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

FEBRUARY 2008

GETTING OUR MONEY'S WORTH

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ACCESSIBLE PATIENT SERVICES
SUSTAINABLE FUNDING
A PRODUCTIVE SYSTEM
SHARED RESPONSIBILITY

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The Québec government set up the Task Force on the Funding of the Health Care System at the time of the 2007-2008 Budget Speech of May 24, 2007,[1] to make recommendations on how best to adequately fund the health care system.[2]

The Task Force was chaired by Claude Castonguay. Two vice-chairs, Joanne Marcotte and Michel Venne, were appointed after consulting with the opposition parties.

To respond adequately to its mandate, the Task Force dealt with the question of funding the health care system in its broadest sense: the Task Force is convinced that to secure such funding and by the same token the survival of the system, action needs to be taken on both the revenue and the spending sides, clear objectives must be set regarding public coverage and the system's managers, health care professionals, sector workers and the general public must be made aware of the issues at stake.

■ A central objective

From the outset, the Task Force sought to define a central objective to its task, illustrating its priorities and its vision of things: the Task Force considers that Québec must secure the long-term viability of the public health care system by increasing its productivity and adjusting the growth in public health spending to the growth rate of Québec's economy, while improving access to care and quality of services.

❑ The vision: a new social contract

This objective could form the core of a new "social contract" that would be acknowledged as such by Quebecers as a whole. The Task Force believes that the time has come for Quebecers to agree on what could constitute a new social contract designed to ensure the long-term viability of a system we are all strongly attached to, but which cannot be maintained without rigorous effort and a collective awareness of the issues at stake.

■ Appealing to Quebecers' sense of responsibility

This social contract is first of all an appeal to Quebecers' sense of responsibility. Of all our public programs, the health system is the most significant expression of the solidarity that unites all citizens to respond collectively to the basic needs of every human being. Created during the Quiet Revolution, it quickly became the largest service organization in Québec. However, forty years on, the health system is

1 *Budget Speech*, p. 19, 2007-2008 Budget, May 2007, Finances Québec.

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

suffering from a crisis of confidence: our system is costly compared to our collective wealth, and is not as productive as it could be.

Everyone is aware of the difficulties of the health system, yet the situation is not changing quickly enough. The reason is simple: no-one dares call into question the particular interests at play. There is another reason for this failure to act: we have transformed certain features of our system into dogma, features that other countries have questioned long ago.

In recent years, we thought we could resolve the system's problems by rationing services or injecting massive amounts of new money into it. It soon became apparent that these reactions were inadequate. The amount of financial resources is only one part of the solutions to the problems of the health system. They owe much more to how these resources circulate and are used in the system.

The first condition for improving our public system is to accept that funds circulate differently in the system and must be used optimally. To satisfy this condition, each player in the system, from the individual citizen to the minister, must agree to question what he takes for granted and what he thinks he knows.

■ Values and principles

This new social contract is based on a number of values and principles that should be familiar to all. The Task Force has identified six, namely universality, solidarity, fairness, efficiency, responsibility and freedom.

The Task Force believes it goes without saying that these principles interact and must be interpreted in relation to each other.

■ Specific obligations for each player

The social contract proposed by the Task Force is embodied in a set of obligations that are incumbent on the primary players of the system. The social contract proposed by the Task Force notes that each player in the system enjoys rights and must also satisfy obligations.

— For the citizen, the first commitment should be to accept his share of responsibility regarding his own health. The citizen must also contribute to the system's funding according to his means, and in accordance with his consumption of care.

— The primary responsibility of health professionals, physicians in particular, is to provide the right service to the right person at the right time. Health professionals are the chief guarantors of quality of services. Health professionals also have a duty to ensure continuity of care and good cooperation among various categories of professionals.

— Managers ensure the system runs efficiently. In return for greater recognition of their local autonomy and fair remuneration, they are responsible for offering efficient services at the lowest possible cost.

— The system cannot evolve if the various interest groups fail to agree to make concessions and cooperate on essential reforms. The changes that are needed have all the more chance of succeeding if they are implemented with the support, influence and cooperation of the players involved. Lack of cooperation would therefore put the system itself at risk. The groups concerned must be aware of this. The Task Force invites them to work together. Goodwill is necessary to secure the system's long-term viability.

— The government's first duty is to be consistent. After setting the limits of the public system's commitment, the government must do what is necessary to keep its promises.

  The government must also verify the quality of services provided, assess the system's performance and implement the necessary incentives in this regard. The ministère de la Santé et des Services sociaux must agree to restrict its role to the broad functions of administration, and thus withdraw from care delivery. Lastly, the government is responsible for providing the health system with the financial resources it needs, and doing so on a predictable basis.

  The responsibility of the federal government is also at issue. The federal government must ease the requirements contained in the Canada Health Act. It must keep its part of the social contract through stable funding.

— For the Task Force, the new social contract should make it possible to lift the taboo that is the role of the private sector, while clearly defining the contribution and responsibilities Québec society agrees to assign to it.[3]

  The Task Force believes that the contribution of the private sector should be viewed as a complementary resource: it means giving Quebecers more freedom of choice on how to meet their health needs, while making essential improvements to the public system by introducing elements that will foster vitality and emulation. This is a vision diametrically opposed to privatization.

  The Task Force is convinced that there is a role for the private sector, while keeping to the bases of the public system. The private sector should be recognized as an ally of the public system, while clearly delineating its role, rather than continuing to needlessly view it as a threat.

None of the components of the social contract we have outlined calls the bases of our public health system into question. On the contrary, the Task Force's main proposal is to invite Quebecers to renew their confidence in the public system as

3 See the dissenting position of Michel Venne on certain points relating to this question in the appendix.

part of a collective view of things that calls on the responsibility of every player in the system, from the citizen to the minister.

❑ The current situation: health care in Québec and elsewhere

The Task Force began by reviewing the current situation of the health system in Québec, as it sees it.

■ Québec's health system: its strengths and weaknesses

In chapter 1, the Task Force attempts to set out the system's strengths and weaknesses.

The existing health system in Québec is the most important public program set up and administered by the Québec state, in terms of cost. The system we are familiar with today is the culmination of an evolution that goes back many decades. Québec's health system has been reformed many times, each time with the objectives of making the administrative structures more efficient and improving the organization of care. In contrast with these reforms, the funding method of our health system has changed little.

Québec's health system offers a very broad range of services, with a high level of quality and regardless of the recipient's ability to pay. The vast majority of citizens declare themselves satisfied or very satisfied with the services provided, once they have received these services.

And there is the problem: Quebecers do not have ready access to the services of their health system. In terms of access to care, Quebecers are served less well than citizens of other provinces. Despite recent improvements, this situation persists. In terms of productivity, Québec's health system compares poorly with what is observed in many other jurisdictions. Moreover, Québec's health system faces severe human resources problems.

Québec's health system, with its strengths and weaknesses, is faced with a fundamental problem, namely the whole question of its funding. Since 1998-1999, the economy has grown by an average of 4.8% a year, while during the same period, public spending on health and social services has risen by an average of 6.4% per year.

This gap between growth in public spending on health and growth of the economy reduces, year after year, the financial leeway available to the government to adequately fund other state missions. Accordingly, the share of health spending in the government's program spending is rising consistently.

— In 1980-1981, spending on health and social services represented 30.6% of program spending, i.e. less than education and roughly the same as all other portfolios.

— In 2007-2008, this proportion stood at 44.3% compared with 24.9% for education and 30.8% for all other portfolios. The proportion of program spending allocated to health and social services has consistently risen by five percentage points per decade.

All indications are that the upward pressure on health care costs will continue in the future. According to projections by the Secrétariat du Conseil du trésor, health spending is forecast to rise by 5.81% per year over the period 2008-2018.

TABLE 1

Forecast annual growth in health spending (structural growth), 2008-2018
(Per cent)

	Share of spending	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.

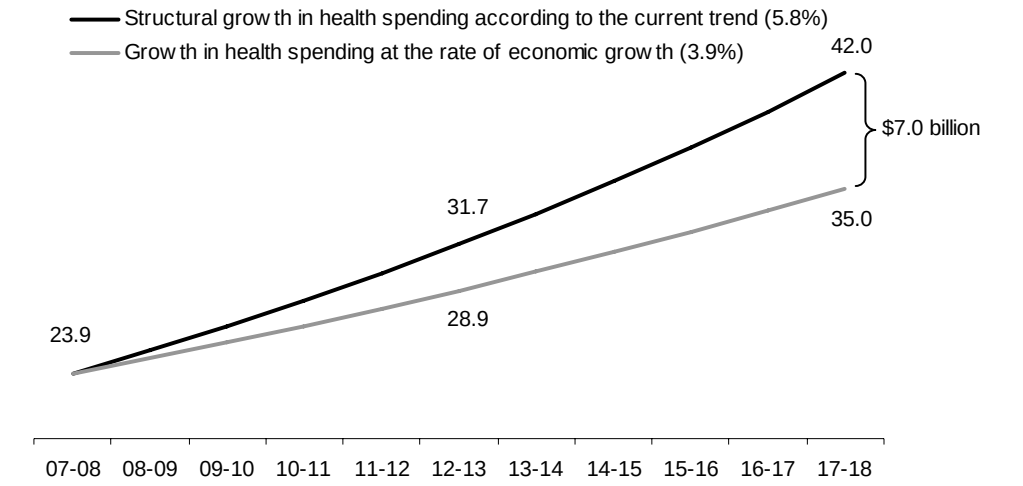
According to the ministère des Finances forecasts from the fall of 2007, the economy and government revenues should grow by some 3.9% per year on average from now to 2017-2018.

That means that a significant gap is anticipated between the increase in government revenues and the rise in health costs, based on conservative assumptions. In absolute terms, and taking 2007-2008 as the base year, the difference would amount to $2.8 billion in 2012-2013 and could reach $7.0 billion by 2017-2018.

These figures encapsulate the entire problem of health funding. To bridge this gap, the government has no choice but to take new initiatives to slow the growth in spending and act on the revenue side to reduce pressure of public finances.

CHART 1

Projected public spending on health
2007-2008 to 2017-2018
(Billions of dollars)



Source: Ministère des Finances du Québec.

■ The international economic context: a source of inspiration for Québec

Chapter 2 examines the international context, looking for sources of inspiration that could apply to the situation in Québec.

The questions regarding how Québec's health system operates and its current and future funding arise in most industrialized countries, often in similar terms.

In all industrialized countries, other than the United States, the common value and fundamental objective of health systems is universal access to care.

The problems are of the same nature: the share of public and private spending on health is rising in relation to GDP, pressure on health costs is acute for demographic reasons, public spending on health is increasing faster than the economy and government revenues and, in recent years, societies are becoming aware of the issue of quality of care.

To resolve these problems and meet these challenges, the health care systems of industrialized countries have undergone numerous reforms over the last twenty years.

In all these countries, there is agreement on the priority that must be placed on ambulatory care and front-end service.

The development of well-organized medical clinics with clear objectives helps to improve both access to and quality of care. Since they are not burdened by the cumbersome structures of hospitals, medical clinics can achieve significant cost reductions.

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

International data confirm that it is possible to improve cost-effectiveness of health systems through better delivery. Some budgetary practices often only result in encouraging institutions and professionals to do less.

In general, the goal is to reduce the politicization of the system and, in return, establish clear lines of accountability.

In systems where funding and delivery of care is a public responsibility, the measures taken to separate the roles of insurers or purchasers from those of producers of services have generally proven effective.

The emphasis has been put on decentralization in many countries. The objective is for decisions to be taken at the level where the action is. De-emphasizing top-down measures and programs fosters innovation and motivation.

It has also been observed that where they have been implemented, automated information systems have had a very positive impact, both on quality of care and on cost.

❑ A frame of reference: setting fair and realistic limits

The Task Force recommends that the central objective it has identified be given practical form as a frame of reference, setting quantitative and qualitative limits on the public health system.

■ A quantitative limit: adjust growth in public health spending to that of the economy

The frame of reference the Task Force is proposing includes a quantitative limit, justified and explained in **chapter 3**.

— Limits have always been placed on services offered under the public health system. The Task Force mentions this at the outset.

— The Task Force notes that, more than ever, new limits must be defined for the public health system and that, in this regard, choices must be made. The reasons forcing these choices must be stressed once again.

— The Task Force proposes that these choices be reflected in a quantitative target, representing the quantitative limit set on the growth of public health spending. The proposed limit is demanding, but can be achieved, providing the corresponding resources are made available.

  The proposed approach is that the government set a clear objective that everyone understands and whose implementation can be easily assessed and quantified. The Task Force believes it is fair that growth in health spending follow the pace of growth of the economy.

— However, this objective is very demanding and the Task Force is well aware of this. Significant efforts will be needed to achieve it. To begin with, it must be supplemented by a qualitative limit on the coverage of the public health system.

  Setting this objective must go hand-in-hand with a realistic and operational action plan. The broad outlines of the plan proposed to the government are given in the Task Force's report.

■ A qualitative limit: set limits on public coverage and set priorities

Chapter 4 focuses on the qualitative limit proposed in the report, consisting in setting limits on public coverage on the basis of quality and efficiency criteria, with choices based on scientific knowledge and public deliberation.

By proposing a redefinition of the existing public coverage, the Task Force is raising a sensitive debate.

— This debate requires pointing out first of all the problems that result from the public coverage applied by Québec's health system, coverage that is incoherent and rigidly defined.

— The Task Force has sketched the broad strokes of a mechanism for changing and redesigning this coverage, with a view to proposing an approach to the government that is both credible and legitimate.

— However, the application of such a mechanism and the resulting limits set on public coverage can only be successfully achieved provided certain conditions are satisfied. The Task Force has attempted to identify them.

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

❑ Services: the right health service offered by the right person at the right time

Reducing growth in public health spending while improving quality of care and access to services implies an effort and initiatives that concern many key elements of these various services. In many cases, the government will have to make targeted investments in the knowledge that such investments have substantial 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 system so that in our system, the right health service is offered by the right person at the right time.

These recommendations, proposals and suggestions as well as the thinking behind them are articulated in five chapters.

■ Healthy living and limiting costs through prevention

Chapter 5 focuses on prevention: the goal is to propose that Quebecers adopt a healthy lifestyle and thereby limit the costs of the system.

— The Task Force begins by stating what it means by prevention, by setting out the economic dimension of successful prevention.

— In recent months, the government has launched major prevention initiatives. In most industrialized countries, issues relating to prevention, such as efforts to combat smoking or obesity, are at the top of the public agenda. Taking these concrete examples, the impact of prevention on the health system, and the general economy, can be measured.

— These reflections and analyses naturally lead to a number of guidelines that all seek to boost individual and collective investment in prevention.

■ A primary health care clinic for everyone in Québec

In **chapter 6**, the Task Force deals with the question of primary care, a question that is crucial to the smooth operation of the system as a whole.

Accessible and efficient front-end services will help reduce the costs of the health system as a whole, relieve hospital congestion and offer care at lower cost. The Task Force is convinced that the development of health clinics will help relieve hospitals of part of the existing demand, and thus improve the productivity of hospitals overall.

— The Task Force begins by stating what is meant by primary care, which services are included and which stakeholders deliver them.

— Québec has made progress in strengthening primary care. It is important to acknowledge this progress.

— At the same time, it must be recognized that the ground covered is by no means sufficient. Many industrialized countries do much better than us in this regard. The Task Force has primarily attempted to identify the reasons for the delays in organizing primary care.

— At the conclusion of its analysis of primary care, the Task Force formulates a set of recommendations and proposals for the government to bolster its efficiency and accessibility. These recommendations include a consideration of the role of the private sector.

— They also include a financial involvement by users consisting of an annual contribution to health clinics.

■ Initiatives for access to care

In **chapter 7**, the Task Force proposes a number of initiatives to improve access to care. These improvements include a greater role for the private sector so that it becomes an ally of the public sector.

For the Task Force, a review of the organization of care is inseparable from any analysis of the question of health care funding. More effective organization of care will contribute to the solutions to this question. The priority the government must place on primary care will not be enough if we want to improve significantly the organization of care. A number of initiatives that have proven successful abroad must also be introduced in our health care system.

Progress has been made in this regard. However, more needs to be done.

The Task Force has analyzed and accepted four innovations it sees as relevant and promising. The Task Force proposes:

— more transparent relations with associated medical clinics;

— limited openness of mixed medical practice;[4]

— more possibilities for individuals to purchase private insurance;[5]

— increased use of hospital equipment by granting public hospitals the opportunity to access private sources of revenue.

These initiatives must be clearly framed. The Task Force believes it is essential that their results be assessed regularly.

4 Michel Venne has taken a dissenting position on this proposal. See the appendix.

5 Michel Venne has taken a dissenting position on this proposal. See the appendix.

■ A response adapted to aging and loss of autonomy

Chapter 8 contains the Task Force's recommendations and proposals for a response adapted to aging and loss of autonomy.

In 2008, Québec has just over one million people age 65 or over. This number will continue to grow, exceeding two million within twenty years.

The aging of the population is already having an effect on health care funding, and this effect will grow. Average per capita spending rises with age. Considering the impact of the aging of the population on health costs, some predict that a crisis is inevitable, jeopardizing the existence of our social programs. In contrast, others believe that we will deal with the aging of the population without too much difficulty.

— A number of points should be made concerning the impact of aging on the individual and health costs. These points will be made at the beginning of the chapter.

— The Task Force believes that the question of aging must be approached from a long-term point of view, recognizing that the impact of an aging society goes well beyond health services funding.

— The Task Force considers the nature and implications of a public insurance plan for loss of autonomy. It has concluded that Québec should not opt for that solution.

— The Task Force then concentrates on what lies in store for us over the coming years. Based on the experience of developed countries, an analysis of what is happening in Québec and the formulation of a number of observations, the Task Force presents the guidelines of what could be a strategy for the coming decade. This strategy involves six guidelines, the first of them being that the government give priority to home support and that to that end, it maintain a high level of investment in this sector.

■ Better use of drugs at controlled cost

Chapter 9 is devoted to drugs. The Task Force deals with a major therapeutic and economic issue to identify ways to make better use of them and control costs more effectively.

The Task Force explains the scope of the issue before dealing with ways in which the contribution of drugs to the health system can be improved, namely:

— by encouraging optimal use of drugs;

— by improving the funding rules of the Régime général d'assurance médicaments.

❑ Marshalling resources: a productive and efficient health system

By formulating the central objective on which this report is focused, the Task Force has put implementation of a productive and efficient health system front and centre. To secure the long-term viability of the public health system, we must improve its productivity, which means we must marshal the resources needed to offer necessary services to the population.

Five chapters are devoted to these resources.

■ Governance: instilling a new culture

Chapter 10 examines the governance of the health system: a new direction is needed and a new culture must be instilled.

Our health system is, by far, the largest and most complex organization in Québec. It operates 24 hours a day, 365 days a year, and affects every citizen without exception at the most basic level and often when they are most vulnerable.

Governance of such a system is extremely complex and presents a daunting challenge. The Task Force is sensitive to the efforts that have been made to improve matters. At the same time, it is convinced that many initiatives can be taken to improve governance, and that that provides us with a strategic means to significantly improve the system's productivity.

— We must begin by profiling the system from the standpoint of its governance and its operation. Positive changes have been implemented, but it must be agreed that our system is performing well below its potential.

  In terms of management of our health care system, the results are far from positive. More generally, the Task Force reaches conclusions on governance and the operation of the health system regarding the transposition of policies, responsibility and accountability, changes in structure and the existence of a two-boss system in institutions.

— The Task Force concludes from its observations that a change in culture is necessary to build a coherent system of governance all of whose components are working for the satisfaction of citizens' needs. This change is backed by four principles of governance.

— Concretely, the Task Force formulates a set of recommendations and proposals affecting most aspects of the system's governance and management. These recommendations and proposals apply at a number of levels:

  — The Task Force recommends that the very governance structures of the health network, i.e. the ministère de la Santé et des Services sociaux and

the regional agencies, be kept separate from producers of services, namely all the institutions offering care to individuals.

- Producers of services, namely the CSSS, but also health clinics and all the other institutions providing care, must have broad autonomy but be fully responsible for their management.
- The health system should be based on the rights and obligations of all stakeholders, including physicians, by means of contractual agreements.
- Each regional agency and each institution should be headed by a board of directors consisting of a limited number of independent members, selected for their skills, and remunerated.
- Citizens should be participants at various points in the decision-making process.

— Lastly, the Task Force stresses the necessity of performance assessment and proposes that there should be no hesitation in testing new approaches regarding management.[6]

■ Incentive and strategic allocation of resources

In chapter 11, the Task Force considers the questions relating to the allocation of resources, by identifying ways to make it an incentive and strategic tool for performance.

Public spending on health, whose size and extremely rapid growth threaten the system's long-term viability, can be used as a management tool, to improve our system's efficiency and productivity.

The Task Force specifically examines the allocation of resources, i.e. how public resources are used within our health system. The terms and conditions under which resources are allocated within the system are a powerful tool that can be used to improve performance and efficiency. It appears that Québec has not really put this tool to work.

Almost all industrialized countries have more or less thoroughly changed how budgets are set for institutions, with the objective of better controlling rising health costs.

These changes stem from a common observation: the old budgeting methods allow no room for efficiency incentives. To remedy this shortcoming, the new methods are based essentially on funding services provided. Accordingly, the Task Force recommends that for the purposes of funding institutions, the historical budgets method be gradually replaced with the service procurement method.

6 The section devoted to demonstration projects for testing new management approaches has prompted a dissenting position by Michel Venne. See the appendix.

■ Dynamic and efficient organization of work

Chapter 12 puts the accent on human resources and their management, by pointing out the existing difficulties and laying the foundations for dynamic and efficient organization of work.

The Task Force is convinced that the organization of work in the health sector is one of the keys to resolving the current challenges.

— The persons and organizations consulted by the Task Force painted a negative picture of the situation in institutions, characterized by bureaucracy and confrontation. These observations are not new. They must be analyzed clearly.

— New models for organizing work are available and some of them have started to prove their worth, even here in Québec.

  The Task Force describes their main features with a view to formulating recommendations and proposals to enable their implementation. These recommendations and proposals are based on the conviction that it is possible to resolve labour relations problems through the organization of work.

■ A credible and independent organization to play a strategic role: the Institut national d'excellence en santé

Chapter 13 introduces a new organization the Task Force recommends be created, namely the Institut national d'excellence en santé, a credible and independent organization slated to play a strategic role for the smooth operation of our health system.

The Task Force believes there is a need in Québec for a credible organization to carry out, rigorously and efficiently, functions that currently are only partially fulfilled by a number of organizations. The Task Force is referring to strategic functions for the entire health sector, such as definition of public coverage of care, determination of performance indicators, periodic review of the list of insured drugs and the production of clinical protocols and practice guides.

In this section of the report devoted to the resources to be used to build a productive and efficient health system, the Task Force more specifically explains the nature of such an organization, using examples from abroad, and the arguments in favour of its implementation, based on the amalgamation of existing organizations.

■ New information technologies at the service of patients and managers

Chapter 14 puts forward a set of initiatives to put new information technologies at the service of patients and managers.

New information technologies are an essential tool to make our health system more productive and efficient. The Task Force believes it is important to examine this question, especially since the government, in 2005, launched an ambitious plan so that by 2010, each patient in Québec will have an electronic file, the Dossier de santé du Québec (DSQ), or Québec health file.

— Computerization of each patient's medical history seeks both to improve the quality of care and enhance management efficiency. For these two reasons, new information technologies have become indispensable in the health sector as well as in many other fields. The Task Force feels it is important to mention this.

— The Task Force then describes the current situation regarding the ongoing computerization process in the health network. Some risks must be mentioned that justify conducting a DSQ pilot project. As for the use of new information technologies in the health sector, the Task Force notes that progress has been made, but that much remains to be done.

— Based on this assessment of the current situation and its observations stemming from it, the Task Force proposes an approach that differs somewhat from what has been followed to date. This approach is based on two priorities:

  — As a prerequisite, health institutions and clinics must be computerized;

  — In addition, all future developments must be better planned and coordinated.

❑ Funding: a long-term view, shared responsibilities

In this part of its report, the Task Force deals with the sources of revenue on which the health system will have to rely if we want to correct the imbalance in public finances caused by the growth in health spending.

The Task Force identifies solutions that are both fair and sustainable, with the double concern of taking a long-term view and defining a fair division of responsibilities.

■ Sustainable and diversified sources of revenue

Chapter 15 proposes sustainable and diversified sources of revenue and the creation of a dedicated health stabilization fund, as far as public spending is specifically concerned.

The Task Force thoroughly analyzes existing sources of revenue as well as a number of possible revenue sources, to propose clear options to the government in this matter.

The Task Force first recalls the current situation regarding health system revenue: the public system is funded above all by taxes, and there is substantial private funding in Québec.

A dedicated health stabilization fund

The Task Force recommends that the government create a dedicated health stabilization fund and proposes options for the fund's revenue.

In terms of the system's funding, the problem stems largely from the gap between the growth in public spending on health and economic growth. To resolve this impasse, the Task Force's goal is to adjust growth in public spending on health to the growth in the economy, while improving access to care and quality of services.

Concretely, that means that growth in public spending on health and social services must decline from 6.5% in 2008-2009[7] to 3.9% over a period of five to seven years, i.e. a rate of increase scaled back to the pace of economic growth as established by the fall 2007 economic forecast of the ministère des Finances.

To achieve this, and as we have just seen, the Task Force makes a set of recommendations, proposals and suggestions. The Task Force is convinced that if they are implemented, these many initiatives will help slow the growth of public spending on health significantly.

However, realism is needed, and it must be accepted that the proposed initiatives will not achieve their full effect immediately. The Task Force considers that if the government applies them quickly, a period of five to seven years will be needed for their full effects to be felt. In other words, during this period, there will continue to be a gap between the rates of growth of public spending on health and of the economy. In the meantime, this gap will obviously have to be bridged.

To bridge this gap, the Task Force concludes that the best solution is to create a fund in 2008-2009 with dedicated revenue sources.

— During the initial years, the fund will be used to cover the difference between the increase in public spending on health and economic growth, as long as the measures proposed to increase the system's productivity have not achieved their full effect.

— However, we must look beyond that and guard against fluctuations in the economy, in addition to providing for possible adaptations because of changing needs. For that reason, the Task Force recommends that the fund to

7 The growth rate of 6.5% for 2008-2009 includes the structural increase in spending and development expenditures. This rate corresponds roughly to the average for the last ten years.

be set up be permanent and that once the objective of adjusting public spending on health to growth in the economy is achieved, it be used as an adjustment mechanism against future risks.

The Task Force recommends implementing a simple principle:

— The state would cover, from its general revenues, the growth in public spending on health up to the limit imposed by the rate of economic growth.

— Any difference beyond that limit would be covered by sources dedicated to health. The proceeds of these sources of revenue would be deposited into the dedicated health stabilization fund.

The fund should have two sources of funding, one relating to taxes and the other relating to the use of care.

By drawing simultaneously on two sources of revenue, the government would strike a balance between social solidarity, as expressed by the tax system, and individual responsibility, reflected in a contribution calculated on the basis of the use of medical care.

For the Task Force, it is important that responsibilities be divided in this way between the recipient of care – a question of individual responsibility – and society as a whole.

— The Task Force recommends that the source relating to the use of care consist of a deductible, adjusted for income and use of medical care, and that the tax source be a portion of the proceeds of the Québec sales tax (QST).

  The deductible would be calculated and capped on the basis of income. It should be used to guide use of medical care by individuals in the desired direction. It would not be a barrier to obtaining care. For the Task Force, a deductible is preferable by far to a user fee, which it rejects.

— For reasons of balance and fairness, part of the fund's financing must be provided by society as a whole, through the tax system. The Task Force advocates the use of a consumption tax as a source of revenue for the dedicated health stabilization fund, more specifically the Québec sales tax. Only the Québec sales tax can provide a sufficient financial yield for the purposes of the dedicated health stabilization fund. The Task Force rejects the idea of imposing a health premium.

On the basis of its recommendations, the Task Force presents a simulation of how the dedicated health stabilization fund would be financed. Two options were simulated, according to the relative importance given to financing the fund by the deductible and by the Québec sales tax. In both cases, the fund bridges the gap between the public spending on health forecast after implementing the Task Force's recommendations and the contribution of the Consolidated Fund rising with the economy.

Other sources of funding

The Task Force also deals with a number of other sources of funding for the health sector, which this time does not concern solely the public sector. The Task Force thoroughly examines the question of incidental fees. It also deals with the question of rationalization and service fees.

The impact of the proposed guidelines

To illustrate the scope of the recommendations and proposals made, the Task Force concludes this chapter by presenting the impact they might have on the growth in public spending on health and on the revenues allocated to health funding.

— According to projections discussed previously, health spending could reach $42.0 billion in 2017-2018, a figure corresponding to the structural growth of health spending according to the current trend. There would then be a gap of $7.0 billion between these expenditures and the revenue from the consolidated fund, capped at the rate of growth of the economy.

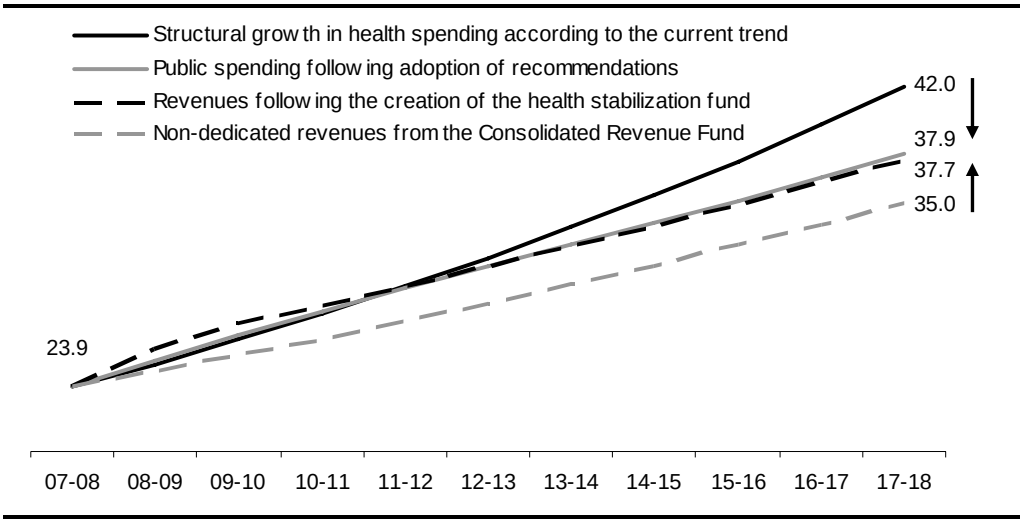
— The various recommendations, proposals and suggestions submitted in the report would make it possible to reduce the growth in public spending on health, so that by 2017-2018, the forecast amount of such spending would decline from $42.0 billion to $37.9 billion.

— The recommendations, proposals and suggestions concerning revenue would increase the revenue allocated to health from $35.0 billion to $37.7 billion in 2017-2018, with the revenue from the consolidated fund being boosted by the revenue from the dedicated health stabilization fund.

According to this illustration, the Task Force's recommendations would result in limiting the growth in revenue earmarked for health and taken from the consolidated fund to the rate of economic growth, while allowing for the time needed to implement the various guidelines.

CHART 2

Projection of public spending on health and of revenue earmarked for health care funding, 2007-2008 to 2017-2018
(Billions of dollars)



Source: Ministère des Finances du Québec.

The projections shown here are based on the assumption that in six years, i.e. during the stabilization period, we are in a position to reduce the rate of growth of public spending on health of the ministère de la Santé et des Services sociaux from 6.5% to 3.9%, and subsequently maintain it at that level until 2017-2018.

— Despite this significant slowdown, these projections mean that government spending on health would still rise by an average of 5.1% per year from 2008-2009 to 2014-2015. Accordingly, public spending on health would continue to rise during this period at a rate in excess of economic growth.

— Moreover, the share of health spending in the government's program spending would continue to increase, rising from 44.3% in 2008-2009 to 48.0% in 2014-2015. If nothing is done, this share would rise to 50.3% over the same period.

During the stabilization period, public spending allocated to health would increase by $10.3 billion, in excess of the rate of economic growth.

TABLE 2

Growth in health care spending during the stabilization period, 2007-2008 to 2014-2015

	According to the current trend		Following adoption of the recommendations	
	2007-2008	2014-2015	2007-2008	2014-2015
Public spending on health as a proportion of program spending	44.3 %	50.3 %[1]	44.3 %	48.0 %[2]
MSSS budget in 2014-2015 (billions of dollars)		35.5		33.8

1 Based on structural growth in health spending of 5.8% per year from 2008-2009 to 2014-2015.
2 Based on the growth in health spending as presented in Tables 19 and 20 of the report.

The projections shown here illustrate the opportunity available to us to adjust the growth in public spending on health to our collective ability to pay.

Obviously, these projections are based on a number of assumptions as to the impact of the proposed initiatives. The Task Force believes these assumptions are realistic and thus wishes to point out that there is a way to ensure the long-term viability of our health care system, while improving access to care and quality of services.

■ Better information with the health account

In **chapter 16**, the Task Force responds to a specific point mentioned in the government's mandate by showing what a health account might be, seen as an instrument of transparency in the management of public funds, providing citizens with better information on health care funding.

The Task Force thus examined what the health account referred to by the government might be, by considering:

— the objectives of such an account,

— the information shown in it,

— how the health account could be used as a tool for accountability.

The Task Force then presents a concrete example of the various tables that might constitute the health account the government would make public.

■ A dysfunctional statute: the Canada Health Act

Chapter 17 corresponds to another specific point of the mandate received from the government. The Task Force studies the nature and impact of the Canada Health Act, a statute with financial implications that lays down certain principles to follow, failing which the provinces are penalized in terms of the federal transfers they receive on account of health.

The Canada Health Act is contested by the Québec government and hampers progress in defining the public health systems of the provinces. The Task Force is of the view that sooner or later, the Canada Health Act will have to be adapted to current realities.

❑ Conclusion

At the end of its report, the Task Force returns to the nature of the guidelines it is proposing and the spirit in which the various recommendations and proposals are submitted to the government.

— The Task Force does not call into question any of the basic principles of the existing system. As part of the social contract it is proposing, the Task Force identifies changes that, in terms of principles, are consistent with efforts previously made and initiatives already taken.

— However, these are major changes. The Task Force is showing the way for profound transformations, compared to what we currently do and the obligations of each citizen as regards the health system. They draw on best practices noted throughout the world. The Task Force recommends that they be implemented in an orderly and gradual way, over a period of five to seven years.

— For the Task Force, the main challenge facing us collectively is to adapt our health system to the realities and context of the 21st century, allowing for ongoing demographic changes, current and future developments in technology, and the political and social realities that characterize our society and our environment. Globalization is one of these new realities that we must incorporate into how we view our health system, as well as most sectors of human activity.

— The Task Force is proposing a stimulating and engaging vision, but it assumes new commitments for each stakeholder in society. The Task Force is convinced that in the health sector as in many other fields, we have rights and obligations. A balance must be struck between what we ask of society and what we hope to receive from it. The Task Force hopes that the vision it has laid out and the guidelines it has proposed are in keeping with this balance.

— Lastly, the Task Force is convinced that there is a pressing need to act in the health sector. Québec is facing a challenge that is also looming in other developed countries. However, we have been slow to introduce certain innovations and make certain changes, at the risk of soon being brought face to face with much more radical choices, which we would be forced to make whether we want to or not.

We can maintain a health system that reflects our view of living as a society and the principles we value, provided we act quickly and with resolve.

However, this effort can be undertaken only if Quebecers support it and share the same vision. The Task Force hopes that this report and the thought and study of which it is the culmination, will contribute directly to this effort.

THE RECOMMENDATIONS OF THE TASK FORCE

Define a central objective

The Task Force considers that Québec must secure the long-term viability of the public health care system by increasing its productivity and adjusting the growth in public health spending to the growth rate of Québec's economy, while improving access to care and quality of services.

The proposed target

Recommendation

The Task Force recommends that the government set an objective, over a period of from five to seven years, of reducing growth in public spending on health so that it does not exceed the rate of growth of the economy.

Review of existing coverage of the public system

Recommendation

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

Healthy living and reducing costs through prevention

Proposal

The Task Force encourages the government to continue existing sickness prevention and health promotion efforts.

A primary health clinic for everyone in Québec

Recommendation

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

This deployment should be carried out over five years.

Recommendation

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

Innovations for access to care

Recommendation

The Task Force recommends that a physician be authorized to exercise according to a mixed practice within prescribed limits and provided there is an agreement with his establishment. [8]

Proposal

The Task Force proposes that the legislation authorize use of private insurance for services already covered by the public system. [9]

Proposal

The Task Force proposes that the initiatives relating to the role of the private sector and those stemming from steps already taken by the government be assessed within five years.

The aging of the population

Recommendation

The Task Force recommends that a collective reflection be undertaken on the medium and long-term repercussions of the aging of the population.

8 Michel Venne has taken a dissenting position on this recommendation. See the appendix.

9 Michel Venne has taken a dissenting position on this recommendation. See the appendix.

Loss of autonomy and home support

Recommendation

The Task Force recommends:

- that, for older persons suffering from loss of autonomy, the government give priority to home support and that to that end, it maintain a high level of investment in this sector;
- that medical, nursing and covered specialized home care be universally covered by the public system and that other home support services, for assistance with daily living and domestic assistance, be covered on a graduated basis based on the degree of dependence, the nature of the service and ability to pay (in every case, the most disadvantaged should be protected);
- that eligibility for a tax credit be subject to a means test.

Recommendation

The Task Force recommends that the ministère de la Santé et des Services sociaux award the operation of CHSLDs on a concession basis, to the appropriate resources, within a period of five years.

Better use of drugs at controlled cost

Proposal

The Task Force proposes that the government tighten the rules on the application of exceptional measures stipulated in the Régime général d'assurance médicaments by urgently taking into account the views of the Conseil du médicament.

The Task Force also proposes that a single organization have authority over all the notices issued within the health system on the therapeutic value and cost-effectiveness of drugs.

Recommendation

The Task Force recommends changing the parameters of the Régime public d'assurance médicaments so that participants cover the entire cost of the plan for their insured group.

Governance: ongoing changes and instilling a new culture

Recommendations

The Task Force recommends that the mission of the ministère de la Santé et des Services sociaux be refocused on setting health objectives and policy, defining insured services, setting national standards, allocating resources for capital investment and operations among regional agencies, setting performance indicators, and assessment and certification by specified organizations.

The Task Force recommends that the ministère de la Santé et des Services sociaux withdraw from the production of care as such.

Recommendation

The Task Force recommends that the mission of the regional agencies be to translate national priorities and policy into implementation strategies in their territories, as purchasers of services from suppliers of care and services, and that to that end they enjoy broad autonomy.

Recommendation

The Task Force recommends that the CSSS and other establishments have substantial autonomy and the means to assume their responsibilities and that, in return, they be fully responsible for their management.

Recommendation

The Task Force recommends that health clinics be fully responsible for their financial resources and their professional and technical staff and that in return, they be fully accountable for their management.

Recommendation

The Task Force recommends that the health 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 establishment be headed by a board of directors whose responsibility is to ensure efficient management of the resources allocated to it.

To that end, the Task Force recommends that the boards of directors consist of a limited number of independent members, selected for their skills, and that they be remunerated.

Recommendations

The Task Force recommends that a well-structured, complete and systematic program be put in place to assess the performance of institutions compared to health objectives as well as in relation to clinical and economic points of view, and that this program also assess patient satisfaction.

The Task Force also recommends that the results of assessments be periodically publicized.

Proposal

The Task Force considers that demonstration projects designed to test other methods of hospital management would help identify productive new options and make worthwhile comparisons in terms of efficiency and performance at various levels [10]

Incentive and strategic allocation of resources

Recommendation

The Task Force recommends that for funding institutions, the historical budgets method be gradually replaced with the service procurement method.

Proposal

The Task Force proposes that the service procurement method be implemented gradually, starting with a pilot region, to allow sufficient time for training and acquisition of the necessary information tools.

Dynamic and efficient organization of work

Recommendations

The Task Force recommends that the government support and encourage health sector institutions to replace the bureaucratic and centralized culture with a dynamic organization of work.

The Task Force recommends that the government allocate a dedicated budget to any institution that submits an organization of work renewal program.

The implementation of this new organization of work could be supported by the foundations and investment funds active in the health field.

10 Michel Venne has taken a dissenting position on this recommendation. See the appendix.

Recommendation

The Task Force recommends that despite the recent appeal filed against the decision of the Superior Court on Bill 30, the government and the unions enter into a dialogue to create a dynamic of positive labour relations at every level, based on mutual respect of the parties involved.

A credible and independent organization to play a strategic role: the Institut national d'excellence en santé

Recommendation

The Task Force recommends that the Conseil du médicament du Québec, the Agence d'évaluation des technologies et des modes d'intervention en santé and the Commissaire à la santé et au bien-être be amalgamated within a single body, the Institut national d'excellence en santé, in order to assign a strategic role regarding the relevance and quality of health services to an independent and credible organization.

The Institut should, in particular:

- Periodically make recommendations on the components of the basket of services insured by the public system.
- Assess new health technologies, including drugs, to recommend their inclusion on the list of insured drugs or in the basket of insured services.
- Review whether technologies and drugs currently covered should continue to be included in the list of insured drugs and the basket of insured services.
- Monitor new technologies and new forms of intervention that appear on the market to identify the most relevant.
- Produce clinical protocols and practice guides.

Proposal

The Task Force proposes that the government take appropriate measures to promote the emergence of the discipline of health economics by supporting research chairs and centres specializing in this field.

New information technologies at the service of patients and managers

Recommendation

The Task Force recommends that the Dossier de santé du Québec not be deployed until a pilot project has been carried out in a region of Québec and the results analyzed. It is important that particular attention be paid to managing change.

Recommendation

The Task Force supports the government's initiative to no longer require the patient's explicit consent (opting in) and replace it with an explicit exclusion mechanism (opting out). It recommends that this initiative be completed.

Recommendation

The Task Force recommends that priority be given to the deployment of the electronic patient file in every health institution and clinic.

Recommendation

The Task Force recommends creating, within the ministère de la Santé et des Services sociaux, a position with responsibility for planning, setting standards and deployment of information technologies throughout the health system, including the Régie de l'assurance maladie du Québec and the institutions.

Sustainable and diversified sources of revenue

Recommendation

The Task Force recommends bridging the gap between the rise in public spending on health and the growth of the economy with new sources of revenue dedicated to health, starting in fiscal year 2008-2009.

To that end, the Task Force recommends that the government establish, as of fiscal year 2008-2009, a dedicated health stabilization fund, with dedicated revenue sources, namely:

- the proceeds of a deductible depending on the use of medical services and family income;
- a percentage of the Québec sales tax.

Recommendation

The Task Force recommends implementing a deductible as of 2009-2010 whose amount would depend on the number of medical visits made during the previous year. The deductible would be calculated and capped on the basis of household income. Low-income families would be exempt.

The deductible would be used to influence the use of medical services in the direction considered the most appropriate. To that end, the government would define the criteria concerning the nature of the medical visits included in the deductible as well as the cost of each medical visit incorporated into the calculation of the deductible.

Recommendation

The Task Force recommends that the government increase the Québec sales tax by half or one percentage point and pay the amount thus obtained into the dedicated health stabilization fund.

Recommendation

The Task Force recommends resolving the question of incidental fees as follows:

- Incidental fees for primary health clinics should be banned as part of an agreement between the Fédération des médecins omnipraticiens and the ministère de la Santé et des Services sociaux.
- In associated medical clinics, fees for delivery of services should be included in the agreements negotiated between the institution and the medical clinic.
- In specialized medical clinics, existing incidental fees should be replaced by a fee system set jointly by the government and the medical federations.

Recommendation

The Task Force recommends implementing a permanent program for reassessing administrative expenses and reviewing fees charged for services.

The health account

Proposal

The Task Force proposes:

- *that the ministère de la Santé et des Services sociaux produce a health account each year,*
- *that the ministère de la Santé et des Services sociaux table this health account in the National Assembly,*
- *that a special session of a parliamentary commission of the National Assembly focus exclusively on the health account.*

APPENDIX

The Task Force on the Funding of the Health Care System was unable to reach a unanimous position on all the recommendations and proposals presented in the report. Mr. Michel Venne registered a dissenting position on three points specifically identified in the report. This position is explained in Appendix 3 of the report, on pages 297 to 303. It is important to note that the summary only gives an extract of the dissenting position. The reader is encouraged to refer to the report for the entire content.

Concentrate our efforts on the public system

At the end of the mandate of the Task Force on the Funding of the Health Care System, I feel an obligation to express my disagreement with three specific points of the report, all of them related to the role of the private sector.

After many months of research, debate and reflection within the Task Force, I have reached the conclusion that it is not advisable to allow, at this time, greater opportunity to the private sector than currently stipulated in Québec's health services.

I express my dissent concerning one recommendation and two proposals.

- I am opposed to lifting the ban on physicians practicing simultaneously in the public and the private systems, what is referred to as the mixed medical practice.[11]
- I also disagree with allowing more opportunity for private insurance.[12]
- Lastly, I am against the idea of entrusting hospital administration to private specialized management companies.[13]

The reasons for this view are serious and well thought out.

- In my view, the three points on which I have expressed dissent constitute breaches in the overall logic of the report. They create a diversion and prompt contradictory interpretations.
- The ban on physicians practicing simultaneously in the public system and the private system as well as the prohibition on duplicate insurance are two significant ways available to the Minister of Health and Social Services to control the relation between the public system and private suppliers. To deprive him of them would be a mistake.

11 My dissent applies to all of section 7.2.2, which begins on page 101 of the report.

12 My dissent applies to all of section 7.2.3, which begins on page 103 of the report.

13 My dissent applies to all of section 10.4.2, which begins on page 187 of the report.

— Lastly, resolving the problems of our health care system requires mobilizing the stakeholders of the system. For this mobilization to succeed, the government must establish unambiguously and irrevocably that it gives priority to the public system. These three measures risk being perceived as a repudiation by a large number of stakeholders of the public system and hindering the implementation of the solutions the Task Force has identified to improve and secure its long-term viability.

Extract from Appendix 3 of the report bearing on the dissenting position expressed by:

Michel Venne,
Vice-Chair of the Task Force on the Funding of the Health Care System,
Montréal, February 8, 2008

Québec