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Meeting the challenges of equity, efficiency and quality

Consultation document

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February 2006

MESSAGE FROM THE PREMIER



Our government has put health at the top of its priorities. We were elected with a determination to put the health system — one of the foundation stones of modern Québec — back on its feet, pulling it out of the unprecedented crisis that had befallen it.

Let us cast our minds back. Three years ago, the system was so severely congested that television newscasts regularly

carried a scrolling banner showing the number of people on stretchers in emergency rooms; hundreds of Quebecers with cancer had to be sent to the United States for treatment; waiting lists for appointments with specialists and for operations went far beyond medically acceptable limits.

We have reversed this trend. Today, our health system is on the road to recovery. We have succeeded in turning the situation around by acting on all fronts. We have made major investments, but we have also changed the way work is organized, reconfigured the network, and simplified management. As well, we have increased admissions in medical faculties and enrolments in nursing sciences in order to remedy human-resource shortages in the medium term.

Tangible progress

In short, we have embarked upon a wide-ranging drive to renew our health system. Tangible progress has been made. Progress which, incidentally, external sources confirm. In 2005 the Fraser Institute determined that the shortest wait in Canada for an appointment with a specialist doctor was in Québec. Statistics Canada records that in two years the average waiting time for a non-urgent operation in Québec has dropped from nine weeks to four, thereby falling into line with the Canadian average.

We are on the right track. The credit for this progress belongs to the personnel in our health and social-service establishments, to our doctors, to our nurses, and to all those professionals, technicians, support employees and managers who have taken the government's intentions on board and have involved themselves with dedication and skill in a process of constructive change. I thank them on behalf of all Quebecers.

However, it would be a mistake to see these improvements as reason to rest. Our health system is still under severe pressures. The aging of the population heralds a sustained growth in demand for healthcare and services. This phenomenon poses problems for the long-term financing of the system, which already absorbs over 40% of the government's program spending.

The work must go on

Our work, then, is not yet over. As we consider how to pursue the overhaul of our health system, the government has had to take into account three events that have entered the picture in recent months:

- The Ménard report, which set out in detail the specific issue of the system's long-term financing, and proposed avenues for solutions.
- The Perrault report, which emphasized the importance of prevention at a time when our lifestyles are giving rise to new and worrying public-health realities, such as obesity and diabetes, the incidence of which is increasing among young people.
- Lastly, the Supreme Court of Canada's June 2005 decision, known as the Chaoulli decision, which ruled that the ban on taking out private insurance to obtain services covered by the public system contravenes the Quebec Charter of Rights and freedoms.

The Chaoulli decision

The Supreme Court decision sparked an outcry, with voices being raised immediately to demand that the government invoke the notwithstanding clause of the Canadian Constitution to circumvent the ruling, which seemed to clash with fundamental principles of our health system.

We have refused to do so. In the past, the government of Québec has invoked the notwithstanding clause to protect its language, to assert the unity of the people of Québec, and to proclaim our identity. The Chaoulli decision does not encroach on this territory. It intervenes in the relationship between citizens and a public service. What is at stake here is not our identity, but our mission as manager of the health system and our ensuing obligations in respect of Quebecers' fundamental rights. To disregard the decision would have meant failing in our State duty.



The Chaoulli decision does not throw the government's action into disarray. At most, it adds weight to our duty to address an issue that has required answers for a long time. This issue, that of the private sector's role in our health system, goes hand in hand with those raised in the Ménard and Perrault reports.

This consultation document deals with these three aspects that will enable us to continue the work of renovating our health system in order to make sure we never again find ourselves in a crisis like the one we have emerged from.

Guaranteed access to services coupled with an opening of the door to the private sector

We invite interested groups and citizens to make their views known, thereby contributing to the government's deliberation on new ways of financing our health system. We also invite them to commit themselves, along with the government, to the search for effective disease-prevention strategies. On the latter issue, a question needs to be addressed: what is a citizen's responsibility regarding his or her health? The government may well promote healthy lifestyles, but its efforts will be in vain unless citizens actively invest in their own well-being.

With regard to the Chaoulli decision, the government is responding to the Supreme Court ruling by progressively introducing guaranteed access to services in the public system, combined with an opening of the door to the private sector in respect of various common surgeries. In this way, while allowing citizens to take out private insurance for certain services, we are telling them that they will be treated in the private sector, at the expense of the public system, if the wait goes beyond an agreed period.

This response to the Chaoulli decision, then, is a reaffirmation of the relevance of our public system in today's context.

Our government has always asserted its unshakable attachment to a public health system within which the private sector could play a greater role. We are taking a cautious step in this direction. In this we are following the path proposed by many, particularly the Clair Commission, with the creation of private clinics affiliated with the public network.

A calm debate

Since we were elected, we have acted with vision and determination to put our health and social-services system back on its feet. In doing so we have reaffirmed the values that underpin the system: compassion, solidarity, and the equality of citizens before pain and disease. We have also acknowledged, in an informed manner, the pressures the system is undergoing. And we have done well.

Today, we are moving into a new phase. We have repaired. Now we can build.

The proposals that are on the table promise lasting solutions. We are submitting them to public debate with an open mind and in the hope of seeing a carefully argued debate, setting aside watertight ideologies, fully committed to a search for solutions that will benefit all Quebecers.

Our public health system is one of our most precious jewels. The purpose of the discussion that is now beginning is to restore its original lustre so that it can play a full part in our progress in this new century.

Jean Charest
Premier

MESSAGE FROM THE MINISTER



Since Spring 2003, our government has acted on a number of fronts to improve the capacity of our healthcare and social-services system to meet the growing needs of Quebecers.

Credits from the Ministère de la Santé et des Services sociaux have been increased by \$3 billion to reach \$21 billion — 43% of total government spending. Globally, about 60% of new government spending

has gone to this essential public mission. This is a measure of the importance our government attaches to healthcare.

Action on all fronts

Beyond the increases in public investment, we have made great efforts to improve the workings of the health network. We have reorganized work in our health establishments to ensure that as many resources as possible are devoted to services to citizens; we have linked establishments in the network in order to improve patient management and ensure better coordination of the various interventions. We have improved the service offering, particularly with the setting up of new family medicine groups and network clinics. We have boosted enrolments in medicine and nursing science and we have set up Recrutement Santé Québec in order to solve, in the medium term, problems of manpower shortages in the network. Thanks to tighter management of medical staffing plans, the distribution of doctors over the territory of Quebec is becoming more equitable.

We have also devoted major efforts to improving the health and quality of life of Quebecers. We have strengthened the Tobacco Act, restored free access to medication for the most disadvantaged seniors, improved support for natural caregivers and launched a major offensive to promote healthy lifestyle habits. Two new vaccines have been added to our children's immunization schedule.

Among our other initiatives have been the tabling of a bill on youth protection and the publication of two major action plans on mental health and assistance for elderly persons suffering loss of autonomy.

We have also launched the biggest healthcare development and modernization project in Canada by giving the green light to the completion of the new Centre hospitalier de l'Université de Montréal (CHUM), the new McGill University Health Centre (MUHC) and the "Growing Up Healthy" project of the Centre hospitalier universitaire Sainte-Justine.

By taking action on all facets of our mission, we have reversed the trend in healthcare. Today we are seeing tangible and measurable signs of improvement in the situation. Chronic bottlenecks in emergency rooms are down. The number of operations is up. No Quebecer suffering from breast or prostate cancer is now obliged to go to the United States for treatment, since all now receive therapy within eight weeks. Waiting lists for heart surgery and cardiac catheterization have also been substantially reduced.

In addition to improvements in front-line services, such as a sharp increase in the number of elderly people receiving home care, we are also working on improving access to diagnostic services. As a result, while technology deployment continues with the addition of magnetic resonance imaging equipment and CT scanners, Québec is maintaining and reinforcing its position as the leader in Canada in the field of positron emission tomography (PET scans).

After catching up: renewal

The progress that has been achieved in these fields demonstrates that our vision is correct and powerfully illustrates the devotion and skill of all the human resources in the health and social-services network who have committed themselves with heart and courage to changes in the way we do things. Our challenge now is to continue with this impetus. To dare to go further. We have done some catching up. We are now called upon to achieve renewal.

After close to three years of sustained action, we now want to take the time to sit down with the population of Québec to measure how far we have come and update our targets, firmly in line with our commitment to a public system within which the private sector can play a role.

New facts have emerged in recent months that we must now take into consideration.

- In November 2004, leading figures from all walks of Québec society, meeting at the *Forum des générations*, acknowledged two inescapable challenges that we face as a society: demographic change and the state of our public finances. These two challenges have a direct impact on the health and social-services system. They must serve as a backdrop for our decisions.
- In June 2005, in the Chaoulli and Zeliotis case, first brought in 1997, the Supreme Court of Canada ordered the government of Québec to lift the ban on private insurance covering services provided by the public sector, while maintaining the achievements of our health system. We must respond to this ruling; we see it as an opportunity for re-evaluation and evolution.
- In July 2005, while the *Forum des générations* was in full stride, *Le Comité de travail sur la pérennité du système de santé et de services sociaux du Québec*, chaired by L. Jacques Ménard, presented its report on the particular challenge of long-term financing for our healthcare system, whose rising costs are accentuated by the aging of the population. We must address the question of lasting financing for our services.
- In September 2005, the *Équipe de travail pour mobiliser les efforts en prévention*, formed in the wake of the *Forum des générations* and chaired by Jean Perrault, sounded the alarm on obesity in our young people and stressed the importance of prevention as a means of improving the quality of life of citizens and of better controlling healthcare costs. We have already put prevention on the agenda, and the time has come to go still further.

Although the judgment in the Chaoulli case caused a stir, to us it seems reasonable to take this judgment into account as we pursue our global assessment of our health and social-services system and of the role that the private sector can play as one of the elements in adapting the system to meet the challenges we face. However, we reassert our commitment to maintaining a strong public system, preserving the values that characterize it and the gains it has made, while allowing the private sector to play a role.

This consultation document represents both a progress report and an upgrading of our strategy to restore the Québec health system to its place among the best in the world.

In this dialogue with Quebecers, we have a joint responsibility to contribute to a calm debate. It is also our duty to open our minds to calling things into question. The progress that we have made, in full respect for the principles of accessibility and universality on which our public system is based, should inspire us. It shows that we can change things and improve the health and social-services system on the basis of values in which we believe deeply.

For it these very values of social justice and fairness that must guide the debate that we have embarked upon. With this crucial step of open discussion and a search for solutions, the government of Québec is pursuing two aims:

- to preserve and improve our public, universal health and social-services system so that it ranks among the best in the world;
- and, in this perspective, to respond to the Supreme Court ruling.

Let me make clear that there can be no solution that would allow the second to prevail over the first. If there is one rule that must underpin the debate that this consultation document seeks to support, it is that the second objective must be subordinate to the first.

For although we will respond to the Supreme Court ruling, we will do so with an eye on lasting solutions for the universal, public network so dear to Quebecers.

What we are proposing is to assert our principles while adapting our practices.

Through this debate, we plan on moving forward together with the aim of providing the best healthcare services while making the best possible use of all resources available for the benefit, not only of the current generation, but also of coming generations.

Philippe Couillard
Minister of Health and Social Services

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INTRODUCTION

Ensuring the long-term survival of our health and social-services system is a major challenge. The system lies at a point of convergence for the many pressures on our society: demographic changes, the need to restore fiscal health, technological and pharmacological developments, rigidity of structures and methods, access problems, relationships between the public and private sectors, etc.

Since April 2003, the government has embarked on a series of changes that have resulted in substantial reductions in a number of waiting times and waiting lists, a revitalization of the organization of the network, and extended services to citizens, particularly to elderly people suffering loss of independence. But we admit that we are, at best, at the halfway mark in our bid to bring about a renewal of our health and social-services system.

Despite the progress that has been made, the issues of access, quality, efficiency and financing remain pressing. In parallel, various expert reports and other events have provided fodder for the public debate on the evolution of our system.

The discussion that is now beginning will help us achieve new consensus positions that will guide us in major choices. Through this public consultation, we are taking the time to share with the greatest possible number of Quebecers our reading of things before embarking determinedly on a second phase of change.

This consultation document contains six chapters that provide a measure of the progress achieved in the various dimensions of our health and social-services systems, and enable us to determine various courses of action that will help us continue to progress.

This consultation is open to all citizens and organizations that wish to participate, as part of a broad public discussion to be held in spring 2006. In compliance with the commitments our government has made to the Supreme Court, the first measures arising out of these commitments will be announced as early as the spring, but we must expect that the decisions taken will have impacts in the medium and long term.

In the solutions we wish to discuss with citizens, the focus should be on reviewing our way of doing things and on implementing tried and tested practices. We must draw on our system's achievements and continue the efforts begun in the last few years. All these measures form part of a search for greater effectiveness of invested resources and improved quality of life for our citizens.

The government is putting forward for discussion solutions in three areas:

- Continuation of policy directions already embarked upon. Consolidation of action taken will focus particularly on preventive services, front-line services, and medical and hospital services. Further actions aim at enhancing the quality of healthcare and social-services.
- A proposal in response to the Supreme Court judgment. This proposal takes the form of an access guarantee defined and monitored for the first time in Canada by the government of Québec. The parameters will be as follows:
 - preservation of the underlying values of our universal public system;
 - the introduction of specialized clinics, built, equipped and managed by private partners, affiliated with a hospital centre or a Centre de santé et de services sociaux. Public establishments will purchase from these clinics services (imaging, minor surgery) provided by doctors participating in the public system, at no cost to users;
 - guaranteed access for certain medical procedures, the first step towards a broader guarantee, which would be extended to further interventions identified by the government and the medical profession acting in partnership;
 - a lifting of the ban on private insurance, only for procedures that are included in a guarantee of access covering the entire population. Tertiary cardiology and cancer treatment, however, will remain under the ban, since these services are also covered by an access guarantee;
 - maintenance for physicians of the watertight seal between opting into and opting out of the Régie de l'assurance maladie du Québec (RAMQ).

- 
- In the wake of the Ménard committee report, an open examination of the issues surrounding longer-term financing of the health and social-services sector in the context of a wider debate on the future of our public finances.

The government has committed the health and social-services system to a process of change that is bringing results.

Our health and social-services system symbolizes the values of social justice, compassion and solidarity that unite Quebecers. It is founded on the principles of universality, equity and the public nature of services. These Québec values and fundamental principles are not called into question.

The discussion that is now beginning must not weaken, but strengthen them. This consultation must point us towards methods that will enable us, in the remainder of this decade, to assert Québec values and the fundamental principles of our health and social-services system while meeting the challenges of quality, efficiency and financing that we face.

1

PREVENTION AS A FACTOR IN THE EVOLUTION OF THE HEALTH SYSTEM

Improving the health and welfare of citizens is a central aim of the health and social-services system and prevention is vital to achieving this aim. Information on health and access to high-quality preventive services are essential for maintaining and improving the health of the population. Prevention can save lives, improve the quality of life and substantially reduce spending on medical care.

ACHIEVEMENTS TOWARDS PREVENTION AND CITIZENS' WELFARE

- **A government campaign promoting healthy lifestyles.**
- **A strong gesture in favour of public health with the tightening up of the Tobacco Act and a ban on smoking in public places.**
- **Prevention brought to the forefront:**
 - **prevention was a major theme of the Forum des générations, with the creation of the *Équipe de travail pour mobiliser les efforts en prévention*;**
 - **the issue was at the heart of consultations aimed at the development of the Youth Action Strategy.**
- **Better protection for children with the addition of free vaccination against pneumococcus and chickenpox.**
- **Actions to foster personal welfare:**
 - **a Mental Health Action Plan focused on better front-line services and improved prevention**

1.1. HEALTH PROFILE IMPROVING OVER THE YEARS THANKS TO PREVENTION

The health of the population of Québec has greatly improved in recent decades. The improvement is shown in particular by a substantial increase in longevity¹ and a notable reduction in the infant mortality rate²⁻³.

Many of the gains that have been made in recent decades can be attributed to improvements in hygiene, to changes in living conditions brought about by industrialization and to advancements in science. In this regard, progress in the treatment of patients and research into the causes of disease have contributed to improving the health of the population. More widespread access to curative services and preventive intervention also explain these gains. Many preventive measures have proven themselves: vaccination has reduced mortality caused by infectious diseases⁴; a fall in smoking can contribute to reducing cardiovascular disease and lung

cancer; preventive interventions among women in disadvantaged socio-economic communities in pregnancy and until their children reach the age of two has appreciably improved the mental health of mothers and thereby reduced the risks of children suffering from abuse and negligence⁵.

Prevention also reduces the costs generated by disease by reducing the number of hospitalizations, reducing the length of hospital stays and causing a fall in the consumption of other health services. A few examples illustrate the impact of prevention on the healthcare system. The introduction of conjugate vaccine against pneumococcus in December for children aged between two months and four years halved invasive pneumococcus infections in children in this age group in a matter of months⁶. Furthermore, it is estimated by some that a 1% reduction in smoking would benefit Québec by some \$114 million, including about \$41 million

1. Choinière, R. "L'état de santé des Québécois : Des signes encourageants," in M. Venne (ed.), *L'annuaire du Québec 2005*.

2. Family and Social Affairs Council, *Des victoires sur la mort*, 1983

3. *Registre des événements démographiques du Québec* (Fichier des naissances vivantes et Fichier des décès), compilation made by Le Service de la surveillance de l'état de santé, Direction générale de la santé publique, Ministère de la Santé et des Services sociaux, décembre 2004.

4. World Health Organization, *The world health report 2003 - shaping the future*, 2003.

5. Boyer, G. and Laverdure, J. *Le déploiement des programmes de type Naître égaux - Grandir en santé au Québec*, 2000.

6. Ministère de la Santé et des Services sociaux, *Fichier des maladies à déclaration obligatoire (MADO)*, 2005.



in direct healthcare costs and \$73 million in indirect costs such as lost productivity caused by mortality and morbidity due to smoking-related diseases⁷.

In short, prevention is a sure means of improving the population's health, improving the quality of life, and reducing pressure on the system, as stressed by the Ménard Committee⁸.

1.2. ISSUES THAT THE HEALTH AND SOCIAL SERVICES SYSTEM MUST ADDRESS

Despite the progress made in recent decades, the Québec health and social-services system is faced with major problems.

Aging of the population

The acceleration in the aging of the population of Québec that will occur in the coming decades will increase the pressure of demands on healthcare services, despite improved health for tomorrow's seniors. The rise in incapacity will result in increased use of medical and hospital services and will have significant effects on long-term services, accommodation, and protection services⁹. The prevention of chronic disease falls and infectious diseases along with efforts directed towards the social integration of elderly people will contribute to maintaining their health and preserving their autonomy.

Chronic-disease epidemic

In Québec, four chronic diseases — despite the fact that it would be possible to reduce their incidence among the population — are alone responsible for over 70% of deaths: cancers, cardiovascular disease, respiratory disease and type 2 diabetes. In addition, obesity, which is a major risk factor in cardiovascular disease and diabetes, has increased by 56% since the mid-1980s¹⁰ and today affects

12.4% of the population aged 20 and over¹¹. It is possible to prevent a good proportion of these diseases by taking action on lifestyle habits (inadequate nutrition, sedentary lifestyle, tobacco use and excessive alcohol consumption) which are a factor in up to 80% of deaths from chronic disease and in about 40% of all deaths¹².

New infectious threats

The start of the century has been marked by the threat of various infectious diseases: influenza pandemic, nosocomial infections, severe acute respiratory syndrome (SARS), and the return in force of a number of sexually transmitted and blood-borne diseases. An increase in vaccination rates and the control of nosocomial diseases are preventive ways to reduce the impact of infectious diseases.

Mental-health problems

Many children and adolescents present problems of social adaptation that could persist into adult life. In addition, one person in five will have a mental-health problem during their lifetime¹³. Lastly, Québec has one of the highest suicide rates in the world¹⁴. And yet it would be possible to reduce the human, and social and financial costs of such problems by stepping up preventive measures.

Health inequalities

In all countries, the most socio-economically disadvantaged people are in poorer health than those better off. In 2000-2002, the most disadvantaged men could expect to live eight years less than the most advantaged, with the gap being three years for women¹⁵⁻¹⁶⁻¹⁷. It is possible to focus on transitory measures to attenuate the negative effects of poverty and inequality on health and to create an alliance with other sectors of activity in society to tackle the structural causes of poverty¹⁸.

7. Ouellette, P. et al., *Étude d'impact des modifications proposées à la Loi sur le tabac*, study conducted for the Ministère de la Santé et des Services sociaux, 2005.

8. Comité de travail sur la pérennité du système de santé et des services sociaux du Québec, 2005.

9. Lutbiz, J. *Getting older, Staying Healthier: The Demographics of Health Care*, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004.

10. Schaefer, C. and Mongeau, L. *L'obésité et la préoccupation excessive à l'égard du poids : Éléments d'une problématique et réflexions pour l'action*, 2000.

11. Statistics Canada.

12. World Health Organization, *Global Strategy on Diet, Physical Activity and Health: Facts Related to Chronic Diseases*.

13. Health Canada, *A Report on Mental Illnesses in Canada*, 2002.

14. Registre des événements démographiques du Québec (Fichier des décès), compilation made by the Service de la surveillance de l'état de santé, Direction générale de la santé publique, Ministère de la Santé et des Services sociaux, 2005.

15. Pampalon, R., *Espérance de vie et défavorisation au Québec, 1996-1998*, Québec City, Institut national de santé publique du Québec, 2002.

16. Registre des événements démographiques du Québec (Fichier des décès), compilation made by L'Institut national de santé publique du Québec, 2005.

17. Statistics Canada, *Canadian Community Health Survey*, 2001.

18. Ministère de la Santé et des Services sociaux, *Rapport national sur l'état de santé de la population du Québec: Produire la santé*, Québec, 2005.

1.3. STEPPING UP PREVENTIVE EFFORTS

1.3.1. For the young

During the *Forum des générations* held in the fall of 2004, a task force was mandated by the government to define preventive approaches aimed at offering young people environments conducive to healthy lifestyle habits, particularly as regards nutrition and physical activity¹⁹. Many of the recommendations of the *Équipe de travail pour mobiliser les efforts en prévention* (Perrault Report) are relatively explicit about the importance of a preventive approach.

Adopting a policy on diet and nutrition

Adopting and applying a policy on diet and nutrition are important tools in support of an improvement in dietary habits. With this in mind, the task force proposed favouring the following actions:

- setting up educational activities to make young people aware of the importance of a healthy diet, providing them with basic knowledge and providing their parents with information;
- ensuring that the contracts of food-service operators with schools and municipalities adhere to this policy.

Gaining the support of players in the agro-food sector to develop partnerships aimed at providing healthy food

Partnership with the agro-food sector is essential for ensuring the availability of healthy food and making the population aware of the existence of such food. To achieve this, we must:

- make the agro-food sector aware of the policy;
- facilitate contact between consumers and food producers.

Increasing physical activity among young people and their families in various living environments

The many benefits of regular physical activity on health are well known and it is important to develop favourable environments that encourage and support physical activity in the living environments of children, young people and families. The Perrault Report proposes in particular:

- intensifying physical activity among children attending a Centre de la petite enfance (CPE) or school;
- offering extra-curricular physical activities and organizing sporting challenges at school;
- increasing the accessibility of school and municipal infrastructures and equipment in order to foster physical activity.

1.3.2. For the entire population

With regard to the question of organizing preventive activities, Québec has adopted a *Programme national de santé publique 2003-2012*, which sets out preventive activities to be carried out in all local territories of Québec, for the entire population. These activities focus on avoidable health problems that are the most important in terms of gravity and extent, and they comply with effectiveness standards recognized in recent scientific documentation. Implementation has begun, but many interventions or services still remain to be consolidated and their adaptation to vulnerable groups must continue.

Informing the population of ways to stay healthy

The population must be kept informed about its state of health and the factors that contribute to it. This is vital for people to be able to take charge of their own health.

The main information activities to be reinforced are:

- communication campaigns and healthy lifestyle habits;
- activities to promote safety on the roads, in the home and in sport;
- communication campaigns on preventing violence, sexual aggression and mental-health problems.

These information campaigns are necessary, but they are not sufficient to influence the population's health in an appreciable way. They must be complemented by high-quality and accessible preventive services and an initiative that involves various players (environment, education, employment, etc.) in improving people's living environments.

19. *L'amélioration des saines habitudes de vie chez les jeunes*. Report presented to the Ministre de la Santé et des Services sociaux by the Équipe de travail pour mobiliser les efforts en prévention, 2005.

Improving access to and quality of preventive services

Prevention is generally implemented as part of front-line services²⁰⁻²¹, and this calls upon physicians and all health professionals to play a crucial role, particularly in counselling, the detection of risk factors and the implementation of preventive measures as early as possible.

Particular attention should be paid to the consolidation of certain preventive services:

- preventive services during the perinatal period and early childhood for socio-economically disadvantaged families;
- prevention of chronic disease, notably through stepping up preventive clinical practices (counselling on lifestyle habits, services to support those who wish to give up smoking, early detection of chronic disease);
- fall-prevention services for elderly people living at home;
- screening programs for sexually transmitted and blood-borne diseases;
- prevention of mental-health problems.

Protecting the population from threats to health

Protection activities must also be carried out to counter situations that threaten the health of the population: an unusually high number of cases of whooping cough in a school or a spill of toxic substances on the road are examples of situations that can constitute a threat to health. In a similar vein, government intervention in the event of an influenza pandemic is currently being prepared.

Health authorities must intervene, having the necessary capacity to:

- carry out epidemiological investigations to find out more about the threat to the health of the population;
- ensure that social and health measures likely to counter-act or remedy the dangerous situation are implemented;
- when necessary, alert persons concerned in other fields of activity so that they can correct the situation;
- maintain vaccination levels and increase vaccination coverage in accordance with scientific recommendations.

Creating and maintaining healthy physical and social environments

The health and welfare of a population depends not only on individual factors (heredity, lifestyle habits, etc.), but also on physical and social environments. Hence, in order to improve the health of the population, we must favour action that involves all sectors likely to exercise an influence on health (employment, income, education, environment, etc.). Projects inspired by the *École en santé* approach, which builds health-promotion and prevention activities into the daily school curriculum, are one example. These should allow application of recommendations by the recent task force mandated by the government to define preventive approaches aimed at providing young people with environments conducive to healthy lifestyle habits, particularly the application of a nutritional policy and the creation of possibilities for stimulating physical activities²².

To maintain and improve the health of the population, then, it is essential:

- to step up concerted, planned actions with partners in other sectors of activity in order to create environments that are favourable to health, like the *École en santé* projects, and to disseminate these projects over the whole territory of Québec.

The beneficial effects of prevention have been clearly demonstrated. We know which health problems can be avoided, what factors cause these problems and, in many cases, appropriate preventive interventions.

In a context of scarce resources, and considering both the population's state of health and the demographic context of aging, prevention represents one of the most reliable ways of improving the health profile of the Québec population and of curbing certain health expenditures. Accordingly, the health and social-services system will continue and step up preventive initiatives in the coming years. Efforts need to be continued with a view to attaining optimal balance in the distribution of preventive and curative services offered by the health and social-services system.

20. Health Council of Canada, *Healthcare Renewal in Canada: Accelerating Change*, 2005.

21. Centers for Disease Control and Prevention, *The Power of Prevention*, 2003.

22. *L'amélioration des saines habitudes de vie chez les jeunes*. Rapport présenté au ministre de la Santé et des Services sociaux par l'Équipe de travail pour mobiliser les efforts en prévention, 2005.

IN BRIEF

Prevention is an effective means of improving, year by year, the health portrait in Québec. Despite this progress, our health and social-services system is faced with important issues, including: the accelerating aging of the population; the persistence of major chronic diseases such as cancer, cardiovascular disease and diabetes; threats from various infectious diseases, notably influenza, nosocomial infections and SARS; mental-health problems; and worrying inequalities in the field of health. Various measures are therefore being planned to step up prevention efforts, aimed both at the young and at the population as a whole. Among these, we are aiming to:

- adopt a diet and nutrition policy;
- increase the amount of physical exercise among young people and their families;
- inform the population about ways to stay healthy;
- increase access to, and the quality of, preventive services;
- protect the population in the event of threats to health;
- maintain and create healthy physical and social environments.

2

IMPROVING THE ORGANIZATION OF SERVICES AND THE MANNER IN WHICH THEY ARE DELIVERED

The health and social-services system must adapt to changes in the needs of the population and adopt practices and technologies that will constantly make it possible to better meet these needs. This adaptation is guided by three objectives:

- consolidating front-line services;
- making use of skills through optimal sharing of tasks and responsibilities;
- adopting service-provision methods that are firmly oriented towards supporting people in the community, particularly those in need of long-term care and the most vulnerable members of society.

ACHIEVEMENTS TOWARDS IMPROVED ORGANIZATION OF SERVICES

- 95 *Centres de santé et de services sociaux* (CSSS), adapted to the reality of each territory, created by grouping together CLSCs, CHSLDs and, in most cases, a hospital centre.
- Number of public establishments reduced by 42%, from 339 to 195.
- Management teams of merged establishments rationalized, to the benefit of services to the population.
- Clinic project put in place in each of the 95 health and social-services centres, adapted to the needs of the local population.
- The right care available in the right place thanks to the FMGs and network clinics.
- 2005-2010 Action Plan for Seniors Who Have Lost Autonomy adopted, emphasizing the development of services in the community in order to adequately serve all elderly people who are losing their independence.

ACHIEVEMENTS TOWARDS ORGANIZATION OF WORK CENTRED ON CITIZENS'S NEEDS

- Bill 30 passed, making it possible to reduce the number of union certification units in the network from over 3,600 to about 900.
- Also thanks to the adoption of Bill 30, negotiation of 26 provisions relating to work organization decentralized to the local level, enabling resources to be used efficiently in line with the needs of the population and of each establishment.
- New naming conventions for position titles adopted, allowing the number of job titles to be cut from 500 to 285.
- Use of human resources improved through the development of the profession of nurse practitioner and an end to employment uncertainty for personnel in nursing and cardio-respiratory care.
- Better personnel training, with more than 62 million additional dollars devoted to human resources development, including \$14 million for patient attendants working with people at home and in CHSLDs.
- \$13 million invested in retaining personnel aged 55 and over who are eligible for retirement and for whose position there are deemed to be shortages.



2.1. ESTABLISHING A SOLID FOUNDATION: CONSOLIDATION OF FRONT-LINE SERVICES

Efficient organization of services must be based on a strong front line. The creation in 2004 of the *Centres de santé et de services sociaux* (CSSS) was aimed at this goal. Today there are 95 CSSSs in the territory of Québec. These organizations were formed by grouping together the Centre local de santé communautaire (CLSC), the Centre d'hébergement et de soins de longue durée (CHSLD) and, in most cases, a hospital.

Setting up CSSSs has made it possible to integrate health services and social-services in a local area and thereby to provide the population in this area with better access to these services. In addition, the CSSSs enable better management of users who have access to services while guaranteeing them continuity in their path through the health and social-services network.

CSSSs must ensure that all actors in the health and social-services network and their partners in the local area share responsibility for the population of the area. This responsibility implies that the network has to mobilize, on the one hand, to improve the health and welfare of the population and, on the other hand, to promote access, continuity and quality of services and the management of vulnerable clientele (elderly people suffering loss of independence, chronic disease sufferers, etc.). In order for this latter function to be performed effectively, services must be tiered according to whether they belong to the front line (basic services), or the second (specialized services) or third line (ultra-specialized services), and coordinating mechanisms must be provided.

Moreover, the reform of front-line services would not be complete unless we sought to improve accessibility to medical services and the complementarity between the public network and private general practices. The family medicine groups (FMGs) and network clinics were created with this double goal in mind.

Services offered by FMGs include, in all cases, medical activities with or without appointment, in the office or at home for those whose condition requires it, during business hours in the week and on a walk-in basis on weekends. Special services to registered persons whose health is precarious and those suffering severe loss of independence and living at home is provided outside the FMG's regular business hours. Moreover, permanent on-call medical

service (24 hours, 7 days) is provided by members of the FMG in collaboration with professionals of the health and social-services network.

Creation of the network clinics aims at two goals: on the one hand, guaranteeing access to walk-in medical services outside hospital emergency rooms, every day of the year and on weeknights and, on the other hand, providing operational coordination between physicians in an area, who are responsible for patient case management, and the CSSS, which is responsible for access to services and continuity of service to the population.

By January 2006, 105 FMGs had been accredited, spread over close to 190 clinical sites. They serve a territory of over 730,000 people. Further projects will soon come into being. Half of the CSSSs have reached agreements with the FMGs in their territory. As for network clinics, to date twelve have been accredited on the territory of the Agence de la santé et des services sociaux de Montréal; the number will increase and the model could be extended to other regions.

The government intends to pursue development of the FMGs and network clinics and to support partnerships with the public network, with the aim of creating a strong and effective front-line structure.

2.2. MAKING BEST USE OF ALL SKILLS: OPTIMAL TASK SHARING

Remodelling the way services are organized is only one part of the solution. It has to be accompanied by adaptation of clinical practices. There are several reasons that make this adaptation necessary. We can simply state here that the problems to be dealt with are ever more complex and require collaboration from a range of actors with varied skills. Moreover, shifting the locus of care to the community will always require increased flexibility and latitude. For example, it is practically impossible to reproduce exactly the division of labour that occurs in a health-care institution in the home of a person receiving home support.

Professional practices must change in light of new needs and interventions to be prioritized, particularly in the current context of a relative shortage of specialized resources. Hence the necessity to redefine the division of tasks between nurses and physicians. This redefinition, made possible by recently adopted legislative and regulatory provisions, aims at decompartmentalizing practices and



promoting teamwork. A new profession, that of specialized nurse practitioner, has just entered the Québec health and social-services system, following the government's adoption of regulations governing this new field of practice. Working in cardiology, neonatology and nephrology, the new specialized nurse practitioners will be able to perform certain actions that were hitherto reserved for physicians.

Yet another professional should be integrated into the health and social-services network in the coming months: the front-line specialized nurse practitioner. These nurse practitioners will work in family medicine groups (FMGs) and network clinics. They will be trained to deal with common health problems.

Beyond formal remodelling, there must be room for flexibility in everyday practice. Working in multidisciplinary teams is the way forward. We will adopt this formula in all areas where it has proven successful. There are many examples: services to elderly people suffering loss of independence, musculo-skeletal care, services to chronic disease sufferers, etc. The clinical benefits of working in multidisciplinary teams are recognized: improved speed of response, better coordination of interventions, optimal use of competencies, greater user satisfaction, etc.

2.3. CONSTANTLY IMPROVING OUR INTERVENTIONS: ADAPTING THE WAYS IN WHICH SERVICES ARE PROVIDED

The ways in which people's needs are met have changed a great deal over the past 25 years. Formerly, they were chiefly organized around the health establishment. Today, they are increasingly oriented towards supporting people in their natural living environment. Institutionalization is now the last resort, only applicable when support in the home or in the natural living environment — which is favoured by a very great majority of people — is no longer possible.

Major efforts have been made to improve all forms of home support or support in the natural living environment. But much remains to be done to better meet the needs of today's society, particularly to support people with permanent disabilities.

In addition, the way services are organized needs to be reviewed so that they can be adapted to young people in serious difficulty and provide a front-line response to the

needs of young people and their parents. In this regard, a bill to amend the Youth Protection Act was tabled in the National Assembly and will be the subject of a public consultation this winter.

2.3.1. Services to people with permanent disabilities

People with permanent disabilities include elderly people suffering loss of independence and the disabled — those with physical or intellectual disabilities and those with pervasive developmental disorders.

Although they all receive specific services based on their needs and the objectives aimed at, they also share a range of common services, particularly home-support services. Conditions of access to these services must be the same for all, regardless of the nature of anyone's disability. Here again, under the principle of universality, needs alone determine access to services.

2.3.1.1 The context

The current model of services to the elderly is geared towards institutionalization in a residential and long-term care centre (CHSLD). Maintaining the status quo would involve adding new residential places to take into account increases in the numbers of elderly people and especially very elderly people (aged 85 and over).

The effects of the aging of the population are thus already making themselves felt. The number of people aged 65 and over will have increased by 20% between 2001 and 2009. The very great majority of people in this age group are independent, but the fact remains that one person in five needs some form of long-term services. The increase is even more marked among those aged 85 and over, whose numbers will have increased by almost 45% in the same period.

Maintaining current levels of residential accommodation would, in the next 10 years, lead to accommodating some 12,500 more elderly people, compared with the 36,200 people currently in long-term care facilities. Continuing down this path would risk draining almost all available human and financial resources. This option would clearly limit the development of services in the community, which are already considered insufficient.



Beyond the question of available resources, it needs to be pointed out that elderly people, even when their independence diminishes, prefer to stay in their own home or in their own community, a desire that is shared by those around them. What needs to be done, then, is to complete the work that has already been begun on reorganizing health and social-services with the aim of providing people with solutions better suited to their needs, as close as possible to their living environment.

Moreover, as far as people with disabilities and incapacities are concerned, the Ministère's policies and policy directions are aimed at developing and consolidating a range of services and measures designed to provide them with conditions allowing true social involvement and better support for their families. To this end, we must first enable people to develop their full potential, and then provide them with support in various forms so that they can play their role in society. The support must be provided over the long term since their disabilities are persistent.

The movement towards rehabilitation in the community that was begun in the 1980s has had a significant positive impact on the quality of services provided to persons with disabilities and their family. However, we need to continue innovating in our practices, particularly as regards accommodation, in order to face the imminent needs in this sector.

Close to 5,000 adults aged under 65 having a physical disability are in residential care for lack of an alternative solution that would better suit their needs. There is a similar number still living with their parents because of an intellectual disability or a pervasive developmental disorder. In the not too distant future, their aging will exert significant pressure on the demand for residential services and home services.

2.3.1.2 The key: diversifying residential environments

To find a way out of this impasse, we need to make profound changes in our current provision of services in order to support people suffering loss of independence in their living environment as well as relatives providing care to them. We must focus more on diversifying accommodation formulas, in order both to provide as many options as possible, particularly to elderly people suffering loss of independence and their relatives, and to absorb the demographic shock effectively.

This scenario was chosen in the *2005-2010 Action Plan for Seniors Who Have Lost Autonomy: A Challenge of Solidarity*. This action plan calls for a substantial increase in the number of elderly people suffering loss of independence receiving services in the community. Public services will in future be provided to such people on the basis of their needs, rather than being tied to a particular care environment. The networks of integrated services to elderly people, which favour accessibility and continuity of care and services within the community, will be augmented.

As far as the elderly are concerned, then, given the shift towards community care, the number of places in residential facilities should remain about the same as at present. Increasingly, these places will be reserved for people presenting more complex clinical needs, with other people benefiting from services provided in the community. A property intervention plan, spread over five years, will allow for the redeployment of beds in regions that are less well provided for and to refit various facilities to better suit the new profile of residents.

This shift towards the community is at the basis of the subsidy program *For a New Partnership Serving Seniors* set up by the MSSS in 2003. This \$12 million program has stimulated the development of about 30 innovative residential support projects for clientele suffering major loss of independence. With more than 500 places supported to date, this is a way for the MSSS to support the development of residences that are better adapted to people's needs.

People with disabilities have other needs that must be met in order to prevent institutionalization and to support social integration and participation, and which require flexible and easily accessed forms of services. These are needs for home support for the persons themselves (help with activities of daily living and domestic activities, community support for accommodation, etc.), for natural caregivers (respite, day care, assistance with parental roles, etc.) as well as needs for support in social integration (supportive care and attention, citizen advocacy, mutual aid resources, etc.). The provision of services should be diversified and call on various partners. For example, we must increase accessibility to "affordable and adapted" accommodation and provide community support for such people. We must foster the development and use of community mutual-aid and social-economics resources.

It is understood that developing non-institutional resources for persons suffering loss of independence will have to involve collaboration between various sectors of activity in order to increase the availability of social housing. The Ministère will have to assume the financing of health services and social-services for residents, on the basis of the resources available to it.

2.3.1.3 Home-support services for all clientele

- **Review and harmonization of various home-care programs**

Currently, a number of measures exist to support home care: *Financial Assistance Program for Domestic Help Services*, direct grants, services provided directly by the CSSS (CLSE mission), and tax credit for home support of an elderly person and for persons with disabilities. A review is necessary in order to verify that these various measures are effective and efficient.

Thus, one of the measures under the *2005-2010 Action Plan for Seniors Who Have Lost Autonomy: A Challenge of Solidarity* calls for examining the possibility of supporting elderly people suffering loss of independence and their natural caregivers in obtaining home-care services²³ based on the person's degree of incapacity and on the possibility of choosing the type of services and the provider. To this end, work on reviewing the various home-care programs and the current access modalities has been started.

In view of the fact that a number of the programs offered also apply to other clientele, such as disabled persons, the proposed modifications will also have to apply equitably to all clientele.

IN BRIEF

The health and social-services system must adapt, and must adopt practices and technologies that will respond better to changes in the population's needs. To achieve this, the following avenues are proposed:

- consolidate front-line services now provided by the CSSSs by creating mechanisms for coordination between tiered services and by continuing to create FMGs and network clinics;
- make use of all available skills by focusing on optimal sharing of tasks, particularly between nurses and physicians;
- adopt service-provision modes oriented towards supporting people in the community, particularly for those with a permanent incapacity and those for whom accommodation environments must be diversified and the various home-support programs reviewed.

23. Home-support services include personal assistance and domestic help services, civic-support activities, meal-preparation and accompaniment services, friendly visits, learning assistance and support with family tasks. For a definition of these services, see Ministère de la Santé et des Services sociaux, *Politique de soutien à domicile, «Chez soi: Le premier choix»*, 2003.

3

THE TIERING OF HOSPITAL MEDICAL SERVICES: CONSISTENCY, CONTINUITY AND COMPLEMENTARITY

Hospital medical services provide specialized treatments for complex diseases and problems. They require expensive infrastructures that must be maintained, renewed and developed. These services consume large numbers of medical staff and specialized professional resources. They thus demand a substantial financial effort from the community. They must therefore be organized in such a way as to generate maximum effectiveness and efficiency.

ACHIEVEMENTS TOWARDS BETTER CONTINUITY OF CARE

- **Creation of four *Réseaux universitaires intégrés de santé* (RUIS) to improve access to specialized services, particularly by giving the RUISs the responsibility of providing services to the regions for which they are responsible. The RUISs advise health and social-services agencies in determining the missions of each establishment in their territory. They provide service offerings in their university hospitals, respond to the service corridors and support the regions.**
- **Better routing of citizens between the services they require, thanks to the creation of the CSSSs.**
- **A commitment to improving services in the regions through decentralized medical training, which will enable medical residents to gain experience of medical practice in the regions:**
 - **development of medical-training satellite campuses (Trois-Rivières and Saguenay);**
 - **deployment of new family medicine units (Baie-Comeau, Trois-Rivières, Amos—La Sarre, Maria, Kamouraska—Rimouski—Rivière-du-Loup—Les Basques) and upgrading of existing units (Beauce-Etchemin, Rimouski, Maizerets in Québec City);**
 - **the number of months of decentralized training in designated regions rose from 2,088 in 2004-2005 to 3,242 in 2005-2006 — a 55% increase.**
- **A firm commitment to the development of university medicine, with \$1.8 billion set aside for the modernization of the CHUM, the MUHC and Sainte-Justine mother and child University Hospital Centre.**

Sound organization of hospital medical services must meet two fundamental conditions. First, services must be tiered (“hierarchized”), enabling the right intervention to be provided in the right place, at the right time, using appropriate expertise and technology. Hospital medical services can be classed into three categories: local, regional and national services. This hierarchy of services is established on the basis of the volume of activity of the services, the complexity and the intensity of the problems dealt with, the skills required and whether it is necessary to have access to a technical support centre of varying degrees of sophistication. This hierarchization eases the patient’s transition from one tier to another, with continuity and without duplication of services. Second, leading-edge expertise must be grouped together in order to treat a critical mass of patients in one place and to ensure optimal quality of interventions.

This organization will favour improved consistency and efficiency of services, particularly in specialized and ultra-specialized services, where at times there is redundancy and duplication, at times under-provision of services.

The government also intends to pursue the development of affiliated specialized clinics to complete and reinforce the service offering. The introduction of this new actor in the provision of health services was proposed in 2000 by the Clair Report, and in the 2004-2007 Modernization Plan presented by the government²⁴. This avenue, which is contributing to the efforts to modernize the State, supports the health system’s production, with a financing mode that remains public, for the purpose of improving access to quality services (see Chapter 5).

24. 2004-2007 Modernization Plan - Modernizing the State. Pour des services de qualité aux citoyens, Secrétariat du Conseil du Trésor, May 2004.

3.1 THE ARCHITECTURE OF HOSPITAL MEDICAL SERVICES

The three levels of hospital medical services are found in institutions having expertise and technology suited to their service offering.

- **Local services** are provided by establishments that have a mandate to provide neighbourhood services. Establishments that offer mainly local hospital medical services are usually part of a CSSS that has a hospital-centre mission. Such establishments provide general hospital care and various basic specialized services, particularly in internal medicine, general surgery, obstetrics, anesthesiology, etc. Where the population's needs warrant, the establishment may also offer more expensive specialized services. It has a technical support centre that corresponds to its mission and basic teaching in medicine is given there.
- **Regional services** are provided by establishments that have specific mandates, which are sometimes exclusive for a region, and which fall into varied and multiple specialty fields. These are the so-called regional hospital centres, which are sometimes integrated into a CSSS. They have an appropriate technical support centre, a concentration of specialized staff, and a volume and catchment area that will ensure service quality. Basic and specialized teaching in medicine and research activities are carried out there.
- **National services** are provided by university hospital centres and university-affiliated institutions and hospital centres. These establishments provide local, regional and national services that require leading-edge expertise and sophisticated technologies, and they handle complex and rarer problems. They also provide teaching, research (with career researchers) and technology-evaluation functions, as specified in the Act respecting health services and social-services.

3.2 LEVERS TO ENSURE THE CONTINUITY AND COMPLEMENTARITY OF SERVICES

3.2.1 Rational organization of resources

Infrastructures must be organized in a territory in accordance with the populations to be served and the demands of optimal organization of services. This is the fundamental criterion which from now on will guide the Ministère and health and social-services agencies in allocating resources and in the general administration of hospital medical services.

3.2.2 Functional, effective service “corridors”

In the field, establishments must work on establishing service “corridors,” that is, channels in which any patient can, where necessary, move from one tier to another, without duplication and without interruption of service. Each service corridor corresponds to a particular health-care issue (cancer, loss of independence through aging, chronic disease, etc.). Service continuity is ensured in the corridor by reference mechanisms, linkages and special agreements between establishments.

Inversely, a group of specialists from an establishment with a regional mandate or from a university hospital centre can provide external consultation services in an establishment that offers only local services.

Thus, establishments that provide only local services must collaborate with establishments in their region that have specific mandates to provide more specialized services. Establishments having these specific mandates will oversee the development and operation of intra-regional service corridors. The same logic will apply to national services.

All agreements and collaboration mechanisms established must give clinicians the latitude they need to be able to tailor the range of services required to suit needs and circumstances.



Service corridors must be planned in a responsible and sustainable fashion. Every CSSS, with the support of the regional agency, must draw up service agreements with establishments serving the population in their local territory. The agencies must see that the establishment that receives persons referred to it has adequate resources to do so, mainly medical staff, technical support centres, and property and equipment. The contract framing the service agreement must provide for the patient to be returned to his or her originating CSSS when the highly specialized services are no longer required. This requires tight planning between the various players.

3.2.3 Engaged university networks tailored to needs

Four *Réseaux universitaires intégrés de santé* (RUIS) cover Québec: RUIS Université de Montréal (40% of the population), RUIS McGill (23%), RUIS Université Laval (23%) and RUIS Université de Sherbrooke (14%). Each has a main service territory to cover, but without strict territorial exclusivity in order to respect patients' and professionals' free choice.

Each RUIS must provide mechanisms to ensure continuity of services between establishments with a local, regional or supra-regional vocation. The aim here is better complementarity between the three service tiers. Other undertakings

must commit teaching hospital centres within the RUIS to provide ultra-specialized services for restricted clientele at all establishments in their RUIS. The service offering of university hospital centres requires, at the outset, concertation on the role of each player in this global offering, thereby avoiding players fighting for the same clientele — those needing heart surgery, for example. This is intra-RUIS complementarity.

On the other hand, there are ultra-specialized needs which, while essential to the population, use minimum service volumes, hence the necessity to agree on sharing of services between the four RUISs. This is what is meant by inter-RUIS complementarity.

The Ministère intends to take advantage of the major investments necessitated by the modernization of university medicine in Montréal – for the construction of the CHUM, the MUHC and the enlargement of the Sainte-Justine UHC – to increase complementarity between the establishments, particularly in a context where sharing of expertise can provide the entire population with the best possible services, meeting quality and safety standards, while making judicious use of public funds.

IN BRIEF

The tiering of hospital medical services fosters better consistency and greater efficiency of services, with particular regard to improving access to specialized and ultra-specialized services. Various levers are proposed to ensure service continuity and complementarity:

- organizing hospital medical services on the basis of the populations to be served at the local, regional and national levels, and the imperatives of optimal service organization;
- establishing functional, effective service “corridors” between establishments;
- strengthening collaboration and sharing expertise between the *Réseaux universitaires intégrés de santé* (RUIS) and establishments in the network so as to foster better complementarity between and within the three service levels.

4

OPTIMIZING SERVICE QUALITY

Citizens and users are — rightly — increasingly demanding of their health system, which must be able to meet their needs and expectations reasonably well. They want to be kept informed of evaluation results, both those that concern them personally and those on establishments they visit. They expect care of optimum quality and safety. They want their concerns to be taken into account. Citizens and users are critical and want to be listened to.

ACHIEVEMENTS TOWARDS BETTER SERVICE QUALITY

- **Action plan on nosocomial infections, backed up by improved knowledge of the phenomenon, better training of interveners and heightened vigilance.**
- **Adoption of Bill 83 which emphasizes quality:**
 - **mandatory certification for private residences in order to guarantee quality services to elderly people who have lost autonomy;**
 - **easier access for users to the complaints investigation process, while fostering their participation and contribution to the life of the network as members of users' and residents' committees;**
 - **Quality Directorate created at the Ministère de la Santé et des Services sociaux ;**
 - **regional concertation tables created for the promotion, defence and protection of users' rights;**
 - **Quality Vigilance Committee set up within the Boards of Directors of establishments.**
- **Joined the Canada Health Infoway in order to obtain funds for the computerization of the network and preparation of a global computerization plan.**

An improvement in the quality of service forms part of the search for greater efficiency. Implementation of quality-control measures is often seen by managers and professionals as a source of additional costs. In view of the costs of non-quality, however, it is possible to reduce overall costs through an improvement in quality. It is even possible, in many cases, to obtain quick return on investment aimed at reducing a particular dysfunction. Non-quality, measured by such indicators as accidents during care, inappropriate hospitalizations, nosocomial infections and overuse of resources, carries a high cost at the economic and human levels. Non-quality mobilizes resources that could be better used. To do more, we have to do better. To improve service quality and increase citizens' and users' trust in their health system, two types of measures need to be considered.

The first type involves assessment — to improve how complaints are dealt with, to set up an information system on accidents in the provision of care and services, and to apply various means of monitoring services provided, both in the health-care and social-services fields. For assessment to be conducive to change, we must favour transparency of results and make sure that all conclusions and recommendations put to decision makers are followed up.

The second type of measure involves upstream intervention on the causes of non-quality and factors that are conducive to quality. Emphasis must be placed on managing risks of accidents and incidents, implementing preventive and monitoring measures, and encouraging good clinical and management practices. Information systems that facilitate the circulation of clinical information during a care episode also make an essential contribution to quality in services.

4.1. SAFETY OF CARE AND SERVICES

The Western world has become aware of the scale of the consequences of avoidable accidents and unwanted effects in the provision of care and services and is concerned with means of preventing them. For its part, the MSSS, back in 2000, set up a ministerial committee on avoidable accidents in the provision of healthcare with the mandate to report on the phenomenon of avoidable accidents, to assess the effectiveness of existing risk-management procedures and to propose prevention mechanisms. The committee's report, *Risk management, a priority for the health and social-services network*, was published in February 2001.

Accidents are not isolated incidents, and are most often systemic phenomena. They are avoidable in over 50% of cases, have impacts on users and their families, and are rarely due to incompetence, negligence or individual misconduct. Patient safety must rank as one of the highest priorities in a drive for continuous improvements in quality. A culture change is necessary. We must turn our backs on opacity, guilt, embarrassment and blame, and embrace transparency, open communication, interdisciplinary teamwork and a systemic rather than an individual approach. Mechanisms are in place throughout the health and social-services network to improve the situation, in collaboration with professional bodies.

Québec's leadership in this regard has been shown concretely through the adoption of amendments to the Act respecting health services and social-services concerning the safe provision of health services and social-services. Obligations were created in terms of disclosure to patients and declaration of incidents and accidents, plus the introduction of a monitoring system through the setting up of a risk- and quality-management committee within each establishment. This committee's mandate is to research, develop and promote means of ensuring user safety and reducing the incidence and recurrence of service-provision-related accidents.

Unwanted events carry a high social, economic and human cost. Concerted efforts to improve patient safety are required of authorities, managers and providers. We must avoid attempting to identify the guilty parties, but instead use "system" approaches, modify working environments and create institutional defenses to prevent accidents and reduce their impacts. The first challenge is to change attitudes and "think safety."

In the first place, we must focus on the training of interveners, which represents one of the best intervention strategies for understanding why accidents happen and for preventing them from happening and from recurring. As well as being able to manage risks, we must also be able to support the victims of accidents. In the second place, an information system for the safety of care and services must be put in place, allowing for the constitution of the national and local registers provided for in the Act. This will be an essential tool for prevention, regulation and monitoring in every establishment, in regional agencies and at the Ministère. Other actions are also necessary to strengthen the prevention and control of nosocomial infections, accidents related to the taking of medication and the use of biological products (transfusions and transplants), and those related to the use of medical equipment.

4.2. THE FIGHT AGAINST NOSOCOMIAL INFECTIONS

Nosocomial infections have always been present in hospitals. However, these environments are at greater risk today because of the elderly and very sick clientele that receive care there, and because of bacteria that are increasingly resistant to antibiotic treatment. Improvements can still be made in hygiene and asepsis and some facilities are obsolete. In addition, nosocomial infections are not limited to hospitals. The problem also concerns all infections contracted during a care episode, regardless of the place (other accommodation environments, outpatient services or home services).

The consequences of nosocomial infections are wide-ranging: clinical complications, patient death, reduced access to health services, major and recurring financial costs, reduction in the quality of care and a loss of confidence in the health system. The *Clostridium difficile* episode reminded the entire network of the importance of better managing the risks of nosocomial infections.

The impacts of these efforts are such that we have observed, thanks to the surveillance system put in place, a 40% reduction in cases compared with the same period last year. The improvements in the situation noted over the past year are doubtless linked to measures brought forward to fight infections transmitted in the healthcare environment, and an outstanding mobilization by the hospital network. Establishments have also been supported by capital funding of \$20 million, which has been used particularly to increase the number of nurses working on infection prevention.



In light of the report of the *Comité d'examen sur les infections nosocomiales*, chaired by Léonard Aucoin, the Ministère and its partners are putting in place means of consolidating the prevention and control of nosocomial infections. An action plan is being prepared. This plan will define orientations and priorities for all players with regard to the prevention and control of nosocomial infections. It will place particular emphasis on the monitoring of nosocomial infections, good practices in the use of antibiotics, training of personnel, sterilization of equipment, and hygiene and health measures.

4.3. NEW LEVERS FOR IMPROVING SERVICE QUALITY

The amendments made to the Act respecting health services and social-services through the adoption of Bill 83 are designed to give the health and social-services network new levers allowing it to adjust more easily to changes in the needs and expectations of users. Among other things, the amendments provide for a number of means to improve the quality of service provided in the network, such as the set of measures that will make it easier for users to make use of the complaint-investigation process, encourage them to participate in and contribute to users' and residents' committees, and increase vigilance surrounding service quality throughout the network. To these are added, for the first time, measures designed to ensure that private residences represent safe living environments that respect the needs, rights and dignity of vulnerable persons living there — particularly elderly people suffering loss of independence, but also other vulnerable clientele.

4.3.1. Dealing with complaints

The processing of complaints will be completely reviewed in order to facilitate recourse by users and to ensure the implementation of measures to improve the quality of care and services. Thus, the functions of the local or regional complaints and commissioner will be re-centred on respect for users' rights, their satisfaction, and dealing with complaints. These commissioners' conditions of service will be adjusted to facilitate performance of their role. In particular, they will report directly to the board of directors and must perform their duties exclusively. Their power to intervene will be strengthened and their mandate adjusted in light of the new reality arising from the obligatory certification for

residences for the elderly. Like the general manager of the establishment or the regional agency, they will be part of the vigilance committee.

From now on, the Ombudsman appointed by the National Assembly will perform the duties of the Protector of Users provided for in the Act respecting the Health and Social Services Ombudsman and his or her reports must be submitted to the National Assembly rather than to the Minister.

Vigilance and quality committees will be created by establishments and regional agencies. These committees' main function will be to follow up, on behalf of the Board of Directors, recommendations on service quality made by various entities in the establishment or agency in carrying out their duties, or by the Protector of Users.

Every establishment will be required to set up a users' committee and, where an establishment provides services to resident users, to set up a residents' committee for each of its accommodation facilities. Every residents' committee must have a representative on the users' committee.

Lastly, the mandate of the risk- and quality-management committee (accidents in the provision of care and services) will be specified in greater detail in order to clarify its responsibilities regarding nosocomial infections.

4.3.2. Certification of private residences

According to the most recent data, about 80,000 elderly people aged over 65 are living in private residences where, in addition to accommodation, services are provided, mainly in connection with safety and assistance with domestic and social life. For comparison purposes, 45,000 elderly people are accommodated in the institutional network (CHSLD), in intermediate resources and foster homes.

The importance of private residences and their contribution to maintaining people in their living environment makes it necessary to check the quality of social and health services provided for loss of independence.

A certification process for private residences based on social and health criteria has therefore been made mandatory through the adoption of Bill 83 in December 2005. The regulations governing this certification will also set out other requirements that operators will have to meet with regard to the safety and salubrity of buildings.



4.4. VISITS TO ASSESS THE QUALITY OF SERVICES

Visits to assess the quality of services provided in substitute living environments accommodating a vulnerable clientele are one of the tools the government has adopted for the purpose of managing service quality proactively.

Since they were introduced in 2003, visits have been made in three separate spheres of activity: CHSLD, Family-Type Resources (FTR) and Intermediate Resources (IR), and youth centres. In these environments, with the exception of youth centres, the private sector is an important partner. CHSLDs, designated “private institution under agreement” and “private institution not under agreement”, provide all services to their users. In FTRs and IRs, the facilities are privately owned and all or a large part of support and assistance services required by users are also provided by the private sector.

Quality assessment visits are always conducted according to the same parameters, which are centred on the welfare and integrity of persons. Whether the service provider is private or public, the assessment always takes into account principally the respect of users’ rights, the ministerial policy directions concerned and recognized good practices. A report, with recommendations, is then sent to the minister. The establishment is requested to produce an action plan and the Ministère follows up on the file in collaboration with the regional agency.

Quality assessment visits differ from other processes aimed at related objectives in a number of ways. The visit teams are formed through a partnership with community organizations whose view is independent of the public network (at the national and regional levels), recognized experts and representatives of the agency. The objectives cover the entire spectrum of preventive and curative intervention. The “focus group” approach used enables the various interveners, users and their families to give their assessment. Use of the same grid for all groups met ensures fairness and continuity in the gathering of data. Lastly, the visits allow a systemic analysis of the operation of each of the sectors assessed, making it possible, at the national level, to support, consolidate, develop, modify and propose practices that will bring improvements to the quality of life of users.

People must be the central concern when considering ways of organizing and providing services. The results obtained from the quality assessment visits provide a concrete and visible demonstration of this concern that is often expressed, but is seldom perceived by citizens, users and their families.

In this respect, these visits represent a prime tool for strengthening the population’s confidence in the system of services put in place. In this context, Quality Assessment Visits can, without a shadow of doubt, be extended to all substitute living environments receiving a vulnerable clientele, regardless of whether the owner of the premises and the service provider is public or private.

4.5. ACCREDITATION OF ESTABLISHMENTS

Since the adoption of Bill 113 on the safe provision of health services and social-services, the Act respecting health services and social-services (Bill 113) obliges all establishments to seek accreditation from recognized accreditation organizations.

The Ministère has also expressed expectations regarding the accreditation of health services and social-services. In particular, it seeks to introduce into the accreditation process an obligation to comply with various recognized standards (e.g., ISO Standard 15189 for medical-biology laboratories), to adhere to a rigorous process, and to take follow-up action on the conclusions of the Quality Assessment Visits.

The importance of accreditation lies in the fact that the process makes it possible to ensure the quality and safety of services to the general public; it promotes optimal use of resources through the development and dissemination of best practices to achieve each establishment’s mission.



Ministerial policy directions regarding the accreditation of health and social-services establishments are in preparation. They are aimed at ensuring that the assessment process is based on high standards and that the process is rigorous, systematic, mobilizing and performed at reasonable cost. All health and social-services establishments in Québec will have to undergo an accreditation process that covers administrative and clinical components, the safety of care and services, plus certification of laboratories and technical services. A mechanism for following up accreditation visits will be put in place. An establishment's accreditation must, both for the public and for government authorities, become a primary means of making sure that services provided are safe and of high quality.

4.6. CIRCULATION OF CLINICAL INFORMATION

With the setting up of local service networks, circulation of information becomes essential to the integration of services. The recent adoption of amendments to the Act respecting health services and social-services (Bill 83) will facilitate the passing of information in the patient's record (with the patient's consent) between authorized professionals. Quality and continuity of services depend on the availability of information to be exchanged, at the right moment, between the various interveners and service providers.

In addition, certain items of information on users who give their consent could be stored at the regional tier. Among these items, which could not be consulted for other than clinical purposes, will be the user's pharmaceutical profile. Restricted access to this confidential information by physicians and pharmacists will help them better fulfill their professional role.

IN BRIEF

To do more, we must do better. To improve the quality of services and the confidence of citizens and users in the health system, two types of measures must be considered:

- Evaluate better:
 - by improving the handling of complaints;
 - by setting up an information system on accidents in the provision of care and services;
 - by introducing surveillance and control methods for services provided, through the certification of private residences and quality assessment visits, among other initiatives.
- Intervene better to prevent non-quality and foster quality:
 - by focusing on management of the risks of accidents and incidents;
 - by putting prevention and control measures in place;
 - by placing value on good clinical and management practices;
 - by contributing to the improvement in information systems that circulate clinical information during a care episode.

5

IMPROVING ACCESS TO MEDICAL AND HOSPITAL SERVICES IN ORDER TO REDUCE WAITING TIMES

Since 2003, considerable progress has been made with regard to access to medical and hospital services, such as the substantial reduction in waiting times for radiation oncology and heart surgery, and the considerable rise in the number of orthopedic and cataract surgery procedures completed.

ACHIEVEMENTS TOWARDS REDUCING WAITS

- 60 million dollars invested in recurrent dollars in reducing waiting times in 2003-2004.
- Marked reduction in tertiary cardiology waiting lists: between 2002 and 2005, the number of people waiting for diagnostic catheterization and angioplasty fell by 40.6%, and for cardiac surgery by 35%.
- Substantial reduction in waits longer than eight weeks for radiation oncology treatment since March 2003. They fell from 206 — all types of cancer taken together— as of March 31, 2003, to four cases as of January 27, 2006. It should be stressed that, as of now, nobody suffering from cancer is waiting longer than eight weeks to receive the radiation therapy treatment his or her condition requires. Cases of prostate cancer waiting longer than eight weeks have also fallen very sharply, with four cases as of January 27, 2006, all of them representing patients who refused to receive treatment in a radiation therapy centre other than the one they had been visiting.
- Sharp fall in waiting times longer than four weeks, data on which have been gathered since June 2005. Whereas on June 3, 2005, 201 cancer patients had been waiting for treatment for longer than four weeks, they numbered only 53 on January 27, 2006, including 15 patients who had refused to receive treatment in a centre other than the one they were already visiting. More globally, the number of people awaiting radiation oncology treatment has been falling progressively each week since June 2005.
- Seven capital projects have been completed in seven radiation oncology centres, increasing the radiation therapy equipment fleet by 15 accelerators, which will enable no less than 6,000 more patients to receive treatment by 2007-2008.

Between 2002-2003 and 2004-2005

- the number of patients who underwent cataract surgery rose by 16.5%, or 9,358 patients;
- the number of patients who underwent knee arthroplasty rose by 23%, or 959 patients;
- lastly, the number of patients who underwent hip arthroplasty rose by 9.6%, or 377 patients.

A symptom of the difficulties faced by most Western health systems, waits for services provided in hospitals continue. The Québec health system is not free of the problems of waiting times.

The importance of the issue of waiting times for medical and hospital services needs no further demonstration. A majority of governments in developed countries face the same issue. Following the federal-provincial-territorial meeting of premiers on health in September 2004, reducing waiting times was selected as the prime objective, especially for services in radiation oncology, cardiology, diagnostic imaging, and joint replacement and vision restoration. In several of these areas, standards on what is medically acceptable have not yet been determined, consensus among experts having been reached with regard to a small number of procedures only.

The necessity of planning medium- and long-term structural action in response to this situation has been heightened by the Supreme Court of Canada judgment²⁵ of June 2005 in the Chaoulli and Zeliotis case brought against the government in 1997. In a split decision, the Supreme Court concluded that Québec legislation prohibiting private insurance for health services violated people's rights to life and personal inviolability guaranteed by the Québec Charter of Human Rights and Freedoms.

25. Jacques Chaoulli and Georges Zeliotis v. The Attorney General of Québec and the Attorney General of Canada, June 9, 2005, File no. 29272.



The government is very sensitive to the situation of people undergoing long waits. It has taken concrete steps in the past few years to improve the situation and is committed to continuing in this direction, deploying the greatest possible efforts. Waits persist, pushing us to implement solutions that will enable us to offer every patient a guarantee that he or she will obtain the care his or her situation requires. Solutions will be introduced gradually, in stages, as the availability of resources, both human and financial, allows.

In a climate in which many people are questioning the future of the public health and social-services system, we must ask ourselves the following question: “What role must the private sector play to enable us to increase the system’s capacity to meet the population’s expectations and needs while maintaining a universal public system that is equitable and accessible to all?”

Pursuing the twin objectives of preserving our public, universal health and social-services system and responding to the Supreme Court judgment — the second being subordinate to the first — the government is proposing a solution geared above all towards improved access to public medical and hospital services. Taking its inspiration from experiences in other countries, it is inviting the entire health and social-services network to put in place a mechanism that will provide guaranteed access to services, adapting its working methods accordingly. The government’s proposal also opens the door, in a highly targeted manner, to private insurance, providing the necessary response to the judgment of the Supreme Court.

5.1. PROBLEMS ARISING OUT OF WAITING TIMES DESPITE THE PROGRESS MADE

In the past few years, major efforts have been made to reduce waiting times. It must be remembered that the government has made major catch-up strides in financing, injecting \$3 billion into the health and social-services sector since 2003. This investment in the entire network, combined with other changes made in the system such as the measures to improve access to a family physician, has brought good results.

People requiring urgent treatment generally obtain it immediately, with high standards of quality. This is the case for obstetric and pediatric care, traumatology, and acute infectious, digestive and neurological illnesses, etc.

The Fraser Institute recently published its annual study of waiting times across Canada. It reports that Québec is the only Canadian province to have initiated and maintained, since 2003, a reduction in the waiting time between consultation with a specialist physician and the treatment he or she prescribes. Also, in Québec this waiting time is the shortest in Canada, at 8.4 weeks. The study also reported that Québec is one of five provinces in which the waiting time between the appointment with the family physician and the specialized treatment has been reduced.

Yet despite the resources invested, despite the increase in the number of procedures, despite the remarkable work accomplished by interveners in the network and despite the various measures taken to improve the functioning of the system, access to medical and hospital services remains a matter of concern for both the population and the government. In this regard, the population’s expectations of the health and social-services system are high, but completely legitimate given the public resources that are invested in it. The government is aware that it must adopt methods that will give a more precise picture of the situation regarding waiting lists and allow it to provide the public with more accurate and informative data.

Over the past few years, attention has been focused mainly on the number of patients waiting rather than on access to services. Accessibility is defined primarily in terms of place through the provision of care and services in the patient’s vicinity, both for services from a doctor and for those provided in an establishment or at home. It also includes a notion of time related to wait for access to elective services with or without appointment. Lastly, it includes availability of access at a broad range of times including unsocial hours, without having to go to an emergency room.



Access to medical services within a clinically acceptable period, in clearly defined places or through clearly defined service corridors, is the strategy that the health and social-services network now intends to pursue. We must stress the importance of instigating active collaboration between health professionals, doctors and establishment administrators so that, through rigorous management, every individual can be guaranteed access to clinical services provided by the right professional, in a timely manner and in the right place.

We must give ourselves the tools we need to manage waiting lists effectively. There are multiple, complementary solutions. Reinforcing front-line services, the availability of basic high-technology and laboratory-medicine infrastructures, access to specialized services in every region and to ultra-specialized services through operational service corridors, and access plans for every medical speciality are essential avenues in the quest for solutions. We must also improve our capacity to evaluate and monitor waiting times through information technologies and the availability of clinically recognized data.

5.2 THE CONTEXT OF THE SUPREME COURT OF CANADA'S JUDGMENT

The judgment of the Supreme Court of Canada invalidates two articles in Québec's laws on health insurance and hospitalization insurance that prohibit taking out private health insurance in Québec for services that are provided by the public system. This decision would open the door, on the one hand, to payment of non-participating physicians by private insurers for medical services currently covered by the public system and, on the other hand, to private insurance for health services currently provided exclusively in hospital, thereby duplicating public provision of these same services. The Supreme Court, after acknowledging that preserving the public system is an urgent, concrete objective, considered that the means of doing so chosen by Québec, namely the prohibition of private insurance, was disproportionate to the objective.

By allowing the private sector to sell insurance policies covering services currently financed by the public sector, the Supreme Court judgment opens the way for the development of a private service-provision network where those able to afford it could obtain medical and hospital services faster than those using services financed by the public sector. This therefore challenges the social foundation of

Québec's public system. This new context raises many issues, particularly regarding the availability of the human and financial resources needed to make the public service network viable. The development of a private service network could risk draining human resources currently employed in the public network towards privately financed services. The development of privately financed services could also lead to an increase in the demand for some publicly financed services and thus bring about an increase in public spending on health. Lastly, at a time when Québec is implementing provisions to ensure tighter integration of services, a parallel private service network could not be developed without links being created between the public and private service networks.

In view of the importance of the issues raised, the government of Québec requested and obtained a stay of the judgment, pushing back its effective date until June 9, 2006. The government decided that it was imperative to set up a strategic inter-ministerial committee to study the question.

5.3 CHANGES IN EXPECTATIONS OF THE PUBLIC HEALTH SYSTEM

Changes in the Québec health system are strongly tied to the expectations of leading actors in society and of the population in general. Until the 1960s, there was a mixed but predominantly private system in Québec: responsibility for the less well-off and disadvantaged fell to the state, while the rest of the population had to rely on private insurance or, failing that, settle hospital bills out of their own pocket. The costs of insurance increased progressively, however, jeopardizing access for people with low incomes, while the costs of hospital medicine were exploding. Demands for change from society intensified and in the early 1960s new values emerged along with social law. Governments, both federal and provincial, passed legislation²⁶ to lay the foundations of a universal health-insurance system throughout Canada. Québec went further²⁷ by bringing health and social-services under a single administration in order to better meet the needs of citizens who require more services, particularly the elderly suffering loss of independence and people with disabilities. The Québec government's intervention in health and social-services also made it possible to reduce inequalities of access between rich and poor and between urban and rural populations.

26. At the federal level, we can point to the Hospital Insurance and Diagnostic Services Act, 1957, the Medical Care Act, 1966, and the Canada Health Act, 1984 as examples.

27. In Québec, we can cite the Hospital Insurance Act, 1961, the Act respecting health services and social-services, 1971, the Act respecting prescription drug insurance, 1996, and the Public Health Act, 2004.



Government moves to make health services public accorded with citizens' expectations. The sustained growth in the costs of health services and the system's difficulties in meeting the population's more adequately moved the debate along. Many commissions and special committees have examined the state of the public health system, means of ensuring its long-term viability, and its functioning and funding. All analyses rejected privatizing the financing of healthcare because this move would bring major disadvantages. Among these are the insufficient protection of private insurance cover, high costs, access and equity problems for people with low income, and the shortage of human resources, particularly doctors, and disparities in their distribution over the entire territory.

The Supreme Court's recent judgment has revived the debate regarding access to services and opening up the system to private medical insurance. Some actors in the population fear the threat of a two-speed system, while others believe that changes are called for and that the state monopoly needs to be broken by providing a better balance between the private and public sectors. This opening up to the private sector is qualified, however: many consider that it must be carried out "cautiously" and that the values of universality and equity that are the foundation stones of the public system must not be sacrificed. The population is calling for a public debate on the question. The problems of funding and the growth of needs, which persist in their entirety, must be addressed.

5.4 EXPERIENCE IN CANADA AND ABROAD

Québec is not alone in facing with the question of public and private financing of the health system. A number of other governments have taken measures to provide a framework for private insurance or to allow private insurance and a network of state-financed services to coexist.

5.4.1 Allowing private insurance

Until the recent Supreme Court judgment, the public health system in Québec was a quasi-monopoly. Hitherto, Québec law has prohibited direct payment of physicians by other insurers, private or public, and private insurance cover for services requiring hospitalization of longer than one day that are already covered by the public system. Many Quebecers do take out supplementary private insurance for services that are not covered by the public system, such as dental and vision care, or chiropractic treatment and alternative medicine, for example. The entire eligible population of Québec is also covered by two public accident-insurance plans, those of the Société de l'assurance automobile du Québec (SAAQ) and the Commission de la santé et de la sécurité du travail (CSST).

In other parts of Canada, there is a degree of ambiguity regarding the allowability of private health insurance. Not all Canadian provinces prohibit it, but all take measures to limit its growth and to prevent weakening of the public sector²⁸. Some provinces favour dissuasion, such as the ban on extra-billing (in Québec, Ontario, Manitoba, British Columbia, Alberta and Prince Edwards Island), non-reimbursement of charges billed directly to patients by doctors who have opted out of the public system (New Brunswick) and legal restrictions to discourage doctors from opting out of the public system (in Manitoba and Prince Edward Island). Other provinces use legislation to restrict access to the private sector: in 1999 Saskatchewan passed an act²⁹ outlawing faster access to a medical service; since 2000, Alberta has not permitted³⁰ private financing (except for private magnetic resonance imaging clinics); and Ontario passed the *Commitment to the Future of Medicare Act, 2004*, thereby reinforcing the ban on a two-speed health system. Only Newfoundland and Labrador allows, in principle, reimbursement for the fees of doctors who have opted out of the public system, extra-billing remaining at the expense of patients or private insurance policies which they may take out. In practice however, there is apparently no physician who has opted out of the province's public system.

28. Jacques Chaoulli and Georges Zeliotis v. The Attorney General of Québec and the Attorney General of Canada, June 9, 2005, File no. 29272, paragraph 174.

29. Health Facilities Licensing Act, 1999.

30. Bill 11: Health Care Protection Act, 2000.

Some member countries of the Organization for Economic Cooperation and Development (OECD) have opted for a legal framework for private duplicate insurance³¹. These countries also provide public coverage, financed by taxation, to the entire population, but most differ from the situation in Québec and Canada by their policy of user fees (copayment) and by conditions that they impose to regulate private insurance. These countries fall into three main groups based on the role played by private health insurance interacting with the public system and the affect this has on health systems³².

- Sweden and Norway make up the first group, in which a negligible proportion of the population (less than 1%) is covered by the private sector. Although there are differences between the Swedish and Québec health systems in the way services and public coverage are organized, Sweden faces similar challenges, such as control of public spending on health, constraints involving medical and professional resources, and the aging of the population. However, these tensions within the public system have not led to a major switch towards privatization of care, in spite of three successive waves of reforms between 1991 and 2003. The dominant position of the public health system is largely explained by copayment policies and the size of the tax burden, with private insurance premiums thereby coming on top of these charges for the population.
- Finland, the UK, Spain, Portugal and Italy occupy the middle ground, with 10 to 15% of their population covered by private insurance. The UK has shown a marked tendency to be in the vanguard of the health system reform movement in OECD countries. In the UK, the performance of public hospitals (Trusts) has been most clearly linked to the possibility of providing wholly private beds, their number being limited by the government and their use being based on latent demand. For example, specialist doctors can earn up to 10% of their income in private practice, but if they exceed this ceiling, they can lose 1/11 of the salary that the government pays them. Hospital staff may work in the private sector during their free time and hospitals can rent out their equipment when it is not being used.

- Denmark, New Zealand, Ireland and Australia make up the third group. Here, a much larger proportion of the population (between approximately 28% and 45%) have private duplicate health insurance, which is encouraged through direct and indirect subsidies or through taxation policy. However, these countries do provide a judicial and regulatory framework for the provision of services by the private sector. For example, Australia prohibits the provision of front-line services by the private sector, but subsidizes private hospitals and allows public hospitals to offer private beds.

5.4.2 Advantages and disadvantages of private duplicate insurance

What lessons can we draw from these experiences for improving the Québec health system? In theory, the primary benefit of private duplicate health insurance would be a reduced load on the public system, since part of the demand and associated costs would move from the public to the private sector, thereby strengthening the responsiveness³³ of the system as a whole.

The availability of human resources, including doctors, must however be sufficient to sustain this growth: this condition is vital in order to enable the entire system (public and private) to treat more people. In addition, it would appear that some countries have chosen to make substantial investments in their health systems to meet the challenge of increasing production capacity.

An examination of the ratio of active physicians per 1,000 inhabitants reveals that there are more active doctors in the United Kingdom (2.2), Australia (2.5), Denmark (2.9), Norway (3.1), and Sweden (3.3) than in Canada (2.1), which was in last place among OECD countries in this respect in 2003. Using a compilation of comparable data, the ratio for active physicians in Québec per 1,000 inhabitants lies at 2.3, whereas the average for OECD countries, disregarding the ratio from Canada (2.1), was three active physicians per 1,000 inhabitants in the same year.

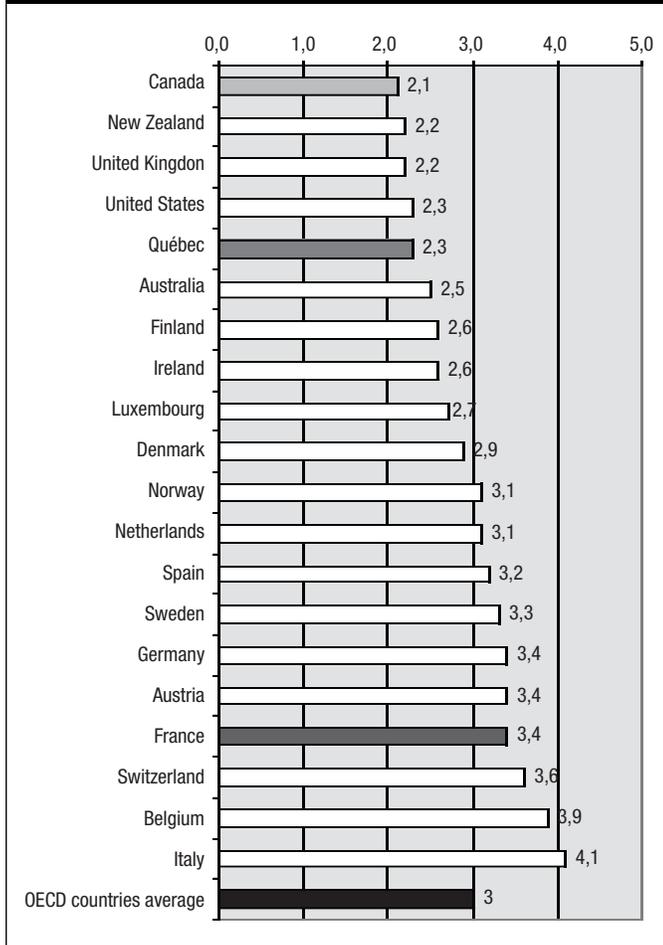
31. Private duplicate insurance covers medically necessary health services even though these are generally covered by the public system.

32. The OECD Health Project: *Private Health Insurance in OECD Countries*, 2004.

33. Responsiveness is defined as the system's ability to meet the population's expectations regarding speed of access to services and satisfaction with services received.

GRAPH 1

NUMBER OF ACTIVE PHYSICIANS PER 1,000 INHABITANTS, IN CERTAIN OECD COUNTRIES AND QUÉBEC, 2003



Sources: Definitions, sources and methods by country: www.irdes.fr/ecosante/OCDE/fr/210030.html, Copyright OECD Health Data 2005, June 2005; data for Québec supplied by the Canadian Institute for Health Information (CIHI) and compiled by the Ministère de la Santé et des Services sociaux du Québec.

However, other countries' experiences with private duplicate insurance involve a number of risks and do not seem to have brought any guarantee of better overall access to healthcare, nor any gains in efficiency in the system as a whole. One important issue is not to sacrifice equity in access to healthcare for the entire population, including vulnerable clientele. In this regard, special attention must

be paid to persons with low income, those suffering chronic diseases or having disabilities (and who would have greater difficulty obtaining private insurance) and to people living far from major population centres. The experiences analyzed confirm that it is mainly workers, through group insurance plans, people in middle age and the more affluent who are able to avail themselves of private insurance.

The wider the door is opened to private insurance, the greater the need for a variety of control measures to be implemented, making management of the entire system more complex. The main adverse effect of overly permissive regulations and insufficient control over duplicate insurance is the siphoning-off of resources from the public sector to the private sector. The consequence can be reduced access to services for users of the public system, since incentives that foster greater productivity would be specifically concentrated on users of the private system, to the detriment of productivity in the public sector. Moreover, even with sufficient additional regulatory supervision, there would be no guarantee of the quality of services provided by the private sector.

5.4.3 Mechanisms for improving access to health services

The health systems of a number of western countries are confronted, like that of Québec, with unacceptably long waiting times for certain services. Among the attempts to deal with this problem that we have analyzed, two countries provide useful examples of mechanisms set up to improve access to healthcare: the UK and Sweden.

The UK

The UK has favoured a gradual approach, begun in 1998 with a major reform³⁴ providing several mechanisms for guaranteeing care within the public system. Since 2002, any hospital that cancels an operation for nonclinical reasons must offer patients another date within 28 days, or pay for them to be treated in the hospital of their choice. Since the summer of 2004, all patients who have been waiting for an operation for more than six months can obtain the service in another hospital or from an independent provider. Agreements (with pricing grids) have been reached with the private sector for obtaining treatments or sending the patient outside the NHS (National Health Service).

34. NHS Plan: a plan for investment, a plan for reform, 2000.



It was anticipated that, by the end of 2005, the wait for an appointment with a specialist for outpatients would have been brought down to a maximum of three months; for patients registered with a hospital for treatment, the maximum wait is six months. By 2008, these periods will progressively be reduced to a maximum of three months. By 2008, these periods will progressively be reduced to a maximum of three months. All hospital appointments will be recorded using an electronic appointment-making system at the convenience of the patient who, on the day of the appointment, will be seen no later than 30 minutes from the appointed time. This new appointment system will make it easier for the patient and the general practitioner to choose a hospital and a specialist. Patients will also be able to choose to be treated by one of four or five different providers, who will be paid according to a nationwide fee schedule and in 2008 patients will be able to obtain service from the provider of their choice.

Sweden

In Sweden, the first agreement (National Guarantee of Treatment) was reached between the government and the Swedish counties in 1991, coming into force the next year. It was an immediate success, but began to run out of steam after three years; after five years things had almost returned to square one. A new formula, the Guarantee of Medical Treatment, introduced in 1996 and revised in 1997, provided better regulation and supervision of front-line and specialist medical services. This failed to yield the expected results and was also abandoned. In 2003, the central government and the counties developed a further formula, the National Treatment Guarantee, which has been in force since November 1, 2005. It covers the entire care episode, rehabilitation therapy and home support being already integrated into the overall process in Sweden. It is based on the 0-7-90-90 rule, i.e., no delay or instant contact with the health-care system, being seen by a general practitioner within 7 days and seeing a specialist within 90 days, and not waiting longer than 90 days after diagnosis for treatment.

The pros and cons

In general, one can conclude that access-guarantee mechanisms bring the benefit of setting structuring targets

for public-health systems and provide recourse for people awaiting services when targets are not met.

However, these mechanisms appear to be complex to manage, and must evolve. In the United Kingdom and Sweden, they are subject to periodic reviews. Such avenues require the availability of human and financial resources in sufficient quantity.

5.5 PRINCIPLES TO BE OBSERVED

In the present debate, the Québec government wishes to reassert its commitment and its attachment to the fundamental principles that have up to now guided the development of the health and social-services system. In addition to reiterating its will to maintain a strong public system, the government is sensitive to the criteria used in the analysis of the various possible avenues for solutions.

- **Universality and equity of the public health system**

Access to health services must be based on people's needs and not on their ability to pay. The government wishes to maintain a health system in which there are no significant discrepancies in terms of access, regardless of the manner in which services are provided. In this regard, special attention must be paid to persons with low income, those suffering chronic diseases or having disabilities (and who would have greater difficulty obtaining private insurance) and to people living far from major cities.
- **Integration of services as a preferred organizational method**

The various solutions must be evaluated, particularly on the basis of their impact on the way services are currently organized, and more specifically on the basis of aspects relating to the integration of services. Like a number of other governments throughout the world, Québec has chosen this solution to deal with the complex challenges posed by managing a health system. We must therefore continue the efforts that began with the setting up of local health and social-services networks and make sure that the choices made do not jeopardize the steps that have been taken towards better integration of services.

- Maintaining and improving the quality of services

The medical establishment and services providers generally have traditionally assumed responsibility for service quality. In response to various problems, in particular those relating to safety of services, public authorities have also made quality a priority, in the same way as accessibility and continuity of services. Although the prerogatives of the various professional bodies should continue to apply regardless of solutions that may be chosen, mechanisms put in place to guarantee the quality of public services must be applied to all service providers, whether public or private.

- The availability of human resources in the public sector

Despite government efforts, such as the increase in the number of admissions in medical faculties (from 500 at the end of the 1990s to almost 800 in 2005-2006), a number of other employment fields in the health sector are experiencing shortages of varying degrees of severity — particularly nurses, radiodiagnostic technicians, etc. What is more, long-term demographic trends suggest this will be a major issue in the coming years as the result of many professionals taking retirement over the next ten years, a fall in the numbers of young people coming onto the labour market, and the increase in demand for health services resulting from the growth in the numbers of elderly people. In this context, any changes in the manner in which services are provided must be accompanied by safeguards to protect the availability of the human resources necessary for the operation of the public health system (see box).

- Increased productivity and better control of the costs of the health system

In a climate in which doubts are being expressed as to the future of the public health system, whatever solutions are chosen must make it possible to increase productivity in the health and social-services system and to better control costs. We must be watchful to ensure that measures chosen do not generate major increases in the overall costs of health for the people of Québec.

MEDICAL STAFF: PROSPECTS

One of the ways that has been chosen to improve access to medical services is to increase the number of doctors in Québec. The fall in medical-school admissions in the mid-1990s, followed by the retirement program in 1997, caused an unprecedented shortage of doctors, both general practitioners and specialists. To remedy this shortage, medical-school admissions for the Québec contingent were increased by 85%, rising from 406 in 1998-1999 to 748 in 2005-2006. The soon-to-be-opened satellite campus in Saguenay—Lac-Saint-Jean will enable 24 additional students to be admitted in medicine, bringing the total admissions for 2006-2007 to 772.

The increase in the number of physicians trained, twinned with intensified recruitment of foreign doctors, will have a significant impact on the number of doctors available to Québec in the coming years. Given the time that medical training requires, the rise in the number of medical-school admissions will contribute to the availability in Québec of about 3,000 more physicians in 2015, even taking into account the predictable effect of doctors leaving to take retirement and for other reasons. This is a rate of growth unmatched in the past 15 years.

Whereas Québec can currently count on the services of 7,500 family doctors, we estimate that in 2015 the rise in admissions will bring this number to about 9,000. The number of specialist doctors should rise to 9,500 in 2015 from the current figure of just under 8,000.

In order to respond to needs adequately, the rise in medical-school admissions must be accompanied by a judicious choice of specialities that will benefit from this increase. In this respect, the rise in admissions must contribute to sustaining the Ministère's priorities, which are cancer, mental health and the reduction of waiting times, in the context of the requisite tiering of services.

NURSING STAFF AND OTHER: PROSPECTS

For establishments in the health network, a growth in the workforce of between 1.6% and 2.5% per year is expected. This means that by 2015, the network will have to recruit between 13,000 and 22,000 persons each year, both to replace personnel who leave and to meet new needs.

In addition, the most pressing recruitment needs involve personnel of whom in many cases there is already a shortage, particularly nurses, pharmacists, physiotherapists, speech therapists, ergotherapists, special-education technicians and radiodiagnostic technologists.

As an example, as of March 31, 2015, there will be a shortage of 10,400 nurses in Québec, that is, 13% of the workforce needed on that date, based on an annual increase in needs of 1.6%.

The government of Québec has already initiated a number of actions with a view to planning the staffing needs of the public network and to respond to immediate needs for personnel in health establishments. Special measures have been put in place in consultation with the Ministère de l'Immigration et des Communautés culturelles (MICC) in order to facilitate the integration and recruitment of various foreign-trained health professionals. For its part, the Ministère de l'Éducation, du Loisir et du Sport (MELS) has implemented measures designed to increase the number of enrolments in health programs as well as measures designed to improve success and graduation rates. Moreover, the government is working to develop a renewal strategy for the health and social-services workforce.



5.6 POTENTIAL OPTIONS IN THE WAKE OF THE SUPREME COURT JUDGMENT

A number of options can be envisaged to improve access to services and to respond to the questions posed by the Supreme Court judgment. Various choices can be made regarding the way medical and hospital services are financed and organized, by both the public and private sectors.

The range of possible choices can be represented as a continuum with the status quo in terms of how services are financed and organized at one end, and at the other end a field that is completely open to private financing and private production of medical and hospital services. Between these two poles are a host of possible combinations of public-and private-sector financing and service delivery, which have been analyzed in light of the principles set out above.

In the following sections, three major options, bringing together the scenarios analyzed, are presented:

- maintaining the status quo regarding financing of health services;
- opening the door to the financing and production of services by the private sector;
- introducing a plan guaranteeing access to services aimed at reducing waiting times.

5.6.1 Maintaining the status quo regarding the financing of health services

Following the Supreme Court judgment, a number of actors in civil society have expressed concern over the consequences that legalizing private health insurance could have on equity of access to care, the availability of medical and professional manpower, and even the integrity of the health and social-services system as a whole. As a result, several interveners have called for the maintenance of the status quo, even if this involves invoking the notwithstanding clauses of the Québec and Canadian charters of rights. This would allow the full preservation of current legislation (Article 15 of the Health Insurance Act and Article 11 of the Hospital Insurance Act).

This would maintain the illegality of private insurance for medical and hospital services covered by the public system. However, non-participating physicians could still choose to practice alongside the public system.

On the one hand, La Régie de l'assurance maladie du Québec (RAMQ) listed a total of 97 doctors who had opted out of the public system in 2004 (fewer than 1% of the total), but there is nothing to indicate that this number will necessarily remain stable over the next few years in the absence of adequate control measures. Under the status quo, these doctors would continue to provide, in return for payment from their clients, services not covered by the public system in private clinics (e.g., cosmetic surgery) and services that are insured solely in a hospital environment (e.g., various same-day surgeries, magnetic resonance imaging, etc.). On the other hand, doctors who wish to opt into the public health-insurance system must continue to respect the rule of a watertight seal in financing, meaning they must forgo any private financing for a service covered by the public health-insurance system administered by the RAMQ.

Maintaining the status quo would also mean that the financing of medical and hospital services would remain very predominantly public, and that private insurance for medical services already covered by the public system would remain illegal. Hospital centres would therefore remain in the public sphere, whereas medical clinics, while being privately owned, would continue to provide services that are essentially covered by the public health-insurance system.

However, nothing would change with regard to the development of privately financed service offerings by nonparticipating physicians, since the rules would be the same as at present. In short, maintaining the status quo would not intrinsically provide any concrete measure to address the concerns of the Supreme Court in relation to individual rights to life and inviolability of the person, as defined in the charters.

Regardless of this judgment, which results from a situation denounced by the plaintiffs in 1997, an ordered implementation of measures to increase productivity remains essential in order to reduce waiting times. Significant action on productivity would require major changes to current practices inside the public health system.

Moreover, maintaining the status quo would not require the adoption of any new legislation or regulations and it would not complicate government control and monitoring of the health system. The overall cost of the public health system should therefore not change in any way if the status quo option is chosen.



Choosing this option would therefore mean that equity of access would be preserved, but merely maintaining the status quo holds out no hope for significant improvements in speed of access to services or significant reductions in waiting times. Nor does anything suggest that, without safeguards, the provision of privately financed services would not increase from the current level if this is the only option chosen.

In the context of the status quo, the option to introduce a form of service guarantees could constitute a quasi-judicial review mechanism that would enable individuals who regard certain waiting times for treatment as excessive to bring a complaint and obtain a referral to another public or private establishment. This option, which would constitute a marginal improvement in the public service offering, would however provide only a partial response to the concerns of the Supreme Court and would risk making management of the system more complex by introducing a form of litigiousness.

5.6.2 Opening the door to the financing and production of services by the private sector

A number of options can be envisaged for allowing the private sector to finance and produce health services. For the purposes of illustration, three options are presented below, ranging from a minimal opening to a virtual free market for health services.

Minimal opening to the private sector

The sale of private insurance for medical and hospital services could be legalized, but only for certain elective surgeries which would be defined in regulations by the *Ministre de la Santé et des Services sociaux*.

The watertight seal between publicly financed and privately financed health services would be preserved by maintaining the obligation imposed on doctors who wish to participate in the public health-insurance system to forgo all private remuneration for services insured by the public system (this is termed exclusivity of remuneration). Consequently, a patient could only purchase a surgical procedure from a physician who has opted out of the public system.

The activities of clinics in which physicians who have opted out of the public system practice would be subject to contractual or regulatory supervision. This supervision would specify such clinics' responsibilities in the event of complications following an operation, quality standards that

must be met, the type of permits that must be held, and obligatory complementarity links with the public health system.

An intermediate approach to opening up to the private sector

In addition to the elements set out above, private firms (clinics and insurers) could be permitted to rent equipment and operating theatres in public health establishments. Such rental would be permitted only outside normal hours of use and only for establishments that have been able to determine their costs reliably (an essential condition for establishing fair pricing). The watertight seal between the public system and the private system would be maintained, with doctors having to choose whether or not to participate in the public system.

A virtual free-market approach to health services

In comparison with the two previous options, this avenue would widen the range of medical and hospital services that could be covered by private insurance. Also, the watertight seal between publicly and privately financed services would no longer exist: doctors who participated in the public health-insurance system could also treat patients for private remuneration for services that are normally covered by the public system. In exchange, physicians who wish to participate in the public health-insurance system could be required to provide a fixed minimum level of service in the public health system.

Contractual or regulatory supervision would be maintained for clinics that sell medical or hospital services. This supervision would cover responsibilities in the event of complications, quality standards to be met, types of permits required, etc.

As in the preceding option, the private sector could use excess capacity of operating facilities in public establishments. The public health system could also purchase services from wholly private clinics.

It would appear that a wide and uncontrolled opening up to private insurance could jeopardize equity of access based on peoples' needs. Indeed, access to privately financed services is governed by market forces and is open only to those who have sufficient financial resources and to workers who have access to a group insurance plan. In this context, the majority of the population, who do not have sufficient financial resources, would experience no improvement in



access as a result of the opening of the door to private insurance and could even see access worsen, to the extent that the expansion of privately financed services would entail hiring specialized, experienced human resources currently working in the public health system.

An alternative to the three options described above would reduce some of the negative impacts of a wide opening of the door to private insurance and protect the integrity of the public health and social-services network. This scenario would maintain the principle of a watertight seal between publicly financed and privately financed services and would introduce safeguards with the aim of supervising medical practice, controlling the potential migration of doctors who would wish to leave the public system, and of ensuring support for the public system from the private system should waiting times become excessive.

The increase in the availability of privately financed health services, which would translate into a greater number of independent actors and fragmentation of the service offering, could compromise the steps taken by the government over the past few years to improve the integration, continuity, and quality of health services and to favour more efficient use of resources. For this reason, it seems likely that the wider the field is opened to private insurance, the more complex overall management of the health system would become, and the more difficult it would be to control the quality and costs of the health system. Opening up to private insurance would in all probability lead to an increase in the proportion of GDP devoted to the health and social-services sector.

Lifting the rule of exclusivity of remuneration for doctors who wish to participate in the public system — a rule that was introduced to ensure a watertight seal between public and private financing — could cause difficulties on two levels. In light of international experience, it appears that when physicians are permitted to work inside the public health system and also to offer privately financed services, there is a significant risk that certain costs will be transferred from the private sector to the public sector. In addition, the rule of exclusivity of remuneration strongly reduces the attractiveness of privately financed practice.

It seems unlikely that there would be conflict between Québec legislation and the Canada Health Act provided that opening the field to the private sector did not jeopardize

access to the public system and provided that there were neither extra-billing nor user fees. The watertight seal between the public and private sectors would be very helpful in not creating problems in this regard.

In the broader context of economic development, the impact of such a formula on the costs that have to be borne by employers must be analyzed, since this is without question one of the criteria that businesses take into account when selecting development sites.

In summary, opening the door to private insurance would allow people who have the means and workers covered by a group insurance plan to obtain access to desired health services more quickly. Such an opening could involve a number of risks for the public health system and raise questions about equity, unless safeguards are imposed. In evaluating solutions, it is worth noting that the number of people interested in taking out private insurance could be limited. According to taxation statistics for 2002, a little over 85% of tax returns are filed by taxpayers with an income of less than \$50,000. Over 48% of tax returns are filed by taxpayers whose income is lower than \$20,000.

In order not to threaten the integrity of the public system, opening the door to private insurance must therefore be accompanied by controlling measures to guarantee equity in access to healthcare, in order to minimize the impact on the availability of human resources in the public health system and to favour continuity, integration and quality of services provided in the health system as a whole, both for publicly financed and privately financed providers.

5.7 THE OPTION FAVOURED BY THE GOVERNMENT: INTRODUCING A PLAN GUARANTEEING ACCESS AIMED TO REDUCING WAITING TIMES

To improve the current situation, taking its inspiration from experiences in other countries, the government must make choices. It intends to orient the actions of the health and social-services network towards introducing a mechanism to guarantee access to services in the public system for hospital services whose waiting times warrant intervention. This new method of service organization would be introduced in stages, in line with changing availability of human and financial resources; these conditions were seen to be essential in the models analyzed.



The proposed scenario also introduces the possibility for citizens to take out private insurance for various hospital services that could be determined by regulation. For the time being these services would be limited to elective surgeries (hip, knee and cataract) for which guaranteed access will be offered. It would not be possible to take out insurance for heart surgery or radiation-oncology treatment, which must always be covered by guaranteed access to public services.

The aim is to open the door to private health insurance but to a limited extent, since in the public system the conditions to increase the production of targeted hospital services and to guarantee access to them will be in place.

The government's proposal is therefore based on two main components:

- a patient-centred mechanism to guarantee access to services by guaranteeing services within set time limits for the entire care episode. Implementing such a service guarantee presupposes sustained efforts to achieve high performance in the system as well as increased use of technological, human and financial resources;
- a limited opening of the field to private health insurance, separating the financing of the public and private sectors with as watertight a seal as possible in order to limit the adverse effects on vulnerable clientele and to maintain the integrity of the public system.

For the government, these main components are both based on the principles that are the foundation stones of the health and social-services system, namely:

- the equity and universality of access to services;
- free choice, for users, of their physician and the establishment where they wish to receive treatment;
- the system's overall responsiveness, that is, its ability to respond to the population's expectations regarding access to services;
- the right of patients to be treated within an acceptable period of time;
- the personalization of patient management.

5.7.1 Hospital services covered by the guarantee of access to services

All services covered by the service access guarantee would be determined by regulation by the *Ministre de la Santé et des Services sociaux*. This mechanism will apply in stages to groups of services provided in the hospital environment. The services would be determined on the basis of the following criteria:

- the severity of the problems and their impact on people's health and quality of life;
- the length of waiting lists;
- the availability of meaningful data on acceptable waits;
- the duration of waiting times beyond recognized standards;
- the required production volume;
- the availability of levers to ensure that the service guarantee is possible (feasibility).

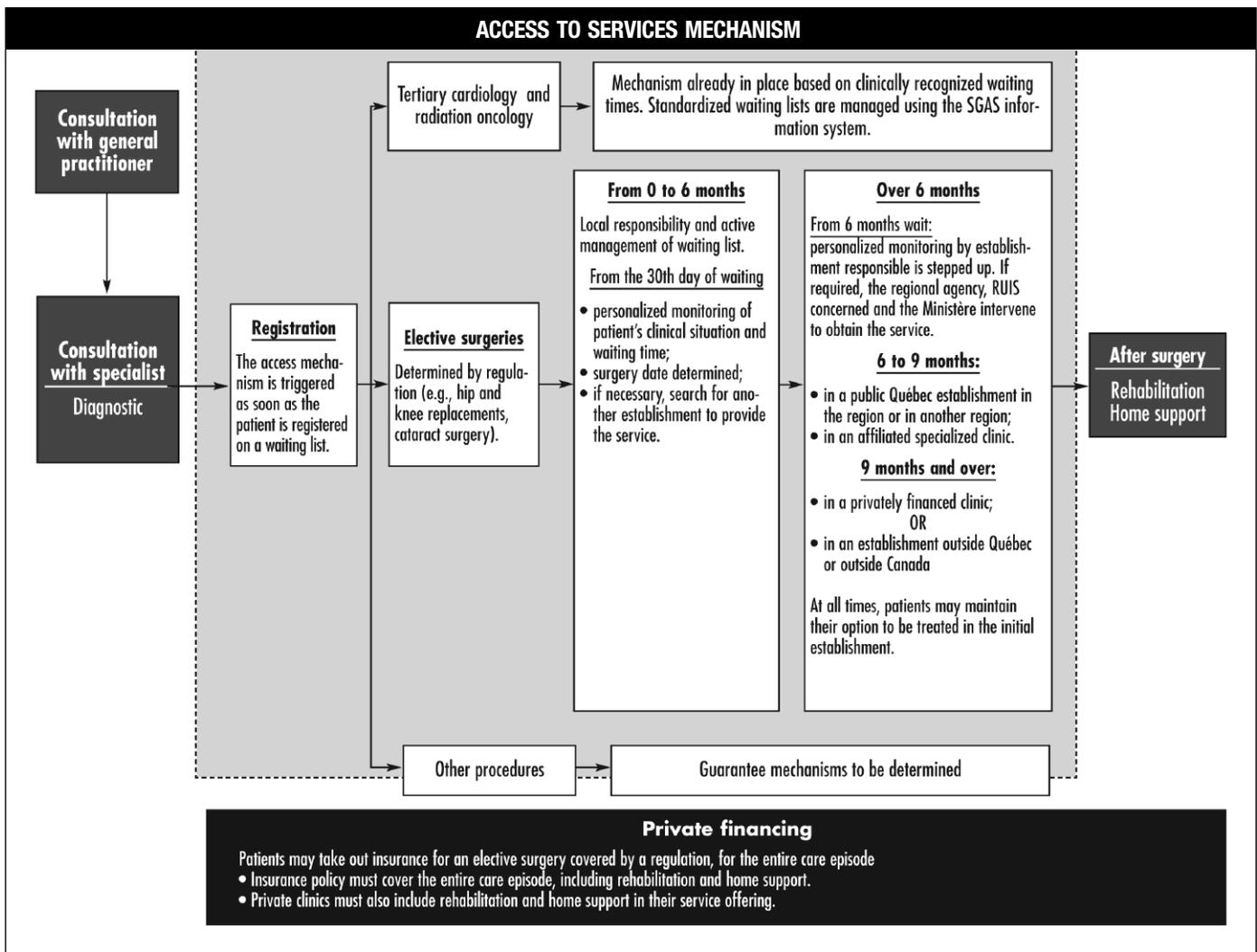
The radiation oncology and tertiary cardiology (including cardiac surgery, hemodynamics, angioplasty and electrophysiology) sectors are already subject to a certain form of guarantee of access to services. Clinically acceptable wait times have already been defined by experts in both these fields; a modern information system to monitor, manage and coordinate waiting lists has already been implemented. These are the first two groups of services that would be covered by a guarantee of access to services mechanism — areas in which considerable progress has been achieved over the past two years.

The access guarantee could be extended to other types of hospital services. Initially, on the basis of the criteria listed above, elective hip, knee, and cataract surgeries, as well as cancer-related surgery, would be targeted. For these types of services, a number of conditions must be put in place in order to guarantee access to services within a period deemed to be reasonable.

This commitment is the first milestone in an open-ended process. Beyond the services mentioned in tertiary cardiology and radiation oncology, certain orthopedic and ophthalmological surgeries, and cancer-related surgery, and access to other types of hospital services could also be guaranteed

when the criteria listed above demonstrate their relevance and feasibility. Extending the mechanism to other clientele calls for a degree of caution: deployment will have to take into account results obtained and resources available.

PLAN GUARANTEEING ACCESS TO SERVICES AIMED TO REDUCING WAITING TIMES



5.7.2 How the guarantee of access to services would work overall

The mechanism to guarantee access to services aims above all at guaranteeing patients treatment within defined periods and at providing personalized patient management. We must remember that in spite of the introduction of such a process, urgent situations where the patient's health is in danger will continue to be treated in priority fashion as at present. The guarantee will be organized in such a way that patient's rights to full, transparent information on their clinical situation, on recognized waiting times, on the state of the waiting list and on the choices of treatment available to them will be respected.

The guarantee of access to services will apply from the moment a patient is registered on the waiting list (see diagram). From that moment, a recognized waiting period will determine the maximum time the patient may wait before obtaining the required service. During this waiting period, changes in patients' condition will be periodically evaluated and the waiting list adjusted as required. In this way, the waiting time may be modulated according to the characteristics of cases using clinically recognized data or in terms of what is medically acceptable.

Patients who require a service covered by the access guarantee must respect certain rules:

- they must have consulted a general practitioner who has opted into the public system;
- they must have consulted a specialist who has opted into the public system;
- they must be officially registered on the waiting list of the initial establishment, that is, the establishment to which they were initially referred.

When the demand for services cannot be satisfied within the recognized waiting period, the initial establishment must find a short-term solution for the patient, that is, find an establishment in the Québec public system able to provide the service rapidly or, if applicable, purchase the service from a private provider (inside or outside Québec).

5.7.2.1 How the guarantee of access to services would work for tertiary cardiology and radiation oncology services

For tertiary cardiology and radiation oncology services, the practices that are already in place would continue to apply. Consequently, the clinically acceptable waiting periods that have been defined by experts in these fields will continue to be used as a yardstick for access to services. Also, the information system already in use in tertiary cardiology and radiation oncology, the *Système de gestion de l'accès aux services (SGAS)* which tracks requests for services throughout Québec, would continue to provide standardized waiting lists on the basis of the priority level of requests for services. Also, the service corridors that allow patients who have been waiting for more than eight weeks to be transferred between radiation oncology centres in Québec would function in the same way as at present. Finally, evaluation would be needed to decide whether various modalities would have to be tightened up in order to provide a full service guarantee in these two fields.

5.7.2.2 How the guarantee of access to services would work for elective surgeries determined by regulation by the *Ministre de la Santé et des Services sociaux*

In introducing the guarantee of access to services for elective surgeries, the government would assume responsibility for the entire care episode. The public system would bear the cost of and responsibility for providing the insured services, in accordance with the parameters currently in force. The clinical situations (elective cases) where the service guarantee would apply would be defined by regulation by the *Ministre de la Santé et des Services sociaux*. Initially, various orthopedic and ophthalmological elective surgeries would be covered (hip and knee replacement, cataract surgery), as well as cancer-related surgery. However, the conditions that would permit the introduction of a service in these fields remain to be put in place.

It is difficult to decide upon an appropriate clinical waiting time that would apply to all situations. This is why a standard, recognized as relevant by those in the field, would be set at six months for targeted elective orthopedic and ophthalmological surgeries. This is the waiting period currently recognized by the scientific community; it will be adjusted in light of new knowledge on medically acceptable waiting times. This period would be a maximum and could not be



substituted for the waiting time recommended by the clinician in each case. An integrated information system would have to be implemented to manage requests for services in a standard manner, thereby enabling the monitoring and management of standardized waiting lists.

The service guarantee for elective orthopedic and ophthalmological surgeries would work as described below. Special modalities will be planned for cancer-related surgery. The government intends to define, in conjunction with the medical establishment, medically acceptable waiting times for each type of cancer.

From registration on the waiting list up to six months' wait

During the period from patients' being put onto the waiting list to the recognized six-month period, their clinical situation will be periodically evaluated and the waiting list adjusted as needed.

Programming of the procedure, including setting the date of the procedure, must be done within 30 days of a patient's being officially put on the waiting list. If no date is set during this period, personalized management of the patient's consideration and waiting time will be triggered.

Responsibility for this personalized patient management is entrusted to a designated person in the establishment where the patient was originally put on a waiting list. This person is supported by a team assigned to this task. This same team is also responsible for periodically evaluating changes in the patient's clinical situation and for finding another place where the service can be provided should the patient be directed to another public establishment.

Between six and nine months' wait

The personalized patient management is stepped up starting from the sixth month of waiting. With the support of the regional agency, the person responsible for routing the patient to the establishment where he or she was put on the waiting list looks at two possibilities:

- obtaining the service in another public establishment in the region or in another region;
- purchasing the service in a specialized clinic affiliated with the public network (see box page 46).

At this stage, the agency intervenes in the planning role during active search for the service and supports the establishment in an intra-regional coordination and arbitration role. Inter-regional arbitration, should this prove necessary, is done at the national level. The Réseaux universitaires intégrés de santé (RUIS) will also be called upon to help in this active search for services, particularly when the patient is transferred from one region to another.

At all times, patients are kept informed of the situation and have the right to maintain their option to be treated in the establishment where they were originally put on the waiting list. They then remain on the establishment's waiting list and their choice is recorded in their file.

Beyond nine months' wait

If the waiting time exceeds nine months, patient management remains the responsibility of the establishment where the patient was originally put on a waiting list. The person responsible for the patient's progress in the establishment then examines the possibility of purchasing the service:

- in a private clinic (non-participating doctors);
- in an establishment outside Québec or outside Canada.

At this stage, the agency and the national tier support the original establishment in its active search to purchase the service. Negotiation of agreements outside Québec is performed at the level of the national tier.

At all times, patients are kept informed of the situation and have the right to maintain their option to be treated in the establishment where they were originally put on the waiting list. They then remain on the establishment's waiting list and their choice is recorded in their file.

In these cases, public financing of the guarantee of access to services is provided from the regional envelope granted to the regional agency.

5.7.2.3 A gradual process

The guaranteed-access mechanism would be implemented gradually and progressively. The mechanism would be subject to continuous evaluation over a period of five years and adjustments would be made as necessary. On the basis of the results obtained and resources available, the guaranteed-access mechanism could be extended to other types of interventions.

A SUMMARY DESCRIPTION OF THE CONCEPT OF AFFILIATED SPECIALIZED CLINICS

The idea of affiliated clinics has been under consideration since the work of the Clair Commission (2000) and since the government included the possibility in its plan to modernize the State starting in 2004, referring to the setting up of certified medical and surgical centres³⁵. Although clinics would be managed by the private sector (firm, cooperative, etc.) under a formal agreement with the public network, the service offering would be public. Referral to affiliated specialized clinics would have the following main characteristics:

- clinics would provide insured services under agreements with one or more public hospital centres with which they would be affiliated; these agreements must provide for continuation of the care episode in the public network, including rehabilitation and home support;
- the cost of services provided by affiliated specialized clinics would be borne entirely by the government, at no cost to patients, just as they are in a hospital centre;
- affiliated specialized clinics must provide services exclusively (or mainly) for the needs of affiliated establishments, under conditions defined in the agreement;
- affiliated specialized clinics would acquire their own equipment and facilities, providing the required capital themselves;
- clinics would be entirely responsible and accountable for their management and the provision of the services concerned, under agreements concluded with the regional agency and the establishments involved;
- services provided in affiliated specialized clinics would be paid for on the basis of standard costs set out in the agreement, including fees for the use of equipment (costs must be compatible to or lower than those of the public network);
- affiliated specialized clinic status would be granted on the basis of an eligibility grid that includes criteria regarding the meeting of the health need, quality, economic and ethical considerations, etc. The status of affiliated specialized clinic would therefore be obtained only by clinics that could meet standards for medical and technical quality of services, complementarity with the public network, and consistency with the establishments' and the regional agency's plans for the organization of medical staff and services.

An affiliated specialized clinic must hold an affiliated clinic permit for the surgical procedures covered by the agreement.

In the context of a shortage of doctors and other health professionals, the conditions laid down for the creation of affiliated specialized clinics must ensure that doctors working in these clinics do not deprive establishments in the public network of the specialized resources they consider that they need to provide services to the population.

5.7.3 Modalities surrounding private financing

Anyone would have the choice to take out private insurance to cover private services for the elective cases defined by regulation which are also covered by the guarantee of access to services in the public system. The private insurer would cover the entire care episode, including rehabilitation and home support.

Purchase of services is limited to private clinics where doctors who have opted out of the public system are practicing. Conditions could be maintained or introduced to limit the number of doctors who decide to opt out of the public system and ensure a watertight seal between the public and private systems, namely:

35. 2004-2007 Modernization Plan – Modernizing the State, Pour des services de qualité aux citoyens, Secrétariat du Conseil du Trésor, May 2004.

- exclusivity of remuneration for the doctor, as is the case at present; it would be impossible for a doctor to participate in the public system and to opt out for certain actions;
- a ceiling on the number of doctors authorized to practice in the private sector, the overriding consideration being the protection of resources necessary for practice in the public sector, in compliance with planning of medical staffing levels;
- capping of pricing, prohibiting doctors working in the private sector from asking for remuneration higher than that provided in the pricing schedules of the RAMQ, or requiring that the reimbursement offered by the insurer be limited to the amount set in the RAMQ pricing schedules.

Regulatory and contractual arrangements between the public system and private provider could specify the following elements:

- required complementarity links with public establishments (service agreements);
- the responsibilities of private providers in the event of unforeseen complications or complications that are induced under their control (for example, private insurers' premiums could be adjusted to take account of possible complications);
- quality standards to be met;
- as applicable, private providers would be required to hold a hospitalization permit. It should be stressed that health professionals would remain, individually, subject to the disciplinary mechanisms of their respective professional bodies.

For various situations, as is the case at present, it would still be possible to take out private insurance to cover other additional fees for the provision of medical goods and services beyond what is medically necessary and insured by the public system. For example, supplementary private health insurance could cover services whose cost exceeds that allowed by the public system, such as highly sophisticated prostheses.

In summary, the opening of the door to private insurance for medical and hospital services would be subject to a set of rules designed to protect the integrity of the public health system.

A strict watertight seal would be kept between publicly financed and privately financed services providers.

The Ministre de la Santé et des Services sociaux would be able to define through regulation the conditions of private insurance coverage and to determine the number of doctors, by speciality, who are able to opt out of the public health-insurance system.

Private clinics and private insurers would be financially responsible for the entire care episode (including surgery, rehabilitation and home-support services).

5.7.4 Managing access to diagnostic imaging services

Diagnostic imaging examinations, particularly magnetic resonance imaging and echography, are not insured by the public system when provided in a private clinic. Currently, therefore, it is possible to take out insurance in order to receive these services in the private sector. The objective is to increase access to the services through public financing.

For magnetic resonance imaging, an increase in the supply of service will be accomplished by adding new equipment in the network and by increasing the availability of time slots. Patients waiting for examinations will be accorded personalized patient management using the same service access mechanism with the involvement of the hospital centre radiology department.

With regard to echography services, it will be possible to increase access by purchasing services for front-line interveners in private clinics. These services will remain financed by the public system. Projects to train and supervise family physicians in front-line echography practice will also be put in place.

5.7.5 A proposal for public debate

Introducing the guaranteed-access mechanism would improve access to targeted services while at the same time increasing the system's capacity to meet the population's needs and expectations. In this respect, this proposal has the merit of determining and clarifying the system's responsibility towards patients waiting for service. It would therefore force public providers to review their practices in order to comply with the guarantee of access to services, in accordance with predetermined parameters, on the basis of clinically recognized and medically acceptable data. In this way, we will be able to provide Quebecers with better healthcare.

In order not to create inequity, the guaranteed-access mechanism would have to be extended gradually to other treatments. We must also remain aware of the pressures that introducing this mechanism would have on the availability of human, material and financial resources. It is in this context in particular that we should bank on the optimization of resources already devoted to the health sector and on boosting efficiency within the system.

Above all, the government considers that the proposal of a guarantee of access to healthcare will make it possible to preserve and improve on the foundation stones of the Québec public system. Access to health services will remain founded upon a basis of equity for the entire Québec population, that is on the basis of patients' clinical situation and not on their ability to pay.

Every opinion on this important question will be welcomed in the public debate. The government considers it essential to weigh up the advantages and disadvantages of all the possible options.

IN BRIEF

Great efforts have been made over the past few years to reduce waiting times for medical and hospital services in Québec. In spite of this, the situation is still a matter of concern and remains a priority for both the population and the government. The Supreme Court of Canada's recent judgment in the Chaoulli and Zeliotis case ordered the government of Québec to lift the ban on taking out private insurance for treatment provided by the public sector. The government undertook to assess the repercussions of introducing private insurance of this type for healthcare services in Québec and to analyze solution avenues in order to improve access and reduce waiting times for medical and hospital services, while safeguarding the integrity of Québec's public system. The various analyses taken together allows the government to present the following options for public consultation:

- The status quo — maintaining the current method of financing healthcare services;
- Opening the door to the financing and provision of services by the private sector (possibly ranging from minimal opening to complete opening);
- A Plan guaranteeing access to services aimed to reducing waiting times and to improve access to public medical and hospital services, while introducing a targeted and progressive opening to private insurance.

The last option is the one favoured by the government. This patient-centred guaranteed-access mechanism will ensure that patients receive services within predetermined time limits, for the entire care episode. The radiation oncology and tertiary cardiology sectors are already covered by a form of guaranteed access to services. It is timely to extend this mechanism to elective hip, knee and cataract surgeries, and to cancer-related surgeries. This is the first step: the mechanism could be extended to other types of hospital services where analysis demonstrated that this was relevant and feasible, on the basis of available resources.

The guaranteed-access mechanism aimed particularly at hip, knee and cataract surgery would involve a stepwise approach:

- the surgical intervention would be programmed within 30 days of the patient's being put on the waiting list. This would then trigger personalized monitoring of the patient by the establishment. If necessary, another establishment able to offer the service would be sought;
- after six months' waiting, the personalized monitoring would be stepped up. If necessary, intervention by the regional and national levels and the RUIS to offer surgery in another Québec public establishment. Possibility of resorting to an affiliated specialized clinic;
- after nine months' waiting, the range of treatment possibilities would be extended to privately financed Québec clinics and to establishments in the rest of Canada and in the United States;
- at all times, patients could assert their option to be treated in the initial establishment.

Private insurance would be permitted, but limited to certain procedures defined by regulation (elective hip, knee and cataract surgery). Insurance coverage and the service offering of private clinics must cover the entire care episode and thus include rehabilitation and home support.

The watertight seal between public and private financing would be maintained: doctors who opt into the public health-insurance plan would be entitled only to the remuneration paid by the RAMQ for the insured services that they offer. Regulatory or contractual arrangements could specify the complementarity links between privately financed providers and public health-care system.

The government reasserts its commitment to maintaining a strong public system, preserving the values that characterize it and the gains it has made, while allowing the private sector to play a role.

6

ISSUES SURROUNDING THE FINANCING OF THE HEALTH AND SOCIAL-SERVICES SYSTEM

Formed in the wake of the *Forum des générations*, the *Comité de travail sur la pérennité du système de santé et de services sociaux du Québec*, chaired by L. Jacques Ménard, clearly set out the problems of financing health services and social-services. The aging of the population and the rapid growth in the costs of medical technologies and medications mean that spending on health will increase at a far faster rate than budgetary revenues, in the long term leading to a financial situation that the government of Québec will find difficult to sustain.

This chapter first sets out the main financial issues likely to affect the health and social-services sector, both in the short and long term. Three possible courses of action, inspired by the work of the Ménard committee, are then presented for the purpose of fuelling a debate on the search for ways of ensuring the long-term survival of the public health and social-services system.

6.1 A SNAPSHOT OF HEALTH EXPENDITURES AND HOW THEY ARE FINANCED

The spending of the Ministère de la Santé et des Services sociaux is expected to amount to \$20.9 billion during the 2005-2006 financial year. Spending is made up mainly of transfers to establishments in the network (\$12.4 billion) and medical services related salary expenses (\$3.2 billion).

The financing of MSSS spending comes mainly from general rates and taxes (60%), contributions to the Health Services Fund (25%) and federal financing in the form of the Canada Health Transfer (15%).

TABLE 1

SPENDING OF THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX AND ITS FINANCING, 2005-2006 (IN MILLIONS OF DOLLARS)					
Spending	Amount	%	Sources of financing	Amount	%
Establishments ⁽¹⁾	12,408	59%	General rates and taxes	12,577	60%
Medical services	3,175	15%	Contributions to the Health Services Fund	5,081	25%
Specific programs (community organizations, blood products, ambulance transportation, etc.)	2,118	10%	Federal-government health transfers	3,114	15%
Medications	1,856	9%	Contribution by the SAAQ for road accidents	90	-
Supported debt	560	3%			
Other	745	4%			
Total	20,862	100%		20,862	100%

(1) Expenditures financed by the MSSS are *net* expenditures, due to the fact that they exclude spending financed out of establishments' independent revenue (surcharges for private or semi-private rooms, contributions from adults accommodated, etc.).

Source: Ministère des Finances du Québec

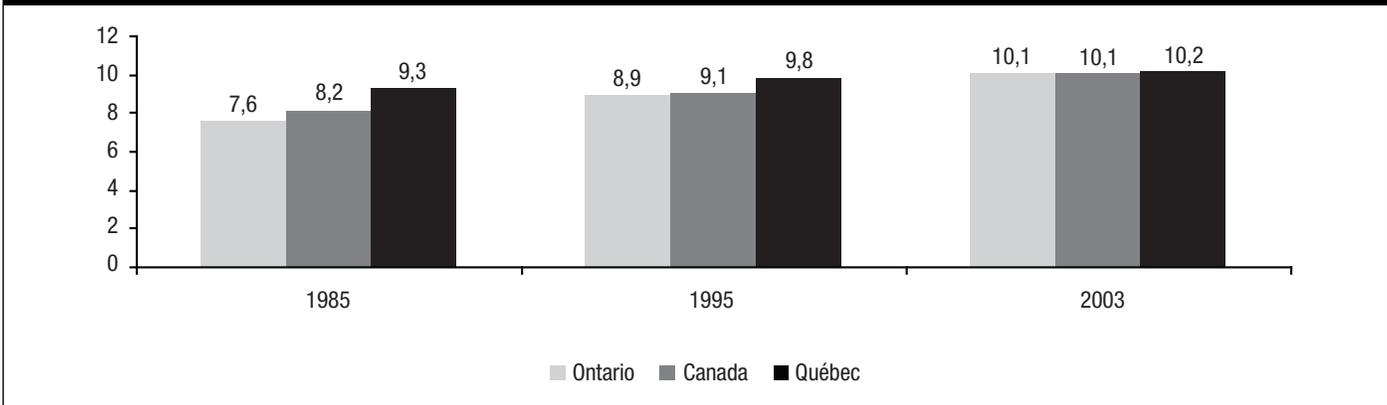
6.2 INTERPROVINCIAL COMPARISONS

Among Canadian provinces and territories, Québec's per-capita spending on health is the lowest. In 2003, according to data from the Canadian Institute for Health Information (CIHI), Québec's total health spending (public and private) was \$3,450 per capita. This amount is 11% below the Canadian average (\$3,884) and 15% lower than that of Ontario (\$4,055). In this respect it should be remembered that, in accordance with its commitments, the government has allocated \$3 billion to health and social-services since 2003-2004.

Since the mid-1990s, it will be observed that the gap between the relative spending of Québec, as a proportion of GDP, and that of other provinces has narrowed. The fact remains that the proportion of GDP devoted to health spending has increased, both in Québec and in the other provinces, over the period. It should be noted that internationally, Québec continues to rank among governments whose health spending is highest as a proportion of GDP.

GRAPH 2

TOTAL HEALTH SPENDING IN QUÉBEC, ONTARIO AND CANADA, 1985, 1995 AND 2003⁽¹⁾ (AS A PERCENTAGE OF GDP)



(1) Most recent year for which definitive data are available.

Source: Canadian Institute for Health Information, *National Health Expenditure Trends 1975 to 2005*.

The fact that Québec's per-capita health spending is lower than the Canadian average does not mean that services to citizens are inferior to those provided in other provinces in either volume or quality. The discrepancy is mainly due to the fact that health-service personnel are paid at lower rates in Québec than in other provinces, by reason of the lower level of its collective wealth, and the size of its spending on programs and of its debt.

However, if one takes Québec's collective wealth into account, its health spending (total health expenditures representing 10.2% of GDP) compares with that of Ontario (10.1% of GDP) and the Canadian average (10.1% of GDP).

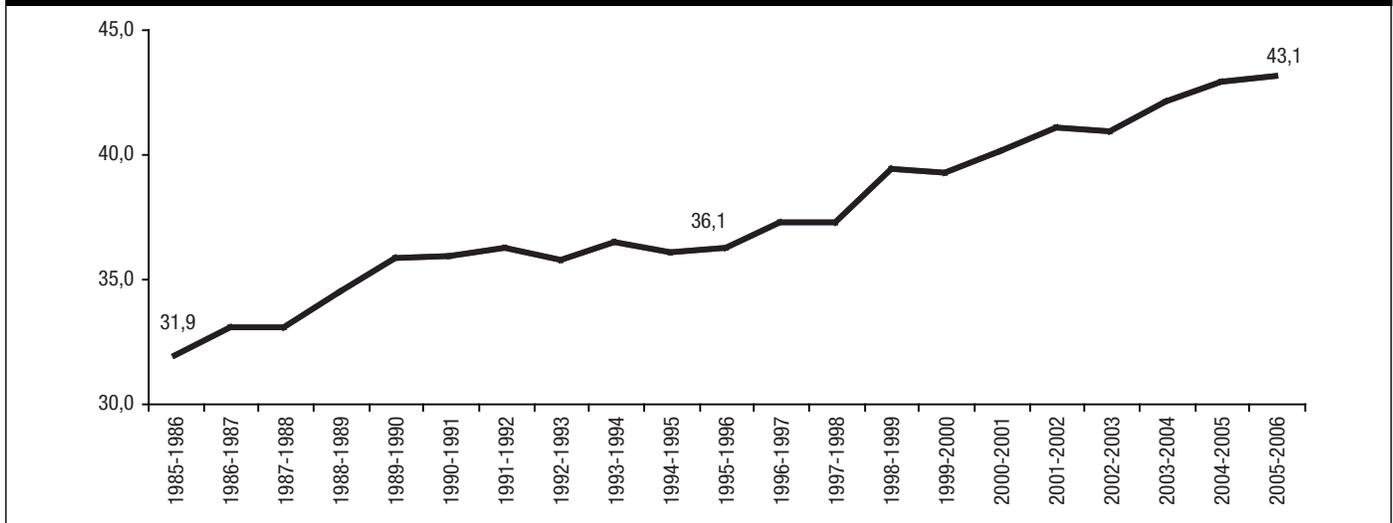
6.3 HEALTH AND SOCIAL-SERVICES: THE GOVERNMENT'S BIGGEST ITEM OF EXPENDITURE

The health and social-services sector represents the government's biggest expense item and its share of total spending has been increasing in recent years. In 2005-2006, it represents 43% of government program expenditure (excluding servicing the debt), compared with 32% twenty years ago.

Indeed, the health and social-services sector has absorbed the bulk of growth in the government's budget. For example, over the past three years, close to 60% of the annual growth in the Québec government's budget has gone to health and social-services.

GRAPH 3

PROPORTION OF SPENDING DEVOTED TO HEALTH AND SOCIAL SERVICES IN ALL GOVERNMENT PROGRAM SPENDING FROM 1985-1986 TO 2005-2006⁽¹⁾ (AS A PERCENTAGE)



(1) Forecast data for 2005-2006.

Source: Ministère des Finances du Québec

Moreover, because of the rapid aging of the population of Québec, combined with pressure brought to bear by other structural factors such as developments in technology, the health and social-services sector's share of program spending is set to increase ever more rapidly in the coming years.

6.4 PUBLIC FINANCES BESET BY MAJOR STRUCTURAL PROBLEMS

As the work of the Ménard committee has shown, there is already strong pressure on Québec's public finances, and these will be amplified by the effects of aging of the population.

We need to bear in mind that the public-finance problems that Québec is currently facing stem from the fact that its collective wealth does not permit it to keep up such a high level of budget spending while maintaining competitive rates of taxation.

Québec's per-capita GDP (\$35,118 in 2004) is 13% lower than the Canadian average (\$40,351) and 16% below that of Ontario (\$41,702). It is also lower than the per-capita GDP of a majority of American States. This therefore means a lower collective capacity to sustain public services given the same taxation burden.

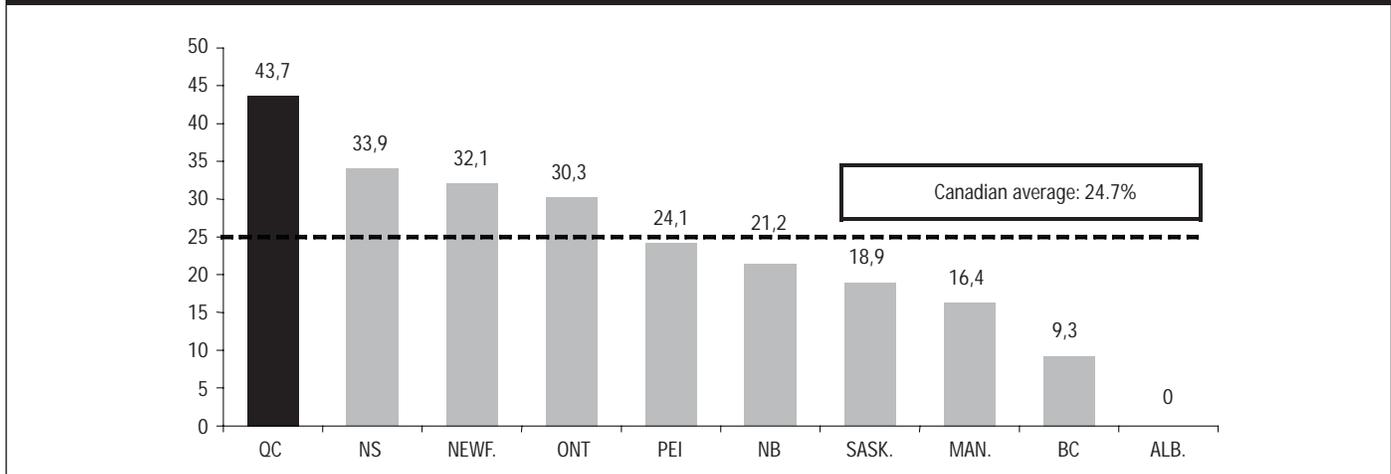
The Quebec government's global spending, on all missions taken together, reached \$7,487 per capita in 2004-2005, compared with \$7,043 for all Canadian provinces and \$6,466 per capita in Ontario. This represents a gap of \$3 billion compared with all provinces and \$7.5 billion compared with Ontario.

This gap in spending is explained by the fact that, over the years, Québec has adopted a wider range of public services than other provinces – for example, postsecondary education that is more accessible than elsewhere, services arising out of the highly developed family policy, and programs designed to protect and highlight Québec's cultural specificity. The gap in spending is also attributable to the fact that per-capita spending on servicing the debt is greater in Québec than the Canadian average, as a result of Québec's higher level of indebtedness.

Indeed, with a total debt of \$116.6 billion as of March 31, 2005, which represents 44% of GDP, Québec is the most highly indebted province. In addition, \$87.2 billion of this debt — about 75% — is the result of deficits incurred during the past to pay for current expenditures, including spending on health and social-services.

GRAPH 4

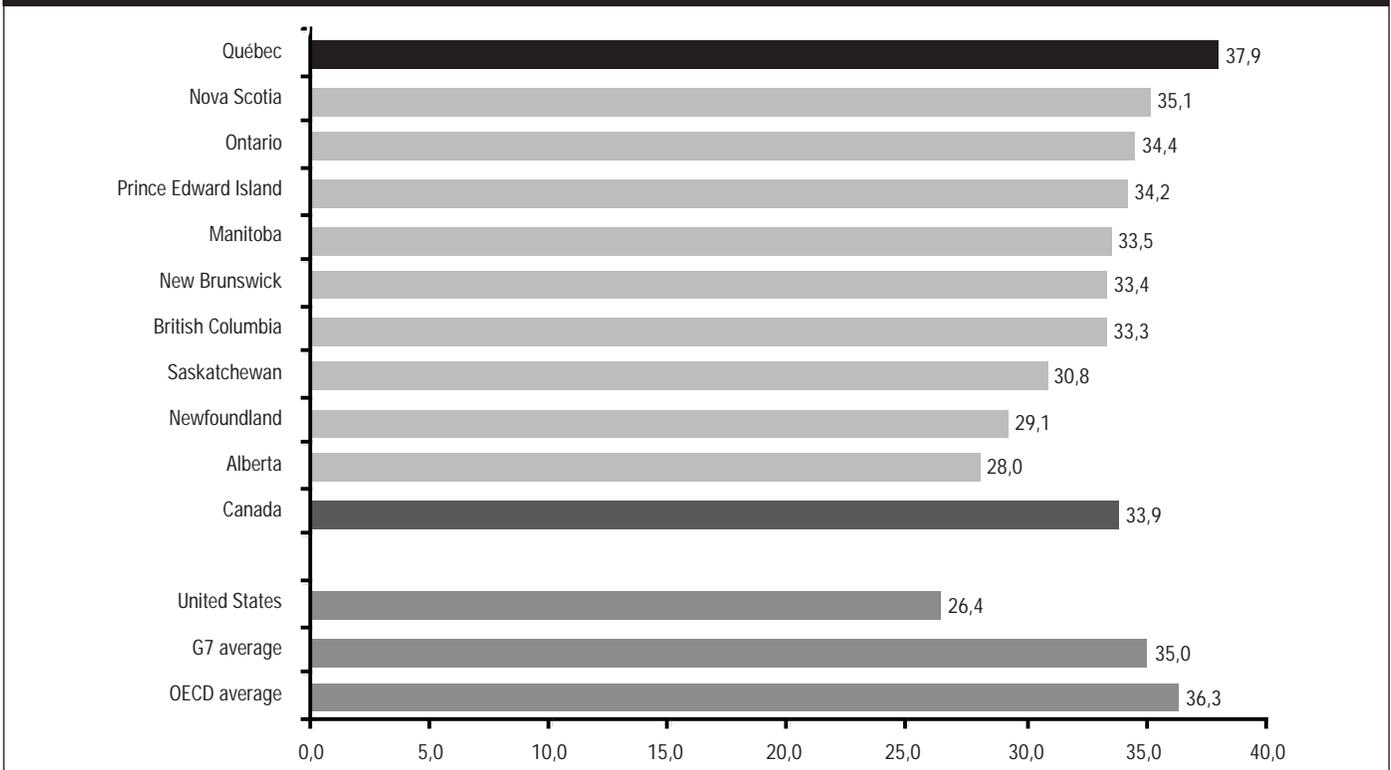
COMPARISON OF PROVINCIAL DEBT AS OF MARCH 31, 2005 (TOTAL DEBT AS A PERCENTAGE OF GDP)



Source: Provincial budget plans and public account – 2005-2006.

GRAPH 5

TAX REVENUE OF ALL PUBLIC ADMINISTRATIONS – 2002



Sources: OECD and the Ministère des Finances du Québec.

Because of a higher level of public spending and indebtedness as a proportion of GDP, Quebecers must bear the heaviest taxation burden in Canada (37.9% of GDP in Québec, compared with 34.4% in Ontario and 33.9% in Canada).

With regard to personal income tax specifically, there is still a gap between Québec and the other provinces totalling \$1.2 billion, despite the fact that this gap has been reduced by half in the past three years. It should be borne in mind that a high taxation burden acts as a brake on growth in the Quebec economy by harming its competitiveness at the international level. In addition, a large portion of the taxation burden is today used to finance the debt contracted in the past to pay for current spending.

6.5 A FINANCIAL SITUATION LIKELY TO PROVE DIFFICULT TO MAINTAIN OVER THE LONG-TERM

These structural problems in public finance are aggravated by changes in demographics, particularly the aging of the population, which will have major repercussions both on the increase in government revenue and on the growth in health and social-services spending.

Economic growth and the financing of public services will be sustained by a smaller proportion of the population, since the number of people working for each elderly person will fall from five to two in the next 25 years. According to the demographic forecasts of the *Institut de la statistique du Québec* (ISQ), the population of the 20-64 age bracket should

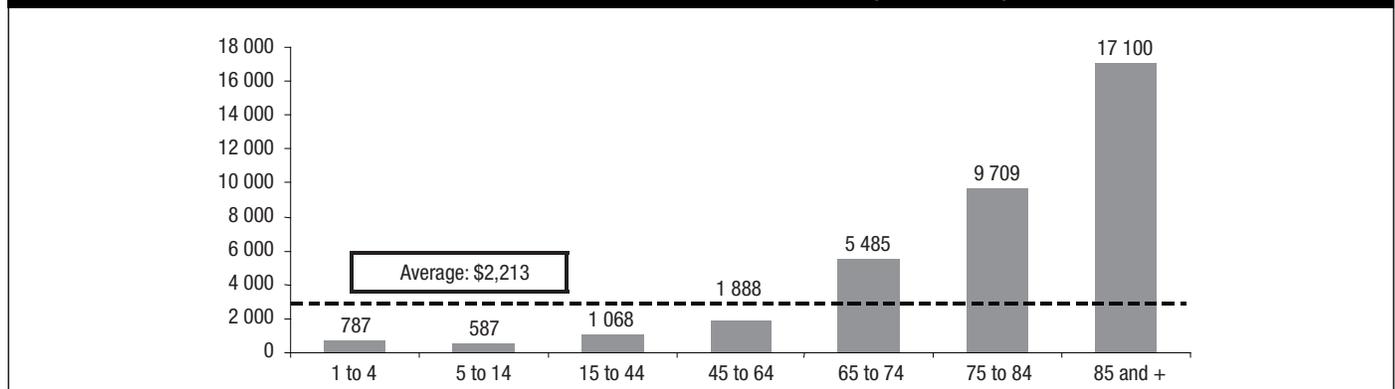
start to drop as early as 2014, thus bringing about a shrinking in the pool of potential workers. In this context, we expect that real economic growth (in constant dollars) will be reduced by close to half 20 years from now, falling from an average of 2.3% per year over the next five years to 1.2% annually between 2020 and 2030. This weaker economic growth should lead to a slowing in the growth of budgetary revenues which should, in current dollars, stand at around 3.5% on average over the next 15 years.

With regard to the growth in health and social-services spending, it should be remembered that the aging of the population will result in a constant increase in the proportion of the population aged over 65, which will double in the next 30 years. It is clear that people's consumption of health services and social-services increases significantly as they grow older.

However, demographics are not the only source of pressure on health spending. The use of new technologies (including new drugs), allowing treatment of patients and diseases which formerly received little or no treatment, brings about an important increase in total health spending. On top of these pressures that are peculiar to the health and social-services system come increases in costs to which other government programs are also subject, particularly the indexing of the salaries of employees in the health and social-services network and the pay of health professionals.

GRAPH 6

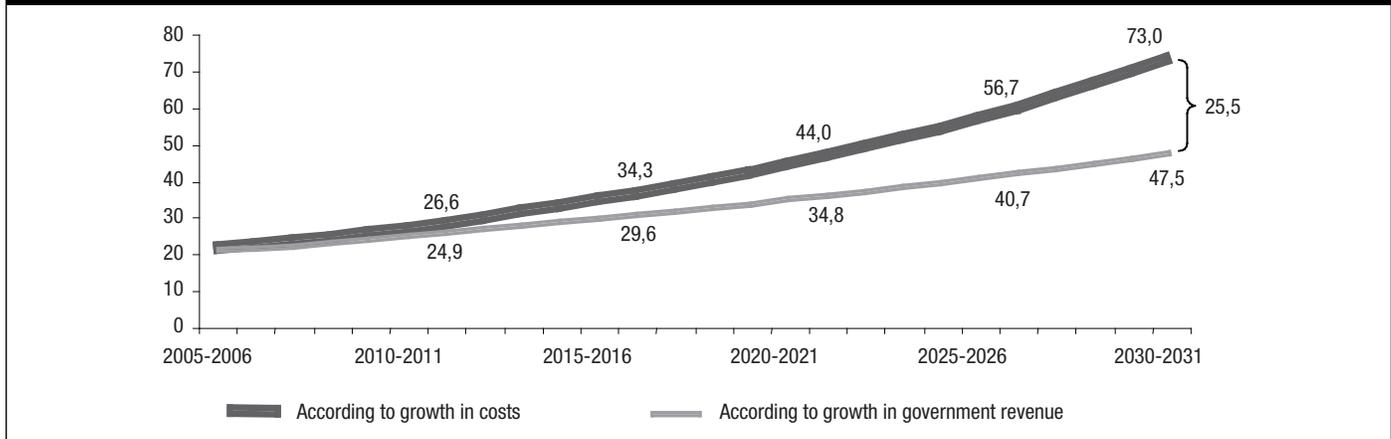
AVERAGE HEALTH SPENDING BY THE QUEBEC GOVERNMENT BY AGE GROUP, 2003 (IN DOLLARS)



Source: Canadian Institute for Health Information.

GRAPH 7

PROJECTED HEALTH AND SOCIAL-SERVICES SPENDING (CUMULATIVE AMOUNT IN BILLIONS OF CURRENT DOLLARS)



Source: Report of the *Comité de travail sur la pérennité du système de santé et de services sociaux du Québec*.

In total, according to the basic scenario set out in the Ménard committee report, health and social-services spending will grow at an annual rate of 5.1% over the next 15 years. Demographic changes alone will cause spending to rise by 1.5% per year, technological developments by 1.6% per year, and general inflation by 2.0% per year.

Consequently, as suggested by the Ménard committee, health and social-services spending is likely to grow much faster (5.1% per year) than budgetary revenues (3.5% per year), which in the long-term will result in a financial situation that the Quebec government will find it difficult to sustain.

In order to respect budgetary balance without increasing the taxation burden, the faster growth in health spending will have to be financed by restrictions in the government's other major missions. In this way, health and social-services spending could represent 50% of program spending by 2015, and two thirds in 2030.

If we wished to maintain the financing of other sectors without increasing the taxation burden, we would have to limit the growth in health spending to the nominal GDP growth rate, which is 3.5% per year. Given structural growth in health spending of 5.1% per year, this would result in a gap that would reach \$1.7 billion in 2010 and over \$25 billion in 2030.

If we wished to both allow health and social-services spending to grow at their structural rate of 5.1% per year and protect the funding of other government missions, we would be forced to increase the taxation burden, which is already too high.

6.6 AVENUES TO BE EXPLORED TO ENSURE THE LONG-TERM FINANCING OF THE HEALTH AND SOCIAL-SERVICES SYSTEM

Over the past few years, a number of commissions and major study groups³⁶ have reported on the fundamental problems of the health system both in Québec and in Canada.³⁷ Most recent of these in Québec is the *Comité de travail sur la pérennité du système de santé et de services sociaux* (Ménard committee).

The main recommendations made in these various reports appear to converge broadly with regard to the organization and provision of services. The main issues are the emphasis placed on prevention and on public health, the development of integrated front-line service networks, improving the efficiency and effectiveness of the health and social-services system, etc. Recourse to the private sector for the production of some services (e.g. the affiliated specialized clinics described earlier) can also appear as an interesting solution to the extent that it allows a reduction in costs while maintaining service quality and accessibility.

36. E.g. Conference Board of Canada, Institute for Research on Public Policy, etc.

37. In the provincial arena, there have been the Mazankowski Report and the Graydon Report (Alberta, 2001 and 2002), the Fyke Report (Saskatchewan, 2001), and the Clair Report and the Ménard Committee Report (Québec, 2001 and 2005). In the Canadian arena have been the Romanow Report (2002) and the Kirby Report (2000-2002). The Ménard Committee Report contains a summary of consensus among various commissions and studies in Canada.



With regard to the financing of health services and social-services, a number of these reports have highlighted the increasing gap between growth in health and social-services spending and growth in government revenues. Because it is structural in nature, this development is a threat to the future of the system and puts at issue the equity between generations.³⁸

To assist it in considering steps to ensure the long-term survival of the health and social-services system, the government wishes to make use of the present consultation to launch a discussion of certain solution avenues envisaged by the Ménard committee. Three of these are set out below. They are: a rise in transfer payments from the Canadian government; implementation of a health and social-services account; and the introduction of an insurance plan against loss of autonomy.

For the moment, the government does not favour any particular avenue in this regard. Rather, it is seeking to stimulate the population to give thought to these issues in order to help the government orient its future work and make choices from among a range of possibilities. In addition, the government wishes to reassert its intention to preserve a strong public in which access is based on people's needs rather than on their capacity to pay.

6.6.1 A rise in federal-government transfer payments

Above all, it appears vital that the government of Québec continue its negotiations with the federal government to secure a rise in federal transfer payments to the provinces for health. Given the large budget surpluses the federal government has achieved, it has the room for manoeuvre it needs to improve funding to the provinces.

Québec has made major gains under the Health Accord reached in September 2004, obtaining an additional \$4.2 billion in federal transfers over six years to strengthen permanent federal support for health and to reduce waiting times. As a result, the federal government's contribution to the financing of health services should obtain close to 25%³⁹ of the provinces' spending in this field in 2005-2006.

Under the asymmetric agreement reached by Québec and Canada during the September 2004 conference, Québec can use federal funds to implement its own plan for reducing waiting times, based on objectives, standards and criteria established by the competent Québec authorities.

Moreover, the federal government has committed itself to working with the provinces and territories to reduce waiting times and to guarantee that all Canadians receive essential medical treatment within medically acceptable waiting times. This collaboration should translate into increased funding from the federal government to Québec, which could use this extra funding in its strategies to provide the population with a guarantee of health services within the required periods.

More globally, there are major financial issues affecting the entire Québec government and consequently the financing of health services and social-services. Particular reference is made to the questions of fiscal imbalance between the federal government and the provinces and territories, equalization, and federal transfers in the fields of post-secondary education and social welfare.

6.7 IMPLEMENTATION OF A HEALTH AND SOCIAL-SERVICES ACCOUNT

The question of the financing of public health and social-services spending can seem especially complex since there is no systematic link between total spending in the health and social-services sector and total revenue used to finance this spending.

In this regard, the Ménard committee viewed it as essential that the population of Québec and all players concerned should be made more aware of the problems facing the financing of health services and social-services. The method recommended by the committee was the implementation of a "health and social-services account."

This account would not in itself represent the addition of any further resources. But it would contribute greatly to increasing transparency in the financing of health and social-services by placing spending on health and social service side-by-side with revenue assigned to their funding. This account would thereby make it possible to create a direct link between the cost of services and their financing, and to make the population aware of the pressures on the

38. These observations are found in the reports of several committees and working groups (Mazankowski, Kirby, Graydon, Clair, Ménard).

39. The gap between this percentage and the one shown in Table 1 (Chapter 6) is due to the fact that this datum includes the value of the Québec special abatement.



health and social-services system. And in the event that new sources of revenue should be put in place, this account would also make it possible to give the population a guarantee that the sums gathered would be assigned exclusively to the financing of health and social-services related spending.

6.8 A TARGETED FINANCING MEASURE: AN INSURANCE PLAN COVERING LOSS OF AUTONOMY

The rapid aging of the population of Québec will cause a substantial increase in demand for services designed to mitigate loss of autonomy – long-term accommodation and care, home support, basic professional services, assistance for natural caregivers, etc.

Moreover, in the short-term, is important to provide a satisfactory response to the needs of elderly people suffering loss of autonomy. It is clear that current accommodation services and home support services are not sufficient to meet the demand. Furthermore, although major efforts have been made in recent years to improve the situation, the fact remains that the range of services offered and the intensity of services provided vary from one territory to another, which raises problems of equity regarding access and treatment.

In light of experience in other countries, particularly in Germany, Luxembourg and Japan, the Ménard committee, like the Clair commission before it, recommended that an insurance plan covering loss of autonomy be put in place. Such a plan would make it possible, in particular:

- to quickly and substantially upgrade services for loss of autonomy, while protecting gains already made;
- to address the major issue of intergenerational equity while guaranteeing the long-term survival of these services.

Since this would be a separate insurance plan, the Ménard committee proposed that management of the plan be handed over to a manager charged with its global regulation (definition of eligibility criteria, setting of scales of services to be provided, etc.). This manager would therefore act as a one third-party payer and would be responsible for implementing a new management framework based on contractual relations and purchase of services on the “money-follows-the-client” principle.

Operational management would be delegated to the Centres de santé et de services sociaux (CSSS), which would be mandated to receive people and assess their needs, to coordinate and manage cases and to ensure the provision of services to insureds. This delegation would make it possible to ensure that care and services were integrated.

To favour intergenerational equity, it would be possible to set up a financial reserve (capitalization) in order to mitigate the impact on future generations of the aging of the population and loss of autonomy. Each year, a portion of premiums deducted for the loss of autonomy insurance plan would be paid into a reserve. This approach has the benefit of guaranteeing elderly people suffering who have lost autonomy better access to care and services. In return, since most people will have contributed to this reserve over a long period before having need of services for loss of autonomy, when the time comes they will expect to receive all necessary services.

IN BRIEF

Québec ranks first among Canadian provinces and territories for per-capita public spending as well as for the size of the taxation burden and public debt expressed as a portion of collective wealth (the GDP). In a context in which the Quebec economy must remain competitive at the international level, particularly in terms of the taxation burden, any attempt to address the question of financing for health and social-services cannot disregard the situation of Québec's public finances.

As the result of a structural factors (notably the aging of the population and technological progress), public spending on health and social-services is tending to grow more quickly than spending on other government missions. Between 1985-1986 and 2005-2006, the share of government program spending allotted to health and social-services rose from 31.9% to 43.1%.

At the present rate, spending on health and social-services could make up half of program spending in 2015 and two thirds in 2030.

To ensure the long-term survival of the health and social-services system and preserve the financing of other government missions, choices will inevitably have to be made. As part of the present initiative, the government is looking to launch a public discussion of the solutions proposed by the Ménard committee to inform its analysis of which measures would be most appropriate:

- an increase in federal-government transfers;
- the creation of a "health and social-services account" to give the population a better picture of the level and components of expenditures in the health and social-services sector and their sources of financing, which essentially come from the Consolidated Revenue Fund;
- the introduction of an insurance plan against loss of autonomy that would guarantee both long-term financing of the services and intergenerational equity.

CONCLUSION

Over the past four decades, Québec society has built up a public health and social-services system, accessible to all citizens. As stated in the introduction, the government reiterates its commitment to maintaining the foundation stones of equity and universality that have guided the setting up and development of this public system.

The challenge that faces us in the coming years is to ensure that a strong public system is maintained. The choices that have to be made require us to be open to new solutions. They also command a sense of responsibilities and duty that is able to confront the dogma that has too often stalled our thinking on these issues.

One thing is certain: the worst solution would be to close our eyes and do nothing. Over the next few years, growth in its costs will outstrip growth in the government's revenue, in a context of rising demand for services and falling numbers of workers able to finance these services through their taxes.

In parallel, new public-health issues have come to the fore, such as obesity, which bodes an increase in the incidence of a number of chronic diseases, even among the youngest members of the population.

The costs of new medical technologies and medications are also contributing to the weight of the financial burden that our health and social-services system places upon us.

To face these challenges, we believe it is important to build on the gains our system has made, by improving efficiency, quality and accessibility.

A further challenge is the Supreme Court of Canada's 2005 decision in the Chaoulli case, which has posed the question of access to services within a reasonable time in new terms. We propose to respond to this ruling with a limited, supervised opening of the door to private insurance, coupled with a guaranteed-access mechanism for all citizens.

This proposal, like all the others contained in this document, is not final. Far from it. The purpose of these proposals is to launch a widespread public debate aimed at taking our health and social-services system out of the expected impasse. The proposals do however represent progress: we are no longer asking ourselves whether action is needed, but what action should be taken.

We invite all citizens and interested groups to take part in this debate, to submit their own proposals and give their answers to the questions at issue. All proposals will be put on the table for discussion, all innovations will be analyzed seriously and with an open mind.

Only one rule remains inviolable: our health and social-services system must meet its challenges without compromising its founding principles of accessibility and universality.

