spending.
- With **Chapter 16**, the Task Force responds to one of the specific points mentioned by the government in its mandate by presenting what a health account could be, viewed as an instrument for transparency in the management of public funds, allowing citizens to have better information about health funding.
- **Chapter 17** corresponds to another specific point of the mandate assigned by the government. The Task Force analyzes the nature and impacts of the *Canada Health Act*, a law of a financial nature setting out a number of principles which hinder the evolution of Canadian provincial health care systems.

CHAPTER 15 – SUSTAINABLE AND DIVERSIFIED REVENUE SOURCES

If we want to ensure its sustainability, our health care system must be able to rely on sustainable and diversified funding sources.

The Task Force performed an in-depth analysis of all the current revenue sources and a certain number of foreseeable revenue sources, in order to offer the government clear options in this matter.

— It is first essential to recall the current situation regarding health care system revenues: the public system is currently funded by taxes and there is substantial private funding in Québec.

— The Task Force recommends that the government create a Dedicated Health Stabilization Fund and proposes some options for its funding.

  The Task Force thereby rejects the introduction of a user fee and the imposition of a health premium. It is important to explain the reasons for these recommendations and choices clearly.

— The Task Force also discusses certain other funding sources for the health care sector, which this time only concerns the public sector.

  The Task Force thus wanted to discuss the entire question of incidental expenses in depth. The Task Force also discusses the question of rationalization and tarification of services.

— To illustrate the scope of the recommendations and proposals formulated, the Task Force, in the conclusion of this chapter, presents the impact they could have on the trend of public health spending and on the revenues allocated to health funding.

15.1 The current situation

The principal quantified data concerning the expenditures allocated to health were presented at the beginning of the report: for 2007-2008, it is estimated that Québec will allocate a little over $33 billion to health. Of this total, public health spending will reach nearly $24 billion[171].

15.1.1 A public system funded by taxes

Public health spending is mainly funded by the general revenues of the Québec State: in 2007-2008 these revenues represented 60.7% of the public revenue sources allocated to health. The rest of the funding essentially comes from employer and individual contributions to the Health Services Fund (22.6%) and federal transfers (15.9%).

TABLE 12

Public revenue s**ources, 2007-2008**
(in billions of dollars)

General government revenues (taxes, etc.)	14.5	60.7%
Employer and individual contributions to the Health Services Fund (HSF)	5.4	22.6%
Federal health transfers[1]	3.8	15.9%
SAAQ and CSST transfers	0.2	0.8%
TOTAL	**23.9**	**100.0%**

1 It should be noted that if Québec did not collect a portion of the federal contribution to provincial health spending from the personal income tax ("special Québec abatement"), these cash transfers would be $1,853 million higher in 2007-2008. A portion of these federal health transfer revenues are recorded under "Other programs" federal transfer revenues of the Consolidated Revenue Fund of the Government du Québec.

In Québec, the vast majority of public expenditures are funded from revenue sources, which are also used to fund all of the State's missions.

— As already noted, an analogous funding model exists in the United Kingdom, Australia and the rest of Canada[172].

— In Germany, France, Japan and Netherlands, funding of public health spending is assured by social insurance funds created for this purpose. In these countries, the resources allocated to health are thus separated from the revenues allocated to the State's other missions.

Two comments must be made at this stage.

171 See above, page 32.

172 See above, page 23.

❑ The norm: mutualization of risks

In the first place, in all the developed countries – with the notable exception of the United States – mutualization of health-related risks is the norm.

Until the middle of the last century, most countries considered that illness was an individual responsibility. They organized their systems around voluntary insurance. These voluntary systems were gradually extended to compulsory insurance systems.

It was realized that health was a development factor not only for individuals but for society. The first social insurance systems for health particularly had the objective of getting sick workers back to work as quickly as possible.

Except in the United States, voluntary private insurance, private health savings plans and user contributions are complementary revenue sources where they are used. On the average, in the OECD countries, compulsory contributions account for 72% of the revenue sources for health.

❑ The two main funding models

Secondly, the two main collective funding models used in the developed countries – funding by taxes and funding by a social insurance fund – each involve advantages and disadvantages.

Tax-based funding models, such as ours, have several positive impacts.

— These systems have a greater capacity to control the growth of costs. Most of the time, the separation of health budgets from other government spending in the social insurance systems has the result of increasing total health spending.

— In a tax-funded system, risk sharing is automatically universal.

— In general, tax-funded systems are less costly to administer.

Funding models by means of a social insurance fund have certain flaws, essentially related to the evolution of the labour market.

— Contributions to social insurance plans are generally calculated according to employment income. Yet this narrow basis of calculation is less and less satisfactory. Self-employment represents a growing share of personal income. In Québec, one third of individuals thus have atypical jobs.

— Increasingly, individuals have more than one job or derive income from other sources, such as capital gains on investments.

— Moreover, in an aging society, a growing number of people are excluded from the labour market while retaining their ability to pay due to income from other sources.

On the other hand, the funding models that use a social insurance fund benefit from other qualities.

— The contributions made to the insurance fund by each individual give that person client status. The relationship between the insurer and the patient is more contractual in nature. The benefits are defined more clearly.

— Social insurance systems are less politicized.

— The public's satisfaction generally is higher under a social insurance system than under plans funded by taxes or by voluntary private insurance.

❑ Trends

It is rare for a country to change models suddenly.

Several health reforms were implemented in Great Britain over the past few years but the principle of tax-based funding was never called into question. The same phenomenon, but in the opposite direction, is observed in Germany and France. However, Spain and Iceland gradually abandoned social insurance for tax-based funding in the 1970s and 1980s.

The Task Force does not find any sufficient reason that would justify replacing our principally tax-funded system with a system funded by a social insurance fund. For the Task Force, taxation must remain the principal funding source of the Québec health care system.

However, in the past few years, several tax-funded health care systems have modified the organization of care and the allocation and payment mechanisms within the public system, in order to create conditions allowing the same advantages as social insurance systems – without modifying the principal revenue sources. Several of the Task Force's recommendations go in this direction.

15.1.2 Substantial private funding

A substantial portion of health spending is assumed privately by individuals. In 2007, this share stood at 28.3%. After declining between 1975 and 1980, this share increased strongly over the next twenty years and seems to have levelled off since 2000[173].

The share of Québec health funding coming from private expenditures is comparable to what is observed in Canada as a whole. The World Bank recently

[173] CIHI, National Health Expenditure Trends 1975 to 2007. See above, page 25.

produced a study of 25 industrialized countries, in which it ranks Canada in the group of nine countries with the highest private share of health funding.

❑ Private insurance

In 2007, private funding thus represented approximately $9.5 billion, coming directly from the patients' pockets or through private insurance[174]. Generally this is group insurance, for which the premiums are shared between employees and their employers.

In the OECD countries, private insurance only represents 6.3% of total health spending on the average. Canada is part of a small group of four countries where private insurance exceeds 10%. In 2004, private insurance represented 12.8% of total health spending in Canada. The United States is an exception, with 36.7%.

TABLE 13

Allocation of health funding by source for certain developed countries, 2004
(percentage)

	Public insurance share of funding total	Private insurance share of total funding	Individual contributions as a share of total funding
Denmark	84.5	1.6	13.9
United Kingdom	82.9	3.3	11.0
Japan	81.5	0.3	17.3
France	78.3	12.4	7.6
Germany	76.9	9.0	13.2
Canada	69.8	12.8	14.9
Australia	67.5	6.8	20.0
Netherlands	65.4	20.0	8.2
United States	44.7	36.7	13.2

Source: Eco-Health, OECD 2006.

❑ Care covered by private funding

In Québec, the largest portion of private contributions covers the cost of services not insured by the public system, particularly dental care, optometry for adults, psychotherapy and physiotherapy. A substantial share of these private expenditures concerns medication.

[174] CIHI, National Health Expenditure Trends 1975 à 2007.

A portion of these private contributions serves to fund public programs. In 2006-2007, these contributions amounted to nearly $2.3 billion, allocated as follows:

— $1.3 billion in user contributions – premiums and co-insurance – to the public prescription drug insurance plan;

— $700 million for the user share of the cost of residential care for seniors suffering from loss of autonomy in CHSLDs;

— $100 million to defray a portion of the cost of ambulance transportation and private hospital rooms;

— $170 million in donations to hospital foundations.

These private contributions also include the incidental expenses charged by physicians for various supplies used in private practice visits – such as medications and anesthetics – or the preparation of certain forms.

The Gouvernement du Québec reimburses a portion of private expenditures through two tax credits for medical expenses, valued at $700 million in 2007.

15.2 A Dedicated Health Stabilization Fund

The main characteristics of our health care system, from the standpoint of its revenue sources, thus have been recalled.

❑ A gap to fill

In terms of the system's funding, the problem largely comes from the gap that exists between the growth of public health spending and the increase in collective wealth.

— Since 1998-1999, the economy has grown at an average annual rate of 4.8%, while public health spending increased in the same period by 6.4% per year[175].

— By 2018, it is forecast that the structural growth of public health spending would be maintained at 5.8%, if nothing is done, while the growth of the economy and government revenues should be around 3.9%[176]

To escape this impasse, the Task Force seeks to adjust the growth of public health spending to the growth rate of collective wealth, while improving access to care and the quality of services[177].

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[175] See above, page 33.

[176] See above, page 37.

[177] See above, page 3.

Concretely, this means, for example, that the growth of public health and social services spending will have to drop from 6.5% in 2008-2009[178] to 3.9% over a horizon of five to seven years – a growth rate reduced to the increase of collective wealth as established by the economic forecast of the Ministère des Finances.

To accomplish this, the Task Force has formulated a set of recommendations, proposals and suggestions, presented in the foregoing chapters. The Task Force is convinced that if they are implemented, these multiple initiatives will slow the growth of public health spending effectively and significantly.

15.2.1 A permanent Fund to adjust and stabilize

However, we must be realistic and agree that the different proposed initiatives will not have their full effect immediately. The Task Force estimates that if the government implements them quickly, a period of five to seven years will be necessary for their effects to be fully felt.

This means that during this period, a gap will persist between the growth rate of public health spending and collective wealth. In the meantime, this gap obviously will have to be filled.

To fund this gap, the Task Force concluded that the best solution consisted of creating a Fund starting in 2008-2009, provisioned from dedicated revenue sources. In the first few years, the Fund thus will serve to make up the difference between the increase of public health spending and the growth of collective wealth, as long as the proposed measures to increase the system's productivity have not produced their full effect.

However, it is necessary to take a longer view.

We absolutely must guard against economic fluctuations and anticipate possible adaptations as needs evolve. For this reason, the Task Force recommends that the Fund created be permanent, and that once the objective of adjusting public health spending to the growth of collective wealth is achieved, it will serve as an adjustment mechanism to future risks.

The principle the Task Force recommends be implemented is simple:

- The State would ensure the growth of public health spending from its general revenues up to the limit imposed by the growth of collective wealth.
- Beyond this, sources dedicated to health would have to cover the difference. The proceeds of these revenue sources would be deposited in a Dedicated Health Stabilization Fund.

[178] The 6.5% growth rate for 2008-2009 includes both the structural increase of expenditures and development expenditures. This rate corresponds to the approximate average for the past ten years.

❑ A Fund provisioned from two sources

This Fund should be provisioned from two sources, a tax source and a source related to the use of care.

By relying simultaneously on two revenue sources, the government would ensure that a balance is established between social solidarity, which is expressed by taxation, and individual responsibility, which is reflected by a contribution calculated according to the use of medical care.

For the Task Force, it is important that the responsibilities thus be shared between the recipient of care – an individual responsibility – and society as a whole.

As can be seen below, the Task Force recommends that the source related to the use of care take the form of a deductible, modulated according to income and the use of medical care, and that the tax source be a portion of the proceeds of the Québec sales tax (QST).

Recommendation

The Task Force recommends that the gap between the increase in public health spending and the growth of collective wealth be covered by new revenue sources dedicated to health, starting in the 2008-2009 fiscal year.

The Task Force recommends that for this purpose, the government create a Dedicated Health Stabilization Fund, starting in the 2008-2009 fiscal year, provisioned from dedicated revenue sources, namely:

— the proceeds of a deductible modulated according to the use of medical services and family income;

— a percentage of the Québec sales tax.

15.2.2 Establishment of a deductible

The social contract proposed by the Task Force implies that each citizen assumes his share of responsibility for his own health[179]. It is important to find means to make citizens aware of the costs of the health care system and the services they use. The establishment of a deductible would be one of the concrete ways to favour empowerment of each of the health care system's beneficiaries.

The principle of such a deductible is simple to describe: it would be a contribution calculated according to the medical services received under the public health care system. This contribution would be collected from the citizens concerned when

[179] See above, page 11.

they file an income tax return – thus in the year after the service is received. The contribution would be collected by Revenu Québec and paid to the Dedicated Health Stabilization Fund.

❑ A deductible calculated and capped according to income

Contrary to a user fee, which has a regressive effect, a deductible is progressive. In fact, a user fee applies to everyone, regardless of income level, while a deductible is calculated and capped according to individual and family income.

The deductible thus would be modulated and capped according to individual or family income, beyond a basic exemption. This cap would be chosen according to the expected financial return of the deductible. As we will see later, the Task Force proposes two options, depending on whether the deductible is capped at 1% or 2% of individual or family income exceeding the basic exemption.

❑ Exemptions for low-income families

Low-income families would be exempted from payment of the deductible. The Task Force proposes that, for this purpose, the government use the employee exemption thresholds for the calculation of the prescription drug insurance premium.

About 25% of families and individuals thus would be exempted from payment of the deductible.

TABLE 14

Québec Prescription Drug Insurance Plan, 2007
Deductions varying by household composition
(en dollars)

	Amount of the deduction
1 adult, no child	13,470
1 adult, 1 child	21,830
1 adult, 2 or more children	24,765
2 adults, no child	21,830
2 adults, 1 child	24,765
2 adults, 2 or more children	27,470

Source: Ministère des Finances du Québec, Information Bulletin 2007-8, November 9, 2007, page 11.

❑ An orienting effect

The deductible should be used to orient the use of medical services by citizens in the desired direction.

— Each taxpayer would receive a "T4 Health" issued by the Régie de l'assurance maladie du Québec. This document would present the costs of the medical services used during the year by the taxpayer. It would indicate the amount to be entered in the tax return.

— All the services received thus would be entered on this form. Only those affected by the deductible would be used in calculating the deductible, but the citizen concretely would see the total costs of the health care from which he benefited.

— The deductible would not apply to all health care received during the year, but only to the costs of medical visits, regardless of whether these took place in a clinic or an institution.

— The medical acts retained for the purposes of the deductible would be determined by the government based on advisory opinions issued by the body which the Task Force recommends be established, the Institut national d'excellence en santé.

— Thus, medical visits by children under age 18 would have to be excluded from the calculation of the deductible.

— It should also be self-evident that the annual checkup performed at a health clinic will not be included in the calculation of the deductible.

— The cost of each medical visit retained for the calculation of the deductible should vary according to the nature of the service or the place of delivery, which effectively would allow the orienting effect of the deductible to be applied.

  The average cost of a medical visit in Québec is about $60. For the calculation of the deductible, the government could decide to charge a lower cost for visits to first-line clinics, while retaining a higher cost for medical visits to the emergency room. Obviously, the goal would be to encourage citizens to use first-line clinics instead of emergency rooms.

— Other modalities of this nature could be envisioned, always with the logic of using the deductible to orient medical visits in the desired direction.

Recommendation

The Task Force recommends the establishment of a deductible starting in the 2009-2010 fiscal year, the amount of which would depend on the number of medical visits made during the previous year. The deductible would be calculated and capped according to household income. Low-income families would be exempted.

The deductible would be used to orient the utilization of medical services in the direction considered the most appropriate. For this purpose the government would define the criteria retained concerning the nature of the medical visits taken into account in the deductible and the cost of each medical visit charged in the calculation of the deductible.

❑ Positive impacts

The deductible recommended by the Task Force would have many advantages.

— In financial terms, it would allow the amounts citizens are able to pay to be directed to the public system.

— It would make citizens aware of the cost of the health care system. It would give them an incentive to stay healthy.

— The proposed mechanics would account for the special needs of chronic patients, who have to visit a physician more often than other people, because it would include a ceiling corresponding to a percentage of the annual income of the person concerned.

❑ The deductible would not be an obstacle to obtaining care

According to the Task Force, the establishment of a deductible would respect the principles of universality and comprehensiveness that govern our health care system.

— The deductible would not be an obstacle to obtaining a service when the need is expressed. It would be collected in the year after this service.

— The deductible would be an equitable mechanism:

  — At equal income, a person using the health care system more would contribute more to its funding than a person using it less.

  — At different incomes, a person benefiting from a higher income would contribute more to health funding than a person with a lower income, if the lower-income person's contribution reaches the maximum deductible more quickly.

— The deductible would not be paid to the care provider but would pass through Revenu Québec.

❑ Rejection of user fees

For the Task Force, a deductible is far preferable to a user fee.

A user fee can be defined in a few words.

— A user fee is another way of linking health care funding to consumption. It is a contribution paid by the patient at the point of service. It therefore constitutes an infringement of the free care offered at a given point.

— Like the deductible, the user fee is intended to make users responsible for medical care. It has the twofold objective of reducing abuses in the consumption of care and generating new funding sources.

The imposition of a user fee raises several difficulties.

— The user fee is a regressive financial charge, even if it is reduced or eliminated for low-income people.

— The user fee is blind. It moderates consumption of useful services as well as useless services. When people give up consulting a physician because of the user fee, this deferment can translate into a worsening of their health status and thus lead them to use more costly services.

— User fees would not contribute to improving the performance of our health care system.

— Its collection would raise practical problems in doctors' offices.

— The financial return of a user fee does not seem to be very convincing.

— Above all, the user fee is a direct obstacle to access to care, because it is collected at the same time as the care is claimed.

15.2.3 A dedicated consumption tax

For the Task Force, the deductible cannot constitute the only source of financing of the Dedicated Health Stabilization Fund. For reasons of balance and equity, a portion of this Fund's financing must be assured by society as a whole, via taxation.

❑ Reliance on the consumption tax

To fund public services, most experts recommend opting for consumption taxes instead of using the income tax. The European countries increasingly choose this option.

— The consumption tax affects more taxpayers than the income tax. Society as a whole would contribute to funding health care, which is not the case when direct taxation is used.

— The regressive nature of the consumption tax is limited considerably – if not eliminated – thanks to the rules currently applied. Reference is made to the tax exemption for essential goods or the existence of a refundable credit.

— Consumption taxes are paid by foreigners who buy goods or services in our territory.

— Consumption taxes are not applied to goods sold abroad. Conversely, the income tax and the tax on corporate profits have an impact on the prices of exported goods.

For these different reasons, the Task Force prefers reliance on a consumption tax as a revenue source to provision the Dedicated Health Stabilization Fund. The Task Force thus endorses one of the recommendations of the Ménard Committee[180].

The Task Force finds that if the government acts on this recommendation, it should use the sales tax for this purpose. Only the Québec sales taxes are likely to ensure a sufficient financial return for the purposes of the Dedicated Health Stabilization Fund.

Recommendation

The Task Force recommends that the government increase the Québec sales tax by one-half of a percentage point, and pay the amount thus obtained to the Dedicated Health Stabilization Fund.

❑ No health premium

While maintaining funding based mainly on general taxation, Alberta, Ontario and British Columbia have introduced health premiums calculated on taxpayers' income.

— Alberta and British Columbia have opted for premium formulas that account for ability to pay, beyond a minimum income threshold.

[180] Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, *Pour sortir de l'impasse: la solidarité entre nos générations – Rapport et recommandations*, July 2005, Recommendation 24, page 105.

— Ontario has opted for a more progressive premium.

The Ménard Committee had expressed serious reservations about the idea of imposing a health premium. Instituting such a premium would be equivalent to increasing the income tax, and this possibility had been rejected immediately.

The Task Force expresses the same criticisms.

— The advantages of a consumption tax compared to direct taxation have already been mentioned.

— It must be added that Québec is still one of the North American jurisdictions with the highest income tax. The income tax penalizes work and excessive tax rates encourage residents and companies to expatriate – particularly young graduates and companies carrying on business in cutting-edge sectors.

— Moreover, health premiums are regressive and impose a needlessly high burden on middle-class households.

For all these reasons, the Task Force does not accept the idea of imposing a health premium.

15.2.4 Funding of the Dedicated Health Stabilization Fund: a simulation of what could happen

Based on the recommendations presented above, the Task Force produced a simulation of the funding mode of the Dedicated Health Stabilization Fund.

Two options were retained for this purpose.

— Option 1 was constructed based on the following assumptions:

  — As indicated above, the deductible is calculated by charging $25 per medical visit, with a ceiling of 1% of family income after exemption.

  — The Fund is also provisioned by payment of one percentage point of the QST.

— Option 2 results from the following assumptions:

  — As already specified, the deductible is calculated by charging $65 per medical visit for the purposes of calculating the deductible, with a ceiling of 2% of family income after exemption.

  — The Fund is also provisioned by payment of half a percentage point of the QST.

❑ The two possibilities

The options presented thus illustrate two possibilities:

— Option 1 signifies that to provision the Dedicated Health Stabilization Fund, the government chooses to rely mainly on the QST, and to a more limited degree on the deductible.

— In Option 2, the choice is the opposite: the Fund is mainly provisioned by the deductible, and to a more limited degree by the QST.

In both cases, the Fund fills the gap between the public health spending forecast after implementation of the Task Force's recommendations and the contribution of the consolidated Fund, increasing according to collective wealth. The two options differ for the balance of the Fund. This balance would be higher in Option 1 than in Option 2.

The following pages present, for these two options:

— an illustration of the cost of the deductible for seven medical visits;

— the maximum annual deductible according to household composition and family income;

— a simulation of the Dedicated Health Stabilization Fund.

- **Option 1: Deductible of $25 per medical visit with ceiling of 1% of family income after exemption**

Example 1

A single person earned an income of $35,000 last year. Under the forecast exemptions, he is entitled to a $13,470 income deduction.

This person made seven medical visits in the taxation year. At the average cost of $25 per medical visit, the deductible payable would be $175 (7 visits × $25 per visit), a lower amount than the 1% ceiling applicable.

Example 2

A couple with two children earned a family income of $65,000 last year. This family is entitled to a $27,470 income deduction.

The two spouses made a total of seven medical visits in the taxation year. At the average cost of $25 per medical visit, the deductible payable would be $175 (7 visits × $25 per visit), a lower amount than the 1% ceiling applicable.

TABLE 15

Calculation table for the deductible payable for a single person and a couple with two children who made seven medical visits during a given year – Option 1
(in dollars)

		Single	Couple with 2 children
Family income	1	35,000	65,000
Deduction	2	– 13,470	– 27,470
Income after deduction	3	21 530	37,530
	4	× 1%	× 1%
Maximum annual deductible under the 1% ceiling[1]	5	215.30	375.30
"T4 Health" amount	6	175.00	175.00
DEDUCTIBLE PAYABLE	**7**	**175.00**	**175.00**
The lesser of lines 5 and 6 to be posted to the income tax return			

1 It is important to specify here that the maximum amount of the deductible is only reached in the case that the number of medical visits multiplied by the cost of the deductible is equal to or greater than 1% of family income after exemption.

- **Option 2: Deductible of $65 per medical visit with ceiling of 2% of family income after exemption**

Example 1

A single person earned an income of $35,000 last year. Under the forecast exemptions, he is entitled to a $13,470 income deduction.

This person made seven medical visits in the taxation year. At the average cost of $65 per medical visit, the deductible payable would be $455 (7 visits × $65 per visit). Accounting for the ceiling of 2% of family income, this person will have to pay a deductible of $430.60.

Example 2

A couple with two children earned a family income of $65,000 last year. This family is entitled to a $27,470 income deduction.

The two spouses made a total of seven medical visits in the taxation year. At the average cost of $65 per medical visit, the deductible payable would be $455 (7 visits × $25 per visit), a lower amount than the 2% ceiling applicable.

TABLE 16

Calculation table for the deductible payable for a single person and a couple with two children who made seven medical visits during a given year – Option 2
(in dollars)

		Single	Couple with 2 children
Family income	1	35,000	65,000
Deduction	2	– 13,470	– 27,470
Income after deduction	3	21,530	37,530
	4	× 2%	× 2%
Maximum annual deductible under the 2% ceiling[1]	5	430.60	750.60
"T4 Health" amount	6	455.00	455.00
DEDUCTIBLE PAYABLE	**7**	**430.60**	**455.00**
The lesser of lines 5 and 6 to be posted to the income tax return			

1 It is important to specify here that the maximum amount of the deductible is only reached in the case that the number of medical visits multiplied by the cost of the deductible is equal to or greater than 2% of family income after exemption.

- **The maximum annual deductible, regardless of the number of medical visits**

For each of the two options retained, the Task Force calculated the ceiling that the deductible would reach – that is, the maximum amount that would be paid by the taxpayers based on their family income, regardless of the number of medical visits.

- **Option 1: Ceiling of 1% of family income after exemption**

TABLE 17

Maximum annual deductible – Annual deductible capped at 1% of family income after exemption
(in dollars)

Family income	1 adult, no child	1 adult, 1 child	1 adult, 2 or more children	2 adults, no child	2 adults, 1 child	2 adults, 2 or more children
15,000	15	0	0	0	0	0
25,000	115	32	2	32	2	0
30,000	165	82	52	82	52	25
35,000	215	132	102	132	102	75
40,000	265	182	152	182	152	125
50,000	365	282	252	282	252	225
60,000	465	382	352	382	352	325
65,000	515	432	402	432	402	375
70,000	565	482	452	482	452	425
75,000	615	532	502	532	502	475
100,000	865	782	752	782	752	725
125,000	1,115	1,032	1,002	1,032	1,002	975
150,000	1,365	1,282	1,252	1,282	1,252	1,225
175,000	1,615	1,532	1,502	1,532	1,502	1,475

Note: According to the deductions granted in 2007.

- **Option 2: Ceiling of 2% of family income after exemption**

TABLE 18

Maximum annual deductible – Annual deductible capped at 2% of family income after exemption

(in dollars)

Family income	1 adult, no child	1 adult, 1 child	1 adult, 2 or more children	2 adults, no child	2 adults, 1 child	2 adults, 2 or more children
15,000	31	0	0	0	0	0
25,000	231	63	5	63	5	0
30,000	331	163	105	163	105	51
35,000	431	263	205	263	205	151
40,000	531	363	305	363	305	251
50,000	731	563	505	563	505	451
60,000	931	763	705	763	705	651
65,000	1,031	863	805	863	805	751
70,000	1,131	963	905	963	905	851
75,000	1,231	1,063	1,005	1,063	1,005	951
100,000	1,731	1,563	1,505	1,563	1,505	1,451
125,000	2,231	2,063	2,005	2,063	2,005	1,951
150,000	2,731	2,563	2,505	2,563	2,505	2,451
175,000	3,231	3,063	3,005	3,063	3,005	2,951

Note: According to the deductions granted in 2007.

❑ Simulation of the Dedicated Health Stabilization Fund: Option 1

TABLE 19

Simulation of a Dedicated Health Stabilization Fund – Option 1

Option 1: 1% QST and a deductible of $25 per medical visit with a ceiling of 1% of family income after exemption
(in millions of dollars)

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Additional funding needs											
Health and social services expenditures[1]	23,903	25,457	26,984	28,468	29,892	31,237	32,549	33,818	35,137	36,507	37,931
% growth		6.5	6.0	5.5	5.0	4.5	4.2	3.9	3.9	3.9	3.9
Contribution from the Consolidated Revenue Fund[2]	23,903	24,835	25,804	26,810	27,856	28,942	30,071	31,244	32,462	33,728	35,044
% growth		3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9
Gap to cover	**0**	**-621**	**-1,180**	**-1 658**	**-2,036**	**-2,295**	**-2,478**	**-2,574**	**-2,675**	**-2,779**	**-2,888**
Dedicated Health Stabilization Fund											
Additional contribution											
Consumption tax[3]	0	1,300	1,351	1 ,03	1,458	1,515	1,574	1,635	1,699	1,766	1,834
Deductible[4]	0	0	532	553	574	597	620	644	669	695	722
Total	**0**	**1,300**	**1,883**	**1,956**	**2,032**	**2,112**	**2,194**	**2,280**	**2,369**	**2,461**	**2 ,57**
Outflow of funds to cover the gap	0	-621	-1,180	-1,658	-2,036	-2,295	-2,478	-2,574	-2,675	-2,779	-2,888
Net contribution to the Health Fund	0	679	702	298	-3	-183	-284	-295	-306	-318	-331
Investment income[5]	0	0	41	85	108	115	110	100	88	75	61
BALANCE OF THE HEALTH FUND AT MARCH 31	**0**	**679**	**1,422**	**1,805**	**1,910**	**1,841**	**1,668**	**1 ,473**	**1,255**	**1,012**	**742**

1 It is assumed that the growth of MSSS expenditures decrease by 0.5%/year form 6.5% in 2008-09 to 4.5% in 2012-13 and by 0.3%/year for the next two years, from 4.5% in 2012-13 to 3.9% in 2014-15 and the subsequent years.
2 This element represents government health funding, which increases at the same rate as collective wealth (GDP).
3 The consumption tax corresponds to one point of QST.
4 The number of medical visits made by persons age 18 and over is estimated at about 41 million. It is assumed that this revenue source increases at the same rate as collective wealth.
5 A return of 6.0%/year on the current surplus is assumed.

❑ Simulation of the Dedicated Health Stabilization Fund: Option 2

TABLE 20

Simulation of a Dedicated Health Stabilization Fund – Option 2

Option 2: ½% QST and a deductible of $65 per medical visit with a ceiling of 2% of family income after exemption
(in millions of dollars)

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Additional funding needs											
Health and social services expenditures[1]	23,903	25,457	26,984	28,468	29,892	31,237	32,549	33,818	35,137	36,507	37,931
% growth		6.5	6.0	5.5	5.0	4.5	4.2	3.9	3.9	3.9	3.9
Contribution from the Consolidated Revenue Fund[2]	23,903	24,835	25,804	26,810	27,856	28,942	30,071	31,244	32,462	33,728	35,044
% growth		3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9
Gap to cover	**0**	**-621**	**-1,180**	**-1,658**	**-2,036**	**-2,295**	**-2,478**	**-2,574**	**-2,675**	**-2,779**	**-2,888**
Dedicated Health Stabilization Fund											
Additional contribution											
Consumption tax[3]	0	650	675	702	729	757	787	818	850	883	917
Deductible[4]	0	0	1,248	1,297	1,347	1,400	1,454	1,511	1,570	1,631	1,695
Total	**0**	**650**	**1,923**	**1,998**	**2,076**	**2,157**	**2,241**	**2,329**	**2,420**	**2,514**	**2,612**
Outflow of funds to cover the gap	0	-621	-1,180	-1,658	-2,036	-2,295	-2,478	-2,574	-2,675	-2,779	-2,888
Net contribution to the Health Fund	0	29	743	340	40	-137	-236	-246	-255	-265	-276
Investment income[5]	0	0	2	46	70	76	73	63	52	40	26
BALANCE OF THE HEALTH FUND AT MARCH 31	**0**	**29**	**773**	**1,160**	**1,270**	**1,209**	**1,045**	**862**	**658**	**433**	**183**

1 It is assumed that the growth of MSSS expenditures decrease by 0.5%/year form 6.5% in 2008-09 to 4.5% in 2012-13 and by 0.3%/year for the next two years, from 4.5% in 2012-13 to 3.9% in 2014-15 and the subsequent years.
2 This element represents government health funding, which increases at the same rate as collective wealth (GDP).
3 The consumption tax corresponds to half a point of QST.
4 The number of medical visits made by persons age 18 and over is estimated at about 41 million. It is assumed that this revenue source increases at the same rate as collective wealth.
5 A return of 6.0%/year on the current surplus is assumed.

15.3 Other funding sources

The health care sector's other funding sources still have to be discussed.

The Task Force wanted to present an opinion at this point concerning the question of incidental expenses charged by certain medical practices. The Task Force also makes a recommendation concerning rationalization and tarification of services.

15.3.1 The orientations regarding incidental expenses

The *Health Insurance Act* allows physicians to bill certain services which are not considered as insured, as well as certain expenses qualified as incidental for medications administered at the office, anesthetics, examinations or minor surgery and forms to be completed.

❑ Complaints and abuses

The Régie de l'assurance maladie du Québec has observed an increase in reliance on incidental expenses in private practice. The creation of associated medical clinics and specialized medical centres to perform elective surgery has relaunched the debate on this subject.

— In the past few years, the Direction des affaires professionnelles of the Régie de l'assurance maladie du Québec had to respond to a growing number of requests for information and reimbursement by insured persons contesting the billing of certain services. The number of cases to be handled more than doubled in three years, from 250 in 2003-2004 to 550 in 2006-2007[181].

— An increase in requests for information was also observed from private insurers, who want to obtain more precise information on insured services, uninsured services and incidental expenses.

— Insured persons increasingly have difficulty determining the legitimacy of the expenses billed to them in private practice.

This situation is all the more worrying in that the billing cases submitted to the Régie for reimbursement only represent the tip of the iceberg[182]. For a given billing practice, very few people will go as far as a claim to the Régie, either out of ignorance of the law, or out of fear of reprisals by the physician against whom a complaint is filed, or simply because some people accept to pay.

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[181] *État de situation sommaire sur les frais accessoires.* Régie de l'assurance maladie du Québec, Québec, July 2007.

[182] *État de situation sommaire sur les frais accessoires*..., op. cit.

— In some surgical clinics, sometimes prohibitive charges for equipment, dressings, the technical platform and staff are passed under the heading of incidental expenses.

— The Direction des affaires professionnelles of the Régie de l'assurance maladie also wonders what to do in the case of health cooperatives that request a social share and sometimes an annual contribution to fund the clinic's operating expenses, whereas historically these costs have been assumed by the physician, part of whose fee for service is stipulated to cover such expenses.

❑ Proposed solutions

The Task Force finds that the reliance of certain private practices on incidental expenses in fact raises the entire problem of their underfunding. In 2008, faced with the growing controversy, the Minister of Health and Social Services established a committee of clinical experts, the Chicoine Committee, to review this question.

The Task Force was able to discuss with the chair of this committee and, after analysis, arrived at the following conclusions. These conclusions must be distinguished depending on whether reference is made to first-line health clinics, associated medical clinics or specialized medical clinics.

■ First-line health clinics

According to one of the recommendations formulated by the Task Force, health clinics which have made an agreement would be entitled to collect an annual contribution from registered patients[183].

The advantages of such a contribution have already been mentioned:

— An annual contribution would make it possible to establish a concrete contractual relationship between the patient and his family doctor.

— It would facilitate the establishment of health clinics.

— The annual contribution would concretize the principle of the patient's freedom of choice, because he could decide the health clinic where he wishes to register and pay his contribution.

— In general, it would serve as an incentive for the productivity and quality of first-line care .

[183] See above, page 84.

For the Task Force, the possibility of adding a direct contribution by the registered patient to the funding of first-line clinics will make reliance on incidental expenses obsolete and unjustified, especially since incidental expenses are a non-structuring modality of revenue collection, with no effect on the system's performance.

■ Associated medical clinics

As we have already seen[184], Bill 33 allows an institution that operates a hospital centre to associate with a medical clinic, which will provide specialty medical services to its patients.

Given that these services are completely financed by public funds, at no charge to the patient, the Task Force recommends that all the expenses incurred to provide the required services be included in the agreements made between the institution and the associated medical clinic. Consequently, the notion of incidental expenses does not apply in this situation.

■ Specialized medical clinics

A significant share of certain specialty care is offered in private practice. Given the rise in the cost of the medical equipment and new technologies required to provide these services, the specialized medical clinics resort in turn to charging incidental expenses.

The Task Force has analyzed the situation we are facing here, namely that of specialized medical clinics in which the physicians participate in the public plan.

The Task Force recognizes that for these clinics, the outright abolition of incidental expenses would weaken their funding. The Task Force proposes that in replacement of these incidental expenses, the government institute a tarification plan for clearly identified services. These rates would have to be established jointly between the government and the medical federations. They would have to be posted and known to the patients, in complete transparency.

Such a mechanism would reduce the risks that a practice of informal payments would arise in Québec, undermining public confidence in the system.

■ The Task Force's recommendation

For the entire question of incidental expenses, the Task Force therefore makes the following recommendation.

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[184] See above, page 91.

Recommendation

The Task Force recommends that the question of incidental expenses be resolved as follows:

— Incidental expenses for first-line health clinics should be eliminated, under an agreement between the Federation of General Practitioners of Québec and the Ministère de la Santé et des Services sociaux.

— In associated medical clinics, fees for services should be included in the agreements negotiated between the institution and the medical clinic.

— In specialized medical clinics, the current incidental expenses should be replaced with a tarification plan established jointly by the government and by the medical federations.

15.3.2 Reassessing administrative expenses and reviewing the current tarification of services

Throughout its report, the Task Force has identified precise changes which should affect administrative expenses or tarification of certain services. Recommendations, proposals or suggestions thus have been presented concerning the expenses of general administration of the system at the central and regional levels, certain tax measures, several provisions of the Prescription Drug Insurance Plan or tarification of certain home-support services.

The Task Force has also noted certain worrying situations, without taking a position on the action required. This is particularly the case for tarification of ambulance services.

Appendix 2 contains a summary of several rationalization proposals[185]. The additional revenue potential could amount to over $500 million a year, according to the assumptions retained. This potential is enormous because it is recurrent.

Other situations, which were not studied by the Task Force, would be worth reassessing.

A detailed review of all the relevant factors is necessary if the government wants to restrict overspending, make tarification more realistic and more equitable and adapt the programs to the general orientations proposed. We cannot lose sight of the fact that any money poorly spent has the effect of depriving patients of care or imposing excessive taxes on the taxpayers.

Consequently, the Task Force makes the following recommendation.

[185] See below, page 273.

Recommendation

The Task Force recommends the implementation of a permanent program for reassessment of administrative expenses and review of tarification of services.

15.4 Impact of the proposed measures on the trend of expenditures and revenues

The Task Force wanted to illustrate the impact the different proposed measures could have on the trend of public health spending and revenues allocated to their funding.

— According to the projections presented at the beginning of the report, health spending would reach $42.0 billion in 2017-2018 – this figure corresponds to the structural growth of health spending according to the current trend[186]. There would then be a gap of $7.0 billion between these expenditures and the revenues coming from the Consolidated Revenue Fund, capped at the growth of collective wealth.

— The different recommendations, proposals and suggestions presented in the report would make it possible to reduce the growth of public health spending, so that in 2017-2018, the forecast level of these expenditures will drop from $42.0 billion to $37.9 billion.

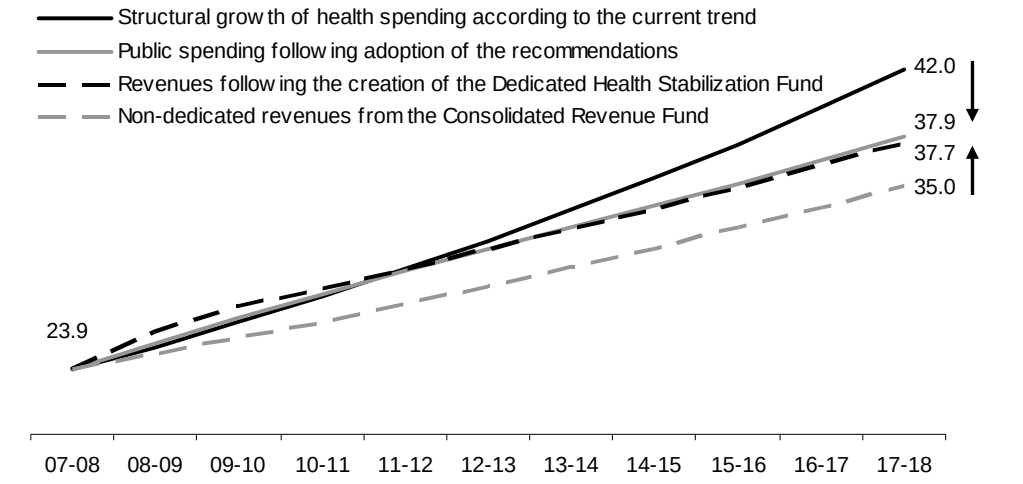
— The recommendations, proposals and suggestions concerning revenues would have the effect of increasing the revenues allocated to health from $35.0 billion to $37.7 billion in 2017-2018 by adding revenues from the Dedicated Health Stabilization Fund to the revenues coming from the Consolidated Revenue Fund.

According to this illustration, the recommendations presented by the Task Force thus would have the result of limiting the growth of revenues allocated to health coming from the Consolidated Revenue Fund to the growth rate of collective wealth, while accounting for the delay necessary for implementation of the different orientations presented.

[186] See above, page 37.

GRAPH 11

Projection of public health spending and revenues allocated to health funding, 2007-2008 to 2017-2018
(in billions of dollars)



Source: Ministère des Finances du Québec.

❑ Trend of public health spending as a share of the government's budget during the stabilization period

The projections presented here are based on the assumption that in six years, namely during the stabilization period, we will be able to reduce the growth rate of the public health spending of the Ministère de la Santé et des Services sociaux from 6.5% to 3.9%, and then maintain it at this level up to 2017-2018.

— Despite this significant slowdown, these projections mean that the health spending recorded in the government's budget nonetheless would increase by an average of 5.1% per year from 2008-2009 to 2014-2015. Public health spending thus would continue to grow during this period at a rate exceeding the increase in collective wealth.

— Moreover, health spending as a share of the government's program spending would continue to grow, rising from 44.3% to 48.0% between 2008-2009 and 2014-2015. If nothing is done, this share would increase by 50.3% during the same period.

During the stabilization period, public health spending would increase by $10.3 billion, exceeding the growth of collective wealth.

TABLE 21

Trend of health spending during the stabilization period, 2007-2008 to 2014-2015

	According to the current trend		After adoption of the recommendations	
	2007-2008	2014-2015	2007-2008	2014-2015
Trend of the weight of public health spending in program spending	44.3%	50.3%[1]	44.3%	48.0%[2]
MSSS budget in 2014-2015 (in billions of dollars)		35.5		33.8

1 Based on structural growth of health spending of 5.8% per year from 2008-2009 to 2014-2015.
2 Based on the trend of health spending as presented in Tables 19 and 20 of this report.

The projections presented here illustrate the possibility available to us to adjust the growth of public health spending to our collective ability to pay.

Quite obviously, these projections have been established on the basis of a certain number of assumptions regarding the impact of the proposed initiatives. The Task Force considers these assumptions to be completely realistic and thus wishes to emphasize that a path exists to ensure the sustainability of our health care system – while improving access to care and the quality of services.

CHAPTER 16 – BETTER INFORMATION, THANKS TO THE HEALTH ACCOUNT

In the mandate it assigned to the Task Force, the government explicitly requested that it propose "a structure for the new "health account" in order to make health funding more transparent, better inform the general public and illustrate the problem of funding in the medium term, particularly regarding the level of federal health transfers"[187].

The Task Force thus reflected on the potential nature of the health account to which the government refers, successively considering:

- the objectives thus pursued,
- the information that would be presented in the health account,
- the way the health account could be used as a tool for accountability.

Very concretely, the Task Force then elaborated an example of the different tables that would constitute the health account made public by the government.

To accompany its reflection, the Task Force commissioned a specific study on this question[188].

16.1 Objectives

A health account is not a health fund or a new budgetary mechanism. It is simply a document recording a certain amount of quantified information on health funding during a defined budget year, which the government would make public on a given date.

This document to some extent would represent a snapshot for that year of the different expenditures incurred and the revenues that allowed these expenditures to be funded.

The health account's objectives are essentially mentioned in the Task Force's mandate: the health account is an information tool, allowing greater transparency of the different budgetary and financial movements that make it possible for the public health care system to operate.

[187] See above, page 1.

[188] François Vaillancourt and Louis Morand Perrault. *Le financement des services de santé au Québec: le compte santé et son financement*, 2007.

The idea of a health account is part of the Ménard Commission's recommendations[189]. It was proposed again in the Guaranteeing access consultation document[190].

In its report, the Ménard Commission identifies three objectives for the health account[191]. A health account is established in order to:

- Improve transparency concerning both the allocation of the amounts budgeted for the health and social services sector and the revenues serving to fund them,
- Increase public awareness of the actual costs of health care and the pressure these costs exert on funding of the State's other missions,
- constitute a basis of discussion for the public debates on the issues and choices to be made in order to ensure the sustainability of health funding.

16.2 The information presented in the health account

Concretely, the health account would have two columns, one devoted to the government's health spending and the other to the revenues that made it possible to fund these expenditures.

❑ Expenditures and revenues

On the expenditure side, the health account thus would include:

- transfers to health and social services institutions,
- remuneration of physicians,
- the expenditures of the public prescription drug insurance plan,
- the debt service of the health care network,
- administration and other activities, including grants to community organizations.

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189 Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, *Pour sortir de l'impasse: la solidarité entre nos générations – Rapport et recommandations*, July 2005, Recommendation 22, page 105.

190 Ministère de la Santé et des Services sociaux, *Guaranteeing access: Meeting the challenges of equity, efficiency and quality – Consultation document*, February 2006, page 60.

191 Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, *Pour sortir de l'impasse: la solidarité entre nos générations – Rapport et recommandations*, July 2005, page 90.

Regarding revenues, the health account would contain information concerning:

- employer contributions to the Health Services Fund,
- federal health transfers in cash,
- the share of the government's general revenues allocated to health funding,
- revenues from the dedicated health funds,
- user contributions, such as the contributions to the Prescription Drug Insurance Plan, residential care and ambulance transportation.

❑ Going a little further

For the Task Force, the information presented in the account should make it possible to go a little further, to obtain a better understanding of the current trends and identify eventual areas that should be given attention.

Thus, the health account would have to include data to make it possible to:

- detect sectors experiencing rapid growth of expenditures,
- highlight the gap between revenues and expenditures for certain sectors,
- pinpoint the revenues and expenditures of the different public insurance plans – health insurance, of course, as well as prescription drug insurance, CSST, SAAQ – to emphasize the extent to which the Consolidated Revenue Fund is solicited to fill the gaps,
- produce a portrait of capital expenditures on medical equipment,
- evaluate the status of the Dedicated Health Stabilization Fund, which the Task Force recommends be established,
- identify the expenditures applied directly to the debt, and the interest on the debt specific to the health sector,
- analyze the trend of federal transfers.

16.3 The health account, a tool for accountability

The health account should be made public each year and present the most recent information possible. Collection of the data included in the health account largely depends on the availability of public accounts. The Task Force thus proposes that, like the public accounts, the health account be published in the autumn following a fiscal year: the 2007-2008 health account thus would be published in autumn 2008.

In the Task Force's opinion, the health account should result in a public debate in the National Assembly.

— The health account would be tabled in the National Assembly in autumn of each year by the Minister of Health and Social Services, who would report on the conditions of health funding.

— A parliamentary committee would hold a special session dealing exclusively with health funding.

— This session would constitute the public forum for accountability concerning the revenues collected for health care and how they have been used.

— Based on the information made public in the health account, the parliamentarians could debate issues and solutions with the aim of ensuring both the sustainability of the health care system and the funding of the State's other missions.

Proposal

The Task Force therefore proposes:

— *that the Ministère de la Santé et des Services sociaux produce a health account each year,*

— *that this health account be tabled in the National Assembly by the Minister of Health and Social Services,*

— *that a special session of a parliamentary committee of the National Assembly deal exclusively with the health account.*

16.4 An example of what the health account could be

For example, the Task Force has elaborated the different tables that would constitute the health account. These tables are reproduced on the following pages.

According to the model imagined by the Task Force, the health account thus would include:

- a table presenting the account itself for the last fiscal year reviewed (Table 22),
- additional information concerning
  - the network's expenditures (Table 23),
  - the services with user contributions (Table 24),
  - capital expenditures (Table 25),
  - tax measures specific to health, seniors and natural caregivers (Table 26).

Another table would have to be added to illustrate the situation of the Dedicated Health Stabilization Fund.

Obviously, the tables presented here are only a model of what the health account could contain. Above all, it is important that, on the basis of this publication, a good portrait of health funding is available, and a rigorous operational analysis tool.

TABLE 22

Health and social services account – Example based on the forecasts for the 2007-2008 fiscal year

Total (Gross) Expenditures[1]	Millions of $	Millions of $	Total Revenues	Millions of $	Millions of $
Department and National Operations		307.3	**HSF**		5,408.0
Administration and Departmental Management	92.7		Contribution to the Health Services Fund		
Advisory Bodies	9.4				
National Activities	205.2		**Federal Transfers**		
E.g.: Intervention Program– Hepatitis C, Hospital Services Outside Québec, Other Transfer Appropriations			Canada Health Transfers (CHT)[2]		3,425.0
					37.0
			Agreement respecting the *Federal Youth Criminal Justice Act*[3]		
Regional Operations		18,700.6	Agreement respecting Employability Assistance for People with Disabilities[3]		46.0
Health and Social Services Agencies	92.9				
Health and Social Services Establishments					
Private Institutions	487.0		**Specific Federal Government Funds**		
Public Institutions	14,709.3		HPV Immunization Trust		0.0
CHQ Rents – Network Institutions	151.3		Wait Times Reduction Trust		281,0
Financial Assistance and Organizations			Patient Wait Times Guarantee Trust		42.0
Financial Assistance to Handicapped Persons	84.4				
Community Organizations	364.3		**User Contributions**		
Financial Exemption Program for Home Assistance Services	59.4		Prescription Drug Insurance		1,403.2
Family-Type Resources	362.8		Premiums	750.9	
Public Health	70.0		Contribution by Insured Persons	652.3	
Purchase of Vaccines and Biological Products	69.8		Contribution by Adults in Residential Care		550.0
Blood System	298.3		Ambulance Services		90.1
Ambulance Services	305.7		Room Supplement		88.1
Remuneration of Interns and Residents	145.4		Intermediate Resources		86.1
Government Contribution to the Retirement Plans	656.6		Foster Families and Family-Type Resources		150.8
Debt Service	613.5		Other Revenues Collected by the MSSS		349.8
Other Transfer Appropriations	229.9				
			Contributions from Other Agencies		
Office des personnes handicapées du Québec		12.3	CSST		86.9
			SAAQ		88.7
Régie de l'assurance maladie du Québec (RAMQ)		7,696.5	Loto-Québec ({Pathological Gamblers)		22.0
Medical Services	3,794.8		Loto-Québec (Seniors Suffering from Loss of Autonomy)		30.0
General Practitioners					
Specialists			**RAMQ Reciprocal Agreements**		37.5
Optometric Care	36.3				
			Contribution from the Consolidated Revenue Fund (balance to be provisioned)		
Dental Care	110.9				
Pharmaceutical Services and Drug Insurance	3,537.9		Contribution from the Consolidated Revenue Fund		14,546.5
Other Services	138.5				
Administration	78.1		**Contribution from the Dedicated Health Stabilization Fund**		
			Contribution from the Dedicated Health Stabilization Fund		0.0
Specified Purpose Accounts					
Pathological Gamblers		22.0			
Seniors Suffering from Loss of autonomy		30.0			
TOTAL EXPENDITURES		**26,768.7**	**TOTAL DES REVENUS**		**26,768.7**

1 The gross total health expenditures correspond to the public expenditures as voted in the National Assembly upon the annual tabling of the expenditure budget, to which are added the contributions of the users and other agencies to the funding of the health and social services system..

2 This is the portion of the transfer actually received by Québec (i.e. the portion in cash). It should be noted that if Québec did not itself received, from the personal income tax a portion of the federal contribution to the provinces' health expenditures ("special Québec abatement"), this cash transfer would be $1,853 million higher in 2007-2008.

3 These federal transfer revenues are recorded under the "Other Programs" of the federal transfer revenues of the Government du Québec Consolidated Revenue Fund.

TABLE 23

Additional information – Network expenditures – Breakdown by service programs – Specific view of fast-growing sectors – Example based on the latest available data, 2005-2006

				Average annual growth (%)		
		(millions of $)	(%)	1 year	3 years	5 years
SERVICE PROGRAMS		**10,574.2**	**74.3**	**6.6**	**5.7**	**N.A.**
Physical help		4,972.1	35.0	10.0	6.9	N.A.
– Nursing	1,950.4			N.A.	3.3	N.A.
– Therapeutic services	1,778.5			N.A.	12.6	N.A.
– Diagnostic services	970.0			N.A.	5.7	N.A.
– Other services	180.9			N.A.	11.6	N.A.
– Home services	88.8			N.A.	– 2.1	N.A.
– Intermediate resources	3.5			N.A.	– 14.8	N.A.
Mental health		836.6	5.9	2.1	3.4	N.A.
Public health		237.1	1.7	7.2	13.2	N.A.
Loss of autonomy related to aging		2,089.4	14.7	2.7	3.6	N.A.
– Residential care	1,474.2			N.A.	2.4	N.A.
– Home services	298.9			N.A.	7.9	N.A.
– Other	316.3			N.A.	5.5	N.A.
Intellectual impairment		642.6	4.5	8.9	6.3	N.A.
Physical impairment		393.0	2.8	6.7	7.3	N.A.
Dependencies		73.7	0.5	3.1	6.7	N.A.
Youth in difficulty		850.6	6.0	3.7	3.8	N.A.
General services– Clinical and assistance activities		479.2	3.4	1.2	6.2	N.A.
SUPPORT PROGRAMS		**3,648.7**	**25.7**	**3.9**	**3.9**	**N.A.**
Administration (incl. Institutions)	1,077.4		7.6	N.A.	4.7	N.A.
Support to services	1,239.9		8.7	N.A.	2.6	N.A.
Building management	1,331.4		9.4	N.A.	4.4	N.A.
EXPENDITURES OF HEALTH AND SOCIAL SERVICES INSTITUTIONS		**14,222.9**	**100.0**	**5.9**	**5.2**	**N.A.**

Source: Ministère de la Santé et des Services sociaux du Québec, June 4, 2007.

TABLE 24

Additional information – Services with user contributions – Example based on the latest available data, 2005-2006

Total (Gross) Expenditures	Millions of $	Millions of $	Revenues	Millions of $	Millions of $
Prescription drug insurance		**2 ,992.9**	**Prescription drug insurance**		**1,226.7**
Recipients of last resort financial assistance			Employment insurance benefits		
With severe employment constraints	404.9		With severe employment constraints	0.0	
With temporary constraints[1]			With temporary constraints		
With no constraints	139.7		With no constraints	15.7	
Children	15.5		Children	0.0	
Members			Members		
Under 18	39.4		Under 18	0.0	
Over 18 at school	10.6		Over 18 at school	0.0	
Ages 18-64	639.6		Ages 18-64	545.8	
Seniors			Seniors		
Receiving maximum GIS	97.3		Receiving maximum GIS[2]	1.7	
Receiving 94% to 99% GIS	61.4		Receiving 94% to 99% GIS	6.7	
Receiving partial GIS	762.7		Receiving partial GIS	228.6	
With no GIS	821.7		With no GIS	428.2	
Dependence, loss of autonomy (2005-2006)		**3,072.4**	**User contribution**		**556.4**
Residential care	2,662.6		(Residential care in CHSLD)		
Home-support services	383.0		Contribution of adults in residential care (budgetary programming)	510.4	
Other services	26.8		Intermediate resources[3]	33.2	
			Family-type resources[3]	7.5	
Ambulance services			Room supplements[3]	5.3	
Pre-hospital emergency services		340.4			
			Ambulance services		**340.4**
CSST			MSSS contribution	257.7	
Health services to industrial accident victims		139.5	Network institutions – interinstitutional transportation and transportation of seniors (related-party revenues)	50.1	
SAAQ			Other departments, mainly the MESSF, for transportation of income security beneficiaries	10.1	
Public health services to road accident victims		55.9	Employers	0.9	
			Federal Government – Department of Veterans Affairs	0.7	
			Individuals and insurers	20.9	
			CSST		**139.5**
			Contributions to the public network for services rendered		
			Network	61.5	
			RAMQ	77.9	
			Ambulance services	0.1	
			SAAQ		**55.9**
			Contributions to the public network for services rendered		
			Network	51.0	
			Ambulance services	4.9	
TOTAL EXPENDTIURES		**6,601.1**	**TOTAL REVENUES**		**2,318.9**

1 EIB with temporary constraints are combined with EIB with no severe employment constraints.
2 Persons age 65 and over receiving the maximum GIS were exempted from contribution in July 2005. Persons age 65 and over receiving 94 to 99% of the GIS and EIB without severe constraints were exempted in July 2007.
3 Estimate of revenues attributable to the Seniors Suffering from Loss of Autonomy program.

TABLE 25

Additional information – Capital expenditures – Health and social services – Example based on the latest forecasts, 2007-2008 to 2011-2012

(in millions of dollars)

	2007-08	2008-09	2009-10	2010-11	2011-12	Total
Asset maintenance						
– Real estate, furniture and equipment	630.5	715.3	805.,8	838.7	853.8	
– Elimination of the maintenance deficit		202.1	202.1	202.1	202.1	
	630.5	917.4	1,007.9	1,040.8	1,055.9	4,652.5
New initiatives						
– CHUM		95.4	238.4	477.0	143.1	
– MUHC		95.5	238.6	477.4	143.2	
– CHU Sainte-Justine	25.8	64.6	129.3	28.2		
– CHU Sherbrooke	23.3	23.3	41.5			
– Health Infoway	45.0	30.0	33.5			
– IR project – Infoway institutional component	50.0	50.0	50.0			
– CHSLD – 1,000 beds in PPP	17.5	37.5	51.5	32.5	7.5	
– Other projects	630.8	621.6	1,028.2	1,097.6	286.3	
	792.4	739.1	1,163.2	1,130.1	293.8	4,118.6
TOTAL	**1,422.9**	**1,656.5**	**2,171.1**	**2,170.9**	**1,349.7**	**8,771.1**

TABLE 26

Additional information – Tax measures specific to health care, seniors and natural caregivers – Example based on the latest available data, 2005 to 2008

(in millions of dollars)

	2005	2006P	2007P	2008P
Tax expenditures specific to health care				
Non-refundable tax credit for medical expenses	298	334	351	368
– Under age 65	N.A.	N.A.	N.A.	N.A.
– Age 65 or over	N.A.	N.A.	N.A.	N.A.
Refundable tax credit for medical expenses	23	30	31	33
Tax credit for a person with a severe and prolonged impairment in mental or physical functions	24	18	19	19
Tax expenditures in favour of seniors and natural caregivers				
Refundable tax credit for home support services for seniors	91	104	191	204
Refundable tax credit for natural caregivers[1]	17	37	38	38
Refundable tax credit for persons who provide respite to natural caregivers	—	—	5	10

P: Projection.
1 including the refundable tax credit for housing a relative, which was replaced in 2006.
Source: Ministère des Finances du Québec, *Tax Expenditures*, 2007 edition.

CHAPTER 17 – AN UNSUITABLE LAW: THE *CANADA HEALTH ACT*

In the mandate it assigned to the Task Force, the government asks for a study of the "changes that could be suggested so that the necessary adjustments are made to the *Canada Health Act* (R.S.C. 1985, c. C-6)"[192] [193]

The Task Force thus considered this Act, relying for this purpose on an opinion produced at its request[194].

- The *Canada Health Act* is primarily a financial act, setting out certain principles to be observed – failing which the provinces are penalized regarding the federal health transfers they receive.
- Contested by the Gouvernement du Québec, the *Canada Health Act* in fact impedes evolution in the definition of the public health systems of Canadian provinces.
- This Act, sooner or later, will have to be adapted to today's realities.

17.1 The contents of the *Canada Health Act*

In 1984, the Parliament of Canada adopted the *Canada Health Act*. The founding principles of this Act recapitulated those set out in the two previous federal acts – the Hospitalization Insurance Act of 1957 and the Medical Care Act of 1966.

The *Canada Health Act* sets out five criteria to which the provincial plans must conform to receive the federal government's financial participation – public administration, comprehensiveness, universality, portability and accessibility.

At the time of its adoption, the *Canada Health Act* had the explicit objective of prohibiting the payment of contributions by users and the billing by physicians of fees in addition to those covered by the provincial plans. Since its adoption, this Act has never been the object of significant amendments.

However, the federal government seized this opportunity to introduce tight control, via the five criteria, over the provincial hospitalization insurance and medical care plans and their operation.

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192 See above, page 1.

193 The constitutional basis of the *Canada Health Act* is the general spending power the Parliament of Canada claims to possess. From the outset, Québec opposed its adoption. The Gouvernement du Québec considers that the Québec health care system and health insurance plan are under its exclusive jurisdiction and that it has the power to control the planning, organization and management of health services in its territory, on the basis of the Québec legislative and regulatory framework.

194 Patrick MOLINARI, *L'interprétation de la Loi canadienne sur la santé: repères et balises*, November 2007.

The *Canada Health Act*

The *Canada Health Act* came into force on April 1, 1984. Its purpose is to establish the criteria and conditions under which the federal government is authorized to grant and pay *"a full cash contribution"* for *"insured health services [...] under provincial law"*.

Insured health services, as defined by the *Canada Health Act*, include all necessary hospital services and medical services provided by a physician and medically necessary surgical-dental services which can only be provided suitably in a hospital.

The federal government pays the full amount of its cash contribution when the health insurance plan of a province or territory is in compliance with the five criteria defined in the *Canada Health Act:*

- public administration: the plan must be administered and operated on a non-profit basis by a public authority responsible to the government of a province and subject to audit of its accounts and financial transactions;
- comprehensiveness: the plan must insure all insured health services provided by hospitals, medical practitioners or dentists and, where the law of the province so permits, similar or additional services rendered by other health care practitioners;
- universality: one hundred percent of the insured persons of a province are entitled to the insured health services provided for by the plan on uniform terms and conditions;
- portability: when a person settles in another province, the province of origin must assume the costs of the insured health services during the minimum period of residence or waiting period imposed by the new province of residence, a period which must not exceed three months;
- accessibility: the plan must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to these services by insured persons; the plan must also provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists and for the payment of amounts to hospitals in respect of the cost of insured health services.

The *Canada Health Act* in fact is inspired by a centralizing concept of federalism which no longer has any place. According to this concept, the provincial governments, in the absence of a federal framework, would be likely to adopt measures contrary to their citizens' interests – which gives this Act its excessive character.

— The federal Minister of Health and the Government of Canada, which do not have to deal with the difficult and complex problems inherent in the health care systems, have the mission of keeping the provincial governments in orthodoxy and on the straight path plotted fifty years ago.

— By relying on the Act, the federal government can reduce and even cancel the federal contribution to a province, if it considers that there has been a breach of one of the criteria of the Act.

— From the legal standpoint[195], the *Canada Health Act* does not confer any rights on persons that they could invoke to have their province adopt measures intended to give them access to health services that would be in compliance with the Canadian legislation.

— The provinces remain completely free, subject to their citizens' constitutional rights, to legislate as they see fit on anything excluded from the scope of application of the *Canada Health Act*.

17.2 A law that impedes the evolution of health care systems

This law contested by the Gouvernement du Québec has had the effect of impeding any evolution of the health care systems in Canadian provinces.

Since 1984, the provincial health care systems have been closely governed by the random interpretation of the five criteria of the federal Act. In Québec, as in the rest of Canada, there has been little evolution of our health care system, especially when compared to the health care systems of the vast majority of Western countries.

— Hospitalization insurance was introduced in 1960 and was followed in 1970 by coverage of medical care. In both cases, this involved complete 100% coverage of hospital and medical care for citizens. The objective was to cover other care and services in blocks and completely, step by step – including dental care, prescription drugs, home care and physiotherapy.

— However, faced with the faster than anticipated increase in the costs of hospital and medical care, this scenario never materialized. In fact, only hospital and medical expenses remained protected by the federal Act. Certain radiology services in medical clinics were even deinsured.

From many points of view, the foundations of the provincial health care systems have remained the same since their origin, despite the profound changes in knowledge, technologies, care delivery modes and individuals' expectations.

The *Canada Health Act* today is a negation of the evolution of health care at a time when medication, first-line care and ambulatory care are recognized everywhere as more effective and efficient solutions than hospitalization.

For example, all the expenses inherent in a procedure in a hospital environment are covered, while they are not covered if the procedure takes place outside the hospital. The *Canada Health Act* thus unduly privileges hospital care over ambulatory care.

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[195] According to the legal study performed at the Task Force's request, Patrick MOLINARI, *L'interprétation de la Loi canadienne sur la santé: repères et balises*, op. cit.

❑ Many perverse effects

The *Canada Health Act* has many perverse effects.

— The Act requires that access to hospital and medical care not be impeded or precluded by financial obstacles. It thus privileges hospital and medical care alone over other forms of care. In the era of ambulatory care, primary care and home-support services, the exclusive coverage of hospitalization continues to put the priority in the wrong place.

— The experience of a great many countries is that it is possible to correct certain undesirable care consumption profiles by imposing targeted contributions, or deterrent fees, payable by the users. The *Canada Health Act* categorically prohibits such a path. However, the World Health Organizations recommends that the obligations of individuals to participate in the expenses be defined in consideration of their rights to benefits.

— The principle of comprehensiveness, one of the five principles of the *Canada Health Act*, also produces undesirable effects. According to this principle, a provincial plan must cover all medically required health services provided by hospitals and medical practitioners. This principle, as defined, does not seem to allow reconsideration of the effectiveness and efficiency of some of these types of care.

  This is true of deinsurance or exclusion from coverage of certain common care for minor ailments, which could be a completely justified way of reducing the system's costs and redirecting funds to essential needs.

❑ The imprecision of the *Canada Health Act*

Over the years, some analysts have pointed to the imprecision of the *Canada Health Act*, which opens the door to arbitrary interpretations.

According to the *Canada Health Act*, the administration of the plan must be managed by a non-profit authority. Since the *Canada Health Act* says nothing about various other components of the system, all interpretations are possible in their regard.

Thus, a few years ago, the Government of Alberta wanted to favour the development of a broader range of services in private medical clinics, in accordance with the widely recognized concept of ambulatory care. To block this development, the opponents of this initiative successfully invoked the fact that the clinics were not non-profit. Yet the Act is silent on such a question.

This is not the first time that the imprecision of the *Canada Health Act* has been denounced. Thus, the Clair Commission Report deplored the imprecision of the *Canada Health Act* in the following terms: "It is not surprising that in Québec, as elsewhere in Canada, there is no longer anyone who can say for sure, without

consulting a lawyer, exactly what services are really insured, within what time period, by whom and in what circumstances they must be produced"[196].

17.3 The necessary adaptation of the *Canada Health Act*

The *Canada Health Act* penalizes orientations that are legitimate and desirable, when the emphasis clearly should be placed on improvement of access and the quality of care, productivity of the system, efficient use of the enormous resources allocated to health, motivation of personnel at all levels, and innovation.

In seeking to protect the integrity of provincial health care systems designed over forty years ago, the *Canada Health Act* has hindered their evolution to the point that Canada as a whole, in many regards, is lagging behind most countries in health care.

The Task Force is convinced that the orientations proposed in its report not only respect the spirit of the five criteria of the *Canada Health Act*, but would have the effect of improving access and the quality of care.

The unsuitable and unduly restrictive provisions of the *Canada Health Act* should give way to a flexible framework favouring adaptation of the provincial health care systems, based on respect for their jurisdiction in this field. The fact that this Act has acquired a special status with the Canadian population is not a valid reason to avoid its modernization.

[196] Commission d'étude sur les services de santé et les services sociaux. *Emerging solutions – Report and recommendations*, 2000, page 134.

CONCLUSION

At the end of its report, the Task Force wishes to return to the nature of the orientations it proposes and the spirit with which the different recommendations and proposals transmitted to the government were formulated.

Principles respected

The Task Force does not call any of the fundamental principles of the plan into question.

In the Task Force's mandate, the government specified that the recommendations presented should be compatible with the maintenance of a strong public health plan, protection of the most disadvantaged – particularly access to care, regardless of their social status and income level –, and maintenance of high quality criteria, both for the public sector and for private services.

The Task Force is persuaded that this is the case. In fact, the different recommendations were formulated with the idea of ensuring the sustainability of a health care system built on such principles.

Within the framework of the social contract it proposes, the Task Force thus identifies changes that are in continuity, in terms of principles, with efforts already made and changes of direction already initiated.

Profound and orderly changes

However, these changes are major. The Task Force outlines the way to profound transformations in relation to our current ways of doing things and the obligations of each citizen to the health care system. These transformations are inspired by the best practices observed around the world.

The Task Force recommends that they be implemented in an orderly and gradual manner, adopting a horizon of five to seven years for this purpose.

Adapting to the realities of the 21st century

For the Task Force, the principal challenge we have to face collectively is to adapt our health care system to the realities of the 21st century context, taking into account current demographic trends, present and future technological changes, and the political and social realities characterizing our society and our environment.

Globalization is one of these new realities which we must integrate into our vision of the health care system, as in most sectors of human activity.

The balance between rights and obligations

The vision the Task Force proposes is stimulating and motivating, but It supposes new commitments for every player in society.

The Task Force is persuaded that in the health care sector, as in many other areas, we have rights and obligations.

A balance must be achieved between what we are asking of society and what we want to receive from it, between what we are ready to offer it and what we expect of it. The Task Force wants the vision it outlines and the orientations it proposes to respect this balance.

The urgency of action

Finally, the Task Force is persuaded that it is urgent to act in the health care sector.

Québec is confronted with a challenge that also faces the other developed countries. However, we have been late to introduce certain innovations and initiate certain changes, running the risk that we will soon be faced with challenges that are much more radical, which we would be compelled to apply against our will.

We can maintain a health care system that reflects our vision of life in society and the principles to which we are attached, on condition that we act quickly and with determination.

This collective effort can only be taken, however, if citizens endorse it and share this same vision. The Task Force hopes that this report and the reflections of which it is the culmination will contribute directly to such an effort.

APPENDIX 1

THE TASK FORCE'S RECOMMENDATIONS

❑ Defining a central objective

The Task Force considers that Québec must ensure the permanence of the public health care system by increasing its productivity and adjusting the growth of public health spending to the growth of collective wealth, while improving access to care and the quality of services.

❑ The proposed target

Recommendation

The Task Force recommends that the government adopt the objective, over a horizon of five to seven years, of reducing the growth of public health spending so that it does not exceed the growth of collective wealth.

❑ Review of the current coverage of the public system

Recommendation

The Task Force recommends that the government proceed with a systematic, structured and ongoing review of public coverage, adopting a permanent, credible and legitimate mechanism for this purpose.

❑ Healthy living and limiting costs through prevention

Proposal

The Task Force encourages the government to pursue the efforts undertaken to prevent disease and promote health.

❑ A first-line health clinic for everyone in Québec

Recommendation

The Task Force recommends that the government accelerate the deployment of health clinics, in order to ensure that every Quebecer has access to a family doctor.

This deployment should be carried out over a five-year horizon.

Recommendation

The Task Force recommends that the government give health clinics which have made an agreement with the regional agency the right to collect an annual contribution from the registered patients.

❑ Innovations for access to care

Recommendation

The Task Force thus recommends that mixed practice by physicians be authorized within prescribed limits and on condition of an agreement with their institution[197].

Proposal

The Task Force proposes that the Act authorize recourse to private insurance for services already covered by the public plan[198].

Proposal

The Task Force proposes that the initiatives regarding the role of the private sector and those resulting from the actions already taken by the government be evaluated over a five-year horizon.

❑ An aging population

Recommendation

The Task Force recommends that a collective process of reflection be initiated on the medium and long-term repercussions of population aging.

❑ Loss of autonomy and home-support services

Recommendation

The Task Force recommends:

— that for seniors suffering from loss of autonomy, the government give priority to home-support services and that for this purpose, it support a high level of investment in this sector;

— that medical, nursing and specialized care covered at home be covered universally by the public plan and that the other home-support services, for assistance with activities of daily living and home assistance, be the object of graduated coverage according to degree of dependence, nature of the service and ability to pay (in all cases, the most disadvantaged should be protected);

— that eligibility for a tax credit be the object of an income test.

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197 This recommendation is the object of a dissenting position by Mr. Michel Venne, see Appendix 3, page 277.

198 This proposal is the object of a dissenting position by Mr. Michel Venne, see Appendix 3, page 277.

Recommendation

The Task Force recommends that the Ministère de la Santé et des Services sociaux concede the operation of the CHSLDs to the appropriate resources within a five-year horizon.

❑ Better use of medications at a controlled cost

Proposal

The Task Force proposes that the government tighten the rules regarding the application of the exceptional measures provided in the Basic Prescription Drug Insurance Plan, imperatively accounting for the advisory opinions of the Conseil du médicament.

The Task Force also proposes that a single body be given the authority over all advisory opinions issued in the health care system on the therapeutic value and the cost-effectiveness ratio of medications.

Recommendation

The Task Force recommends that the parameters of the public prescription drug insurance plan be amended so that the members assume the entire cost of the plan for their insured group.

❑ Governance: changes to pursue, a new culture to be implemented

Recommendations

The Task Force recommends that the mission of the Ministère de la Santé et des Services sociaux be refocused on the establishment of the health policy and objectives, the definition of insured services, the establishment of national standards, the allocation of resources for the purposes of capital and operating budgets to the regional agencies, the establishment of performance indicators, and evaluation and approval through the designated bodies.

The Task Force recommends that the Ministère de la Santé et des Services sociaux withdraw from providing care as such.

Recommendation

The Task Force recommends to the government that the regional agencies have the mission to translate the national policy and priorities into implementation strategies in their territories, as purchasers of services from care and service providers, and that they benefit from broad autonomy for this purpose.

Recommendation

The Task Force recommends that the CSSS and the other institutions benefit from a large degree of autonomy and the means to assume their responsibilities, and that in exchange, they be fully responsible for their management.

Recommendation

The Task Force recommends that the health clinics be fully responsible for their financial resources and their professional and technical staff and that, in exchange, they be fully accountable for their management.

Recommendation

The Task Force recommends that the health care system be based on the rights and obligations of all stakeholders, including physicians, by means of contractual agreements.

Recommendations

The Task Force recommends that each regional agency and each institution be governed by a board of directors, whose responsibility is to ensure effective management of the resources entrusted to them.

For this purpose, the Task Force recommends that the boards of directors be composed of a limited number of independent members, chosen on the basis of their competence, and that they be remunerated.

Recommendations

The Task Force recommends that a well-structured, complete and systematic program be established to evaluate institutional performance in relation to the health objectives and the clinical and economic points of view, and to evaluate patient satisfaction.

The Task Force also recommends that the results of the evaluations be publicized periodically.

Proposal

The Task Force considers that the implementation of demonstration projects with the aim of testing other hospital management modes could identify fruitful new paths and make interesting comparisons of effectiveness and performance at different levels[199]

[199] This proposal is the object of a dissenting position by Mr. Michel Venne, see Appendix 3, page 277.

❑ An incentive-based and strategic allocation of resources

Recommendation

The Task Force recommends that for institutional funding, the historical-based budgeting method be replaced with the purchase of services method.

Proposal

The Task Force proposes that the purchase of services method be implemented gradually, starting with a pilot region, to allow enough time for training and acquisition of the necessary information tools.

❑ A dynamic and effective work organization

Recommendations

The Task Force recommends that the government induce and encourage the health care sector's institutions to replace the current bureaucratic and centralized culture with a dynamic work organization.

The Task Force recommends that the government grant a dedicated budget to every institution that presents a work organization renewal program.

The implementation of this new work organization could be supported by the foundations and investment funds intervening in the health care field.

Recommendation

The Task Force recommends that despite the appeal recently filed against the Superior Court judgment on Bill 30, the government and the unions engage in a dialogue with the aim of creating positive dynamics in labour relations, based on mutual respect by the parties involved.

❑ A credible and independent body to play a strategic role: the Institut national d'excellence en santé

Recommendation

The Task Force recommends the combination within an Institut national d'excellence en santé of the Conseil du médicament du Québec, the Agence d'évaluation des technologies et des modes d'intervention en santé and the Health and Welfare Commissioner, in order to entrust an independent and credible body with a strategic role regarding the relevance and quality of health services.

In particular, the Institute should:

— Make recommendations periodically on the composition of the basket of services insured by the public plan.

— Evaluate new health technologies, including medications, to recommend their inclusion on the list of medications or in the basket of insured services.

— Review the relevance of retaining the technologies and medications currently covered on the list and in the basket of insured services.

— Ensure a watch of new technologies and new modes of intervention appearing on the market to identify the most relevant.

— Produce clinical protocols and practice guides.

Proposal

The Task Force proposes that the government take the appropriate measures to favour the emergence of the discipline of health economics, by supporting specialized research centres or chairs in this field.

❑ New information technologies to serve patients and managers

Recommendation

The Task Force recommends that the Québec Health Record be deployed only once the pilot project has been completed in a region of Québec and once its results are analyzed. It is important that change management be given special attention.

Recommendation

The Task Force supports the approach initiated by the government to cease to require the patient's explicit consent ("opting in") and to replace it with an "opting out" mechanism. It recommends that this approach be carried out.

Recommendation

The Task Force recommends that the priority be placed on deployment of the electronic patient record in each of the institutions and in the health clinics.

Recommendation

The Task Force recommends the creation, within the Ministère de la Santé et des Services sociaux, of the position of a person responsible for planning, establishment of norms and standards and deployment of information technology throughout the health care system, including the Régie de l'assurance maladie du Québec and the institutions.

❑ Sustainable and diversified revenue sources

Recommendation

The Task Force recommends that the gap between the increase in public health spending and the growth of collective wealth be covered by new revenue sources dedicated to health, starting in the 2008-2009 fiscal year.

The Task Force recommends that for this purpose, the government create a Dedicated Health Stabilization Fund, starting in the 2008-2009 fiscal year, provisioned from dedicated revenue sources, namely:

— the proceeds of a deductible modulated according to the use of medical services and family income;

— a percentage of the Québec sales tax.

Recommendation

The Task Force recommends the establishment of a deductible starting in the 2009-2010 fiscal year, the amount of which would depend on the number of medical visits made during the previous year. The deductible would be calculated and capped according to household income. Low-income families would be exempted.

The deductible would be used to orient the utilization of medical services in the direction considered the most appropriate. For this purpose the government would define the criteria retained concerning the nature of the medical visits taken into account in the deductible and the cost of each medical visit charged in the calculation of the deductible.

Recommendation

The Task Force recommends that the government increase the Québec sales tax by one-half of a percentage point, and pay the amount thus obtained to the Dedicated Health Stabilization Fund.

Recommendation

The Task Force recommends that the question of incidental expenses be resolved as follows:

— Incidental expenses for first-line health clinics should be eliminated, under an agreement between the Federation of General Practitioners of Québec and the Ministère de la Santé et des Services sociaux.

— In associated medical clinics, fees for services should be included in the agreements negotiated between the institution and the medical clinic.

In specialized medical clinics, the current incidental expenses should be replaced with a tarification plan established jointly by the government and by the medical federations.

Recommendation

The Task Force recommends the implementation of a permanent program for reassessment of administrative expenses and review of tarification of services.

❑ The health account

Proposal

The Task Force therefore proposes:

— *that the Ministère de la Santé et des Services sociaux produce a health account each year,*

— *that this health account be tabled in the National Assembly by the Minister of Health and Social Services,*

that a special session of a parliamentary committee of the National Assembly deal exclusively with the health account.

APPENDIX 2

SUMMARY OF SEVERAL RATIONALIZATION PROPOSALS

❑ A summary of several rationalization proposals

The Task Force has identified certain programs and situations which should be the object of changes, rationalization or a reduction of administrative costs. Recommendations or proposals have been formulated for this purpose.

The potential is high. Depending on the decisions that could be made, this could amount to over $500 million a year.

TABLE 27

Summary evaluation of administrative expense and tarification revision scenarios studied by the Task Force

(presented as an illustration)

Description	Reduction of expenditures Millions of $	Increase in revenues Millions of $
A. Administration of the health care system		
➢ Review the governance of the health care system (MSSS and regional agencies).	50	
B. Pre-hospital emergency services		
➢ Increase the fees for ambulance service. Currently the cost of using an ambulance services is $125 (in force since 1997) plus $1.75 per kilometre (in force since 1989), except for persons age 65 and over for whom the service is free. Currently these fees cover about 25% of the actual cost of ambulance service. For example, a fee revision could take one of the following forms: • Index the fees according to the Consumer Price Index for past years, namely from 1997 for the basic fee and from 1989 for the fee per kilometre, and maintain free service for seniors; • Increase the fee to cover the actual cost of the plan and fix a minimum contribution per trip for social assistance recipients and seniors; • Apply the actual cost for corporate users and fix a minimum contribution per trip for social assistance recipients and seniors.	Between 15 and 100*	
C. Tax measures		
➢ Introduce an income test for the tax credits for home-support services and natural caregivers. This proposal would make it possible to reduce the refundable tax credits for home-support services for seniors and for natural caregivers. The credit would be reduced at a rate of 3% for each dollar of family income in excess of $29,645.		45
▪ **Prescription drugs**		
➢ Ensure that the members of the public plan assume the entire cost of their participation in the Prescription Drug Insurance Plan (see Chapter 9).	211*	
E. Home-support services		
➢ Introduce a user contribution based on income for assistance with activities of daily living and home assistance activities. A user contribution based on ability to pay could be charged for assistance with activities of daily living (washing, eating, getting dressed, personal grooming, etc.) and home assistance activities (housekeeping, preparing meals, doing the laundry, etc.).	Between 25 and 75*	
TOTAL	Between 301 and 436	45

* These proposals would increase the revenues of the health and social services network (institutions, ambulance services, FMGs, etc.) but would translate into an equivalent reduction of government expenditures.

APPENDIX 3

THE DISSENTING POSITION

The Task Force on Health Funding could not achieve unanimity on all of the recommendations and proposals presented in the report. A dissenting position was recorded by Mr. Michel Venne on three points specifically identified in the report. His position is explained in this appendix.

Concentrating our efforts on the public system

At the end of the mandate of the Task Force on Health Funding, I feel obliged to express my disagreement with three specific points of the report, all related to the role of the private sector.

After several months of research, debate and reflection within the Task Force, I have come to the conclusion that it is inexpedient at this time to allow broader openings to the private sector than those already provided for in Québec health services.

I thus express my dissent regarding one recommendation and two proposals.

— I oppose the removal of the prohibition against physicians practising both in the public system and in the private system, which is referred to a decompartmentalization of medical practice[200].

— I also disagree with a greater opening to private insurance[201].

— Finally, I am against the idea of entrusting specialized private companies with management of hospital administration[202].

The reasons for this opinion are serious and well considered.

— The three points on which I express my dissent are breaches in the overall logic of the report, in my opinion. They create a diversion and give rise to contradictory interpretations.

— The prohibition against physicians practising both in the public system and the private system and the prohibition of duplicate insurance are two important means made available to the Minister of Health and Social Services to control the shift between the public system and private providers. It would be an error to eliminate its use.

— Finally, solving the problems of our health care system depends on mobilization of the system's players. For this mobilization to succeed, the government must establish unequivocally and without ulterior motives that it gives priority to the public system. These three measures risk being perceived by a great many stakeholders as a disavowal of the public system and

[200] My dissent concerns all of paragraph 7.2.2, which begins on page 92 of the report.

[201] My dissent concerns all of paragraph 7.2.3, which begins on page 93 of the report.

[202] My dissent concerns all of paragraph 10.4.2, which begins on page 170 of the report.

hindering the implementation of the solutions identified by the Task Force to improve and ensure the sustainability of the public system.

A pro-public report

Before explaining the grounds of my dissent, I consider it important to discern the Task Force's essential message.

The report resulting from our work clearly focuses on the public system's capacity to pursue its reforms and satisfy the population's needs. It is a pro-public report.

The Task Force report contains the elements that would allow the public system to live up to its ambitions, while imposing essential discipline to avoid escalating costs.

The Task Force's recommendations rely on mobilization and the sense of responsibility of all the health care system's players, form the patient to the Minister. The Task Force proposes a new social contract.

Under this new social contract, the Task Force believes it is necessary, however, to recognize and include the existing private sector players in the supply of care. Nearly 80% of family medicine services are provided by private practices. Many private, cooperative or non-profit organizations provide services of inestimable value for our fellow citizens each day. It is time to favour better collaboration with them.

For the objectives established in the Task Force report regarding the public system to be achieved and for more harmonious collaboration with the private service providers, two conditions must be fulfilled.

— The first condition is to establish the priority of the public system unequivocally.

— The second condition is to establish clear supervision of the private offering.

Supervision of the private offering

Let us discuss the second condition first. It is in the process of being achieved. With the deployment of family medicine groups and network clinics, the government has established a framework for first-line medical services. Bill 33 allows regulation of specialized clinics and establishment of the modalities of collaboration between them and the hospitals.

The Task Force report contains several measures complementary to this supervision, particularly:

— The obligation for physicians practising in a hospital environment to make a contractual agreement with their hospital. These agreements should fix the conditions, among others, under which a physician would be authorized to complement his hospital practice with private clinical practice.

— The abolition of the incidental expenses charged in private clinics, which are sources of abuse and loopholes, and their replacement with well controlled revenue sources.

— The obligation to proceed by call for tenders for a hospital to award a contract to an associated medical clinic, so that the process is more transparent.

— Systematic evaluation over a five-year horizon of initiatives related to the private sector. This evaluation must focus on the costs of these procedures, their impact on human resources within the public system and the quality and safety of the care provided.

My conviction is that the measures put in place, apart from a few administrative rules, will favour the desired collaboration. The rules in force and those that we recommend be added will also, in my opinion, allow quite enough control so that private practice does not jeopardize our public system in any way.

Maintaining two means of control

In addition to the rules I have just mentioned, the Minister of Health and Social Services has two important means that allow him to exercise control over the balance between the public system and private practice. These two means are the prohibition against physicians practising in both systems at the same time and the prohibition of private insurance for care already insured by the public plan.

The decompartmentalization of medical practice and reliance on duplicate private insurance are practices permitted elsewhere in the world. In theory, there is no justification that they remain prohibited in Québec. But we are not living in a theoretical world. In practice, it would be an error to remove this prohibition today.

— The reforms initiated recently have not reached maturity. In some environments, they still arouse apprehensions.

— Moreover, the openings made recently to the private sector are encouraging a certain appetite in a minority of physicians tempted to withdraw from the public plan.

  Several stakeholders reminded the Task Force of the problems caused by shortages of physicians in several regions of Québec, including the Greater Montréal region for some specialties.

  The decompartmentalization of medical practice, combined with the extension of private insurance, would give other physicians an incentive to withdraw at least partially from the public system. This situation would have the effect of increasing the difficulties related to the current shortage.

On the one hand, the situation created by Bill 33 is too instable to add reasons for uncertainty. On the other hand, it would be an error to take away these two

important means that allow the Minister of Health and Social Services to control the situation.

Mobilizing the public system's players

There is another reason why I am expressing my disagreement with these two measures. This reason for dissent also applies to the proposal made in the Task Force report to entrust hospital administration to specialized private management companies.

As I have already mentioned, the first condition for achieving our objectives is that the priority of the public system be recognized unequivocally in order to mobilize its principal players.

Yet these three proposals risk being perceived by a great many stakeholders as a disavowal of the health care system.

The Task Force report is a call for mobilization of all of the system's players. The Task Force asks them to make major efforts over the next five to seven years to render this system more productive and more effective. The Task Force asks them to set aside the conflicts that have pitted them against each other and to work together to establish a better workplace climate. The Task Force invites them to change their culture.

To give this venture of renewal and mobilization every chance of success, the system's players must feel that they have the support and confidence of their executives.

To create this favourable climate, it is essential to avoid sending contradictory messages. It is not possible to mobilize the public system's players in a large-scale operation and encourage their adherence to a new social contract if, at the same time, they are given the impression that the ground is being prepared for the private sector.

In particular, the proposal to entrust a private company with administration of a hospital would be perceived as a vote of non-confidence against the public system's administrators who are faced with major challenges every day.

An appeal to the government

I believe in this report.

I hope that the government and the health care sector's different players will endorse it and implement it. It is urgent to improve our public system, increase its effectiveness, and make the most appropriate choices to ensure the population's access to the services it is entitled to expect, particularly that each Quebecer can have a family doctor.

In this operation, the private sector can play a role on certain conditions. But it would be unproductive to go beyond what has already been initiated in this regard.

I therefore invite the government to consider the points mentioned in this dissenting position. My hope is that, very quickly and unequivocally, the Minister of Health and Social Services will announce the rejection of the three proposals that would have the effect of expanding the private sector's role in health services beyond what is already foreseen.

The Minister thus would clearly affirm the priority to be given to the solutions identified by the Task Force to improve the public system and ensure its sustainability. At the same time, he would invite the general public and the system's players to focus their attention on these proposals.

The private sector's role is not the principal problem of the health care system in Québec. Nor would its expansion be the solution to the difficulties confronting us.

The solutions to the public system's problems are essentially found in the public system. There is where attention must be focused and where the debates should be concentrated.

A concern for coherence

This report is a pro-public report. The three points on which I express my dissent create a diversion from our main message. It is the uncertainty created by the presence of these three proposals that obliges me to dissent from them today.

I hope that this dissenting opinion will enlighten my fellow citizens on the deep meaning of the report.

Michel Venne
Vice-Chair of the Task Force on Health Funding

Montréal, February 8, 2008

APPENDIX 4

THE MEMBERS OF THE TASK FORCE AND THE SUPPORT STAFF

❑ The members of the Task Force on Health Funding

Claude Castonguay, Chair

Joanne Marcotte, Vice-Chair

Michel Venne, Vice-Chair

❑ Ministère des Finances

Brian Girard, Secretary and Assistant Deputy Minister for Economic and Fiscal Policies

Pierre Côté, Assistant Secretary and Director of the Direction de l'analyse des politiques et de l'information budgétaire

Alain Boisvert, Advisor with the Direction de l'analyse des politiques et de l'information budgétaire

Gisèle Gauthier, Senior Secretary, Office of the Assistant Deputy Minister for Economic and Fiscal Policies

❑ Ministère de la Santé et des Services sociaux

Jacques Cotton, Assistant Deputy Minister, Direction générale de la coordination, du financement, de l'équipement et des ressources informationnelles

Hung Do, Director of the Direction des politiques et du système financier

❑ Ministère du Conseil exécutif

Jean-Pierre Pellegrin, Assistant Secretary, responsible for the Direction des politiques publiques et des prospectives, Secrétariat aux priorités et aux projets stratégiques

Claire Fecteau, Administrative Technician with the Direction des politiques publiques et des prospectives, Secrétariat aux priorités et aux projets stratégiques

Julie Morissette, Senior Secretary with the Direction des politiques publiques et des prospectives, Secrétariat aux priorités et aux projets stratégiques

❑ Secrétariat du Conseil du trésor

Michèle Bourget, Associate Secretary, Sous-secrétariat aux politiques budgétaires et aux programmes

Jean-François Lachaine, Director of the Direction des programmes sociaux et de santé

Yves Labbé, Analyst with the Direction des programmes sociaux et de santé

Yves Sigmen, Analyst with the Direction des programmes sociaux et de santé

APPENDIX 5

THE INDIVIDUALS AND BODIES MET BY THE TASK FORCE

TABLE 28

List of Consultations Performed by the Task Force

Group or individual	Name	Date of meeting
Ministère des Finances	Ms. Monique Jérôme-Forget, Minister of Finance, Minister of Government Services, Minister responsible for Government Administration and Chair of the Conseil du trésor	June 21, 2007
Ministère de la Santé et des Services sociaux du Québec	Mr. Philippe Couillard, Minister of Health and Social Services	July 12, 2007
	Mr. Roger Paquet, Deputy Minister	July 12, 2007
	Drs. Bureau, Galarneau and Laliberté	August 15, 2007
	Mr. Claude Ouellet Mr. Yves Marchand	October 3, 2007
	Ms. Lise Verrault, Assistant Deputy Minister	November 20, 2007
CIRANO	Mr. Claude Montmarquette, Professor at the Université de Montréal and Vice-President, Public Policies at CIRANO Ms. Joanne Castonguay, Project Manager Mr. Iain Scott, Research Professional	July 12, 2007
Participants in the McGill University International Masters for Health Leadership program	Professor Henry Mintzberg, Dr. Michel Boivin, Dr. Yv Bonnier Viger, Dr. André Dontigny, Mr. Sholom Glouberman, Professor, Dr. Eric Litvak, Ms. Antonia Maioni, Dr. Marie Rochette, Ms. Diane Marie Plante, Dr, Terry--Nan Tannenbaum	August 15, 2007 Sept. 26, 2007 October 22, 2007
Federation of Medical Specialists of Québec	Dr. Gaétan Barrette, President	Sept. 5, 2007
Federation of General Practitioners of Québec	Dr. Reynald Dutil, President accompanied by Drs. Langlois, Godin, Saucier and Asselin	Sept. 5, 2007
Health care network expert	Mr. Yvan Gendron, Executive Director, Centre de santé et de services sociaux – Montérégie	Sept. 6, 2007
Health care network expert	Mr. Michel Larivière, Executive Director Ms. Johanne Roy, Assistant Executive Director Hôpital du Sacré-Cœur de Montréal	Sept. 11, 2007
Health care network expert	Ms. Josée Noreau, CEO, SOGIQUE inc.	Sept. 11, 2007
Health care network expert	Mr. René Rouleau, Executive Director, CHUQ	Sept. 11, 2007
Health care network expert	Mr. Luc Boileau, Executive Director, Agence de santé et de services sociaux – Montérégie	Sept. 12, 2007
Ordre des infirmières et infirmiers du Québec	Ms. Gyslaine Desrosiers, President	Sept. 12, 2007
Fédération des médecins résidants du Québec	Dr. Martin Bernier, medical resident Mr. Jean Gouin, Executive Director Ms. Johanne Carrier, Communications Advisor	Sept. 19, 2007
Conseil pour la protection des malades	Mr. Paul Brunet, President	Sept. 19, 2007
Regroupement provincial des comités d'usagers	Mr. Jean-Marie Dumesnil (CHUM) Mr. Gérald Germain (CHUQ) Mr. André Poirier (CSSS-Arthabaska)	Sept. 19, 2007

List of Consultations Performed by the Task Force (continued)

Group or individual	Name	Date of meeting
Chambres de commerce du Québec	Ms. Françoise Bertrand, CEO Ms. Caroline St-Jacques, VP, Public Affairs and Communications Mr. Jean Laneville, Economist Mr. Alain Robitaille, Consultant with the Mercer firm	Sept. 19, 2007
Health care network expert	Dr. Michel Charest, President and Chief Executive Officer, Médiclub1/	Sept. 26, 2007
Health care network expert	Dr. Josée Provencher, Medical Director, Opmedic	Sept. 26, 2007
Health care network experts	Mr. David Levine, CEO Mr. Louis Côté, Director, Planning and Human Resources Ms. Louise Massicotte, Assistant Executive Director, Agence de la santé et des services sociaux de Montréal	Sept. 26, 2007
Conseil québécois de la coopération et de la mutualité	Ms. Hélène Simard, CEO Ms. Marie-Joëlle Brassard, Director, Research and Development Mr. Gaston Michaud, Founder of La Brunante COOP d'habitation des aînés de Racine, Mr. Bernard Gélinas, physician Clinique coopération d'Aylmer, Mr. Benoît Caron, Executive Director, Fédération des coopératives de services à domicile	Sept. 27, 2007
Health care network experts	Dr. André Munger GMF des Grandes-Fourches	Sept. 27, 2007
Health care network expert	Dr. Fernand Taras, Clinique Rockland Md.	Sept. 28, 2007
Lucie and André Chagnon Foundation	Mr. André Chagnon, President Mr. Pierre Fortin, Professor at UQAM Mr. Jean-Marc Chouinard Dr. Michel Boivin	Sept. 28, 2007
Health care network expert	Dr. Juan Roberto Iglesias, CEO, Agence d'évaluation des technologies et des modes d'intervention en santé	October 2, 2007
Health care network experts	Mr. Marc Giroux, Interim CEO. Mr. Pierre Roy, ex-CEO Mr. Guy Simard, Actuary, Régie de l'assurance maladie du Québec	October 3, 2007
Health care network expert	Mr. Alex Potter, President Ms. Lise Denis, Executive Director Mr. Michel Delamarre, Executive Director, Hôpital Laval, Association québécoise des établissements de santé et de services sociaux	October 9, 2007
Association des centres jeunesse	Mr. Jean-Pierre Hotte, Executive Director	October 9, 2007
Fédération de la santé et des services sociaux – CSN	Ms. Francine Lévesque, President Mr. Claude Saint-Georges	October 9, 2007
Fédération interprofessionnelle de la santé du Québec	Ms. Lina Bonamie, President Ms. Michèle Boisclair, Vice-President Ms. Lucie Mercier, Consultant Mr. Marc Thibault-Belle-Rose, Consultant	October 9, 2007

List of Consultations Performed by the Task Force (continued)

Group or individual	Name	Date of meeting
Health care network expert	M. Louis Côté, Director, Planning and Human Resources, Agence de la santé et des services sociaux de Montréal	October 10, 2007
Health care network expert	Dr. Jean Mireault, Director, Clinical Services, MediaMed Technologies inc.	October 12, 2007
CSN	Ms. Claudette Carbonneau, President Ms. Denise Boucher, 3rd Vice-President Ms. Josée Roy, Assistant to the Executive Committee	October 16, 2007
Fédération des professionelles — CSN	Mr. Tremblay, President Ms. Ginette Langlois	October 16, 2007
Chantier de l'économie sociale	Mr. Nancy Neamtan, CEO Mr. Charles Guindon	October 16, 2007
Fédération des travailleurs et travailleuses du Québec	Mr. Henri Massé, President Mr. René Roy, Secretary General, FTQ Mr. Michel Arsenault, Québec Director, Steelworkers Union Mr. Daniel Boyer, President, Syndicat québécois des employées et employees de service Mr. Michel Poirier, Québec Director, Canadian Union of Public Employees Ms. Louise Valiquette, Assistant Director, Canadian Union of Public Employees Ms. Monique Audet, Economist, FTQ Research Service	October 17, 2007
Quebec Medical Association	Dr. Jean-Bernard Trudeau, President Ms. Claudette Duclos, Executive Director Dr. Alain Larouche, Medical Affairs Consultant	October 17, 2007
Health care network expert	Mr. Jean-Pierre Chicoine, President Mr. Pierre Laliberté Comité de travail sur les frais accessoires	October 17, 2007
Health care network experts	Dr. Robert Maguire, Bas Saint-Laurent Dr. Jocelyne Sauvé, Montérégie Dr. Richard Lessard, Montréal Directors of Public Health, Régie régionale de la santé et des services sociaux du Bas Saint-Laurent	October 30, 2007
Association des fondations des établissements de santé du Québec	Mr. Roland Granger, CEO Mr. Jean-Denis Côté, 1st VP Mr. Donat Tadeo, CEO of the McGill University Health Centre (MUHC) Foundation	November 20, 2007
Collège des médecins	Dr. Yves Lamontage, CEO Dr. Yves Robert, Secretary	December 4, 2007
Association des jeunes médecins du Québec	Dr. François-Pierre Gladu, President	December 18, 2007
Health care network experts	Mr. Michel Grant, Université du Québec à Montréal Mr. Alain Rondeau, Université de Montréal, Professors	December 21, 2007

APPENDIX 6

THE STUDIES COMMISSIONED BY THE TASK FORCE

TABLE 29

List of Studies Commissioned by the Task Force on Health Funding

Study	Produced by	Date tabled
Le financement des services de santé au Québec: le compte santé et son financement (Funding of health services in Québec : the health account and its funding)	*Mr. François Vaillancourt*, Professor, Université de Montréal Mr. *Louis Morand Perrault*, M.Sc. student, Economics, Université de Montréal	August 2007
Personnes âgées en perte d'autonomie : les soins de longue durée à domicile et en milieu de vie substitut (Seniors suffering from loss of autonomy : long-term care at home and in a substitute living environment)	*Mr. Michel Clair*, President Groupe Santé SEDNA	August 2007
Le choix des priorités du « panier de services », la pertinence/efficacité/efficience des soins : des enjeux de financement (Choosing priorities from the "basket of services", relevance/ effectiveness/efficiency of care : funding issues)	*Mr. Léonard Aucoin,* M.Ps., M.P.H. InfoVeille Santé Ltée	September 2007
Modes d'organisation des services prometteurs pour le Québec (Promising modes of organization of services for Québec)	*Mr. Paul A. Lamarche*, Professor, Department of Health Administration, Université de Montréal Mr. *Raynald Pineault*, Institut national de santé publique Mr. *Yvon Brunelle*	October 2007
Efficience et budgétisation des hôpitaux et autres institutions de santé au Québec (Efficiency and budgeting of hospitals and other health care institutions in Québec)	*Mr. Pierre Ouellette*, Professor, Department of Economics, Université du Québec à Montréal	November 2007
Intensité du déploiement des technologies de l'information dans les établissements de santé au Québec (Intensity of deployment of information technologies in health care institutions in Québec)	*Mr. Guy Paré*, Professor, Canada Research Chair in Information Technology in Health Care, HEC Montréal *Mr. Claude Sicotte*, Professor, Department of Health Administration, Faculty of Medicine, Université de Montréal	November 2007
L'interprétation de la *Loi canadienne sur la santé* : repères et balises (The interpretation of the Canada Health Act: references and benchmarks)	*Mtre Patrick Molinari*, Professor, Faculty of Law, Université de Montréal	November 2007

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