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Health Care

Towards significant changes

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"Health Care: it's time for an in-depth reform"

Health care is a very particular issue. Without exception, it affects all Quebecers. Health care alone absorbs almost half of government expenditures. At the time of the last election, the polls confirmed once again that health care is the principal worry of Quebecers.

Since 2003, the Ministry of Health has been managed by a competent and respected Minister under whom measures have been taken to find solutions to the most pressing problems, in particular, improving access to health care. During the last four years, annual expenditures in the health sector have increased from 19 to 23.6 billion which represents an increase of 24%. Relative to 2003, this is 4.5 billion dollars more each year. Despite this massive injection of public funds, an obvious corresponding improvement in

Members of the Canadian Health Care Consensus Group (CHCCG) have come together to provide a platform for bold, reasoned and practical plans for genuine reform of the health system and to demonstrate that there is an emerging consensus among reform-minded observers about the direction that real reform must take. The CHCCG, coordinated by the Atlantic Institute for Market Studies (www.aims.ca), includes medical practitioners, former health ministers, past presidents of the Canadian Medical Association and provincial medical and hospital associations, academics, and health care policy experts, all of whom are signatories to the Statement of Principles.

This paper is the first of a series of discussion papers prepared for the CHCCG, which are intended to contribute to that new debate. These papers do not represent official positions of the Consensus Group, and are not themselves consensus documents, but rather are intended to act as starting points for debate, some of which will occur on the Consensus Group's website (www.consensusgroup.ca). The first few papers will deal with aspects of the "public" versus "private" debate, while later ones will consider other issues which were raised in the Consensus Group's Statement of Principles.

the quantity and quality of the care and services provided did not take place. Such a growth in expenditures, which detracts from other government objectives and which will only accelerate with an ageing population, is clearly not sustainable in light of such limited results.

Health care is the most important issue; it is our greatest asset that must be protected and valued.

It is necessary to accept the evidence which shows that, in its current state, our health care system is unable to respond to the demands which it is now facing. An increasing number of Quebecers of all ages suffer the consequences on a daily basis. Hardly a week passes without the media drawing attention to this unacceptable situation. The conclusion seems obvious to me. We have to move beyond 'the patchwork solutions' and 'filling the gaps' methods used to respond to problems that continue to arise. For far too long, the corrections that have been made have aimed to plug the holes in the system at a cost of billions of dollars. Fundamental changes are essential.

In my view, health care is the most important issue; it is our greatest asset that must be protected and valued. As I see things, the question of health care is so essential that it is really one that is above political allegiance. Understandably, I am deeply disturbed by the current situation. What is important for me is to show that it is possible to bring about changes to the health care system which are capable of re-establishing a balance.

Let us look at what happens elsewhere. The first thing that is critical to note is that all advanced countries are faced with the same pressures. With the exception of the United States, all of them have public health systems whose objective is to ensure universal access to health services. These systems seek to respond to the pressure for the demand for services, which can only increase with the ageing of the population, while at the same time keeping the growth of public expenditures in check. Change in the health sector is inevitable and in no way results from left or right ideological considerations.

Fortunately, we can benefit from the experience of the countries of the European Union. Indeed, even though health care is difficult to deal with on a political level, the large majority of these countries have had sufficient maturity to respond to the expectations of their citizens by making significant changes to their health care systems.

Their experience shows that numerous changes can be made to improve the performance in our health care system while at the same time reducing the growth in public expenditures to a tolerable level. Even though they are generally inter-related, I have grouped these changes into three headings, namely, the governance of the system, resources and their use, and lastly, financing options.

Governance of the system

According to the Organisation for Economic Cooperation and Development (OECD), increasing the efficiency of the health system is an essential part of the effort to reconcile the increase in the demand for services with the constraints of public financing. All of which means that in order to increase efficiency, it is necessary not simply to reduce costs but also to change significantly the way in which money is spent. It is thus necessary to improve the quality and quantity of care without increasing costs and thereby obtain more from the allocated financial resources. The issue of governance of the health care system, therefore,

has particular significance.

In a 2004 report, the OECD presented an evaluation of reforms that have been introduced in the last few years. Generally, in regards to hospital funding and compensation for physicians and other service providers, the reimbursement system for costs, which encourages inefficiency, has been replaced by a system of fee for service or the purchase of services that encourages productivity. The results obtained are significant. Furthermore, to improve even more the desired results in terms of quality and quantity of services, certain countries have begun to introduce incentives by offering bonuses to service providers who attain certain objectives.

In systems where the financing and provision of health care services are a public responsibility, as in the Quebec system, the measures taken to separate payers and service providers in order to provide motivation which results in gains in efficiency have been found to be generally effective. The separation between payers and service providers has allowed incentives to be better adapted to the objectives set out in contracts, the decentralization of decision-making, the introduction of greater competition between the providers, and the establishment of comparative standards for hospital performance.

Let us examine the experience of Great Britain and of France that may be of particular interest to us.

We know that the British system had become a model and even a symbol of inefficiency. During the 1990s, reforms were introduced to the system along the lines which I have outlined. According to the OECD, the problem of waiting lists diminished and everything indicates that the results in general are very positive.

The French health care system is composed of a public system and a private sector which functions according to the same market principles as the United States. The main assets of this system are quality of services, freedom of choice and the equality of access. Reforms have been proposed, but facing resistance, have not been heeded.

Faced with a rise in service costs, the user fees and contributions have been increased on several occasions. In spite of these increases, the deficits in the health care system continue to grow and are considered a principal problem in the public finances of France. According to the authors of the report on health care in the OECD, the repeated injection of money has only resulted in the postponement of necessary reforms. One might think that one was in Quebec.

Let us take a look at how changes of this same kind could be made in the Quebec system.

The fundamental components of our system, namely hospital and medical care, are public and entirely financed by the government. Radiology in private clinics constitutes the only significant exception. Our system, therefore, essentially forms a monopoly.

In our health care system, the Ministry of Health is responsible for all functions. It is responsible for the development of policies and programs, for the allocation of financial resources and the control of their use, and for the evaluation of the performance of the system and its components. It is at the same time judge and

participant, and does not share its powers with any other authority.

The Régie de l'assurance maladie is essentially a pay agent which administers the agreements concluded by the Ministry within the framework of the health insurance and drug insurance programs. It was established solely to create a distance between the Ministry and physicians who feared the controls and interference of the former.

The senior civil servants in the Ministry of Health transformed our system into a heavy and costly bureaucracy. The power is totally centralized in their hands in Quebec City and does not permit any initiative to be taken by those in charge of these services. Protected by anonymity, they have become insensitive to the desires of citizens who wish to have freedom of legitimate choice in relation to their health care. Their most important concern is maintaining rigid control of the system.

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In the area of governance, the most significant change that should be introduced to our system is the separation of the roles of purchasers and providers of health care services. This important sharing of functions could be implemented by giving to the Régie the function of purchasing hospital and ambulatory services. It would have the responsibility of purchasing care at the best price, taking into account standards of quality.

The Régie should likewise be given the function of evaluating the performance of institutions in the system, namely the hospital centres, the CLSC[1] and the clinics financed primarily by the State. Following such a division of responsibilities, the Ministry would continue to be responsible for the essential functions of the system. It would continue to be responsible for the development of health policies, prevention programs and health education, planning and establishment of priorities and ultimate control regarding the quality of care.

The new concept of purchasing care would have significant indirect effects. Firstly, it would bring about some decentralization at the institutional level. It would reverse the very strong, paralyzing tendency toward the centralization of decision-making powers in our system at the Ministry level. Secondly, the new separation of roles would have the effect of lessening the overly great politicization of our system.

In short, the sharing of functions proposed between the Ministry and the Régie would allow our health system, following the example of numerous countries of the European Union, to embark on promising reforms both for the mid and long-term.

Resources and their use

Medical clinics

All the reports in the last years on health care have stressed the importance of an efficient network of ambulatory medical care clinics in order to improve access to care, at less cost, and to relieve the hospitals and refocus them on their first

[1] Centres local de services communautaires (Local Community Service Centres)

priorities. Confronted by the same access problems and financial constraints, most of the OECD countries have taken this route.

In Quebec, the data on medical clinics is somewhat incomplete. The clinics have developed naturally in those areas where the pressures on the health care system are the strongest, notably in Montreal and its periphery. No model should be assumed to be favoured *a priori*. Those that offer the best guarantees from the perspective of quality, cost of services and adjustment to their environment should be put under contract.

Our hospital resources are indeed under-utilized . . .in making them more accessible on weekends and evenings to private practice they could generate revenue and reduce wait times for the public system.

The Régie, in accordance with its objective as purchaser of health care services, would have the responsibility of implementing this approach with the goal of developing a network of clinics staffed by motivated professional teams and supplied with the best equipment in respect of care and administrative management. Such an approach is even more justified in light of a shortage of medical and nursing personnel. It is all the more important to permit them to practice with maximum efficiency and in conditions compatible with their responsibilities.

The orderly development of medical clinics requires that any question of incidental fees be clarified as quickly as possible. In the absence of specific rules, the danger of abuse and errors are obvious. It is important that the development of clinics according to different models not be discredited by the abuse of a few who lack concern for medical ethics.

Finally, it seems to me that financial incentives should be offered to encourage the purchase of equipment and information systems that are essential to the efficient running of the clinics. Such incentives seem to me also to be justified and perhaps more so than those offered to a range of companies that produce non-essential goods and services.

Hospital resources

From a perspective of optimal usage of enormous resources dedicated to health care, a change in policy relating to hospital equipment is imperative. Our hospital resources (operating theatres, laboratory and radiology equipment etc.) are indeed under-utilized. They constitute major investments which, in many cases, have a limited lifespan in view of rapid technological progress. In making them more accessible to private practice in the evenings and on weekends, they could at the same time generate additional revenue for the public system, and in so doing, reduce the demand for care and waiting times.

Administrations should be urged to head in this direction. Additional revenue would result both for them and for doctors, nurses and other personnel. The fact that such a change presents certain difficulties should not constitute a satisfactory reason for rejecting this option.

Financing Options

At the beginning of 2006, following the decision in the Supreme Court in the case of Chaouilli, the Ministry of Health and Social Services published a consultation document entitled “Guaranteeing Access”. Two questions were addressed therein which constitute the fundamental problems of the heath care system: access to health care and financing. In particular, the question was raised

as to how to ensure access with expenses that grow continually faster than our collective wealth and state revenues. In spite of the urgency of this question, the government has not introduced any changes in the financing of the health system since publication of the document.

According to the Ministry document, the negative gap during the last 20 years between fiscal revenues and health expenditures has systematically risen by more than 1% per year. This repetitive gap has resulted in health expenditures occupying an ever growing part of government budgets to the detriment of other government priorities which, in certain cases, suffer greatly from inadequate resources, namely education and its infrastructures.

In 2005-06, health expenditures took up 43% of program expenditures and there is nothing to suggest that the upward trend is going to come to an end. On the contrary, technological progress and the ageing of the population will likely accelerate the growth in expenditures. This is clearly an untenable situation.

As all industrialized countries are facing a similar situation, a review of solutions carried out in other jurisdictions is of significant interest. By a stroke of good fortune, the OECD recently finished the most complete study ever done on the health care systems of its 30 member countries. Thanks to this very detailed study, it was possible for us to analyze in a more rigorous way the health care systems in these countries and the solutions that were implemented to solve funding issues. This extensive study deserves praise for bringing new light and purpose to the questions which for so long were the subject of empty debate. The study has allowed us to examine the three options that are the most largely debated in Quebec, namely user contributions, the “loss of autonomy” insurance fund and private health insurance.

User contributions

Getting users to participate in the funding of their health care systems is a policy applied in more than 50% of OECD countries for health services and in more than 90% in relation to medications. The tariffs are on average about $15 Cdn per doctor’s visit and $17 per day for hospital services.

The imposition of a user’s contribution raises the question of equity and the effect on the state of health care. It has been established that the demand for health services is reduced with the imposition of user contributions. It is interesting to note that the impact of fees is more noticeable on the demand for minor problems such as colds and minor injuries. Yet in all the programs studied, the necessity to offer universal coverage for essential care is recognized to be of great value. For this reason, the majority of countries limit the annual contributions of participants and exempt the most vulnerable in order to ensure equitable access. The OECD study indicates that the health of populations insured by programs which impose contributions is no worse than those populations covered by programs that are entirely free.

Analyses on horizontal equity show that there is little inequity towards the poor in the health care systems of the OECD members. It seems that for general practitioner consultations and hospital services, inequity of access would favour the poor rather than the rich. If any inequity exists, it applies to specialist consultations.

If we look dispassionately at the experience of the European countries, one must conclude that Quebec should introduce a policy of user contributions in order to (1) instill a greater sense of responsibility in persons using health services and to (2) provide room to maneuver in relation to funding. This policy must necessarily include the reimbursement or exemption from fees for those persons who are most vulnerable.

In the short term, however, this approach cannot be considered. The introduction of such a policy, while desirable, remains impossible until the Canada Health Act is amended.

Loss of Autonomy Insurance

Funding growing health care expenditures in order to respond to the demand created by an ageing population is an issue which preoccupies all of the OECD countries and for which a clear solution has still not emerged.

The few countries that have opted for a "loss of autonomy" insurance plan did so some time ago so that the accumulation of funds to finance these programs began before the ageing of the population was felt. In spite of the accumulation of reserve funds, these countries are presently contemplating changes to their programs as a result of the enormous pressures that the programs place on public expenditures.

The experience of the OECD countries confirms the validity of the conclusion that, in the current context in Quebec, the introduction of a loss of autonomy insurance plan is clearly contra-indicated. On top of our enormous public debt, it would be unacceptable and inequitable that the baby-boomers transfer the burden of such a program to future generations.

Certain countries have decided to finance these services directly from the general funds allocated to health care. This strategy has, however, been accompanied in those countries by mechanisms intended to promote growth in the efficiency of the system and, in certain cases, they have introduced into the public program a financially based eligibility test.

Such an approach should be considered in Quebec. The objective should be to concentrate financial resources on priority services and on the greatest needs including, for vulnerable persons, a caregiver assistance program. Considering the inevitable budgetary constraints, eligibility for these services should be subject to an income test and services covered by insurance should be clearly identified.

Private health insurance

Quebec is one of the only jurisdictions where the role of private health insurance is limited to providing coverage for services not covered by the public sector. Yet in countries where private insurance plays a large role in the financing of health care services, it is interesting to note that there is nothing to suggest that access to health care is inequitable towards the poorest. In the majority of countries, the health systems are universal or quasi-universal and the goal of universality of access is generally to guarantee equitable access to all.

According to the OECD, private health insurance is one of the numerous tools that can contribute to improve the reactivity of health care programs, to facilitate the realization of public health care objectives, and to respond to the needs of consumers and of society.

In Quebec, private health insurance would offer an interesting potential to increase health care funding and to reduce the pressures on the public system. It gives citizens a fundamental freedom of choice. The prohibition against private health insurance should be lifted all the more because there is good reason to believe that the prohibition was struck down by the Supreme Court in the Chaouilli decision. However, as already indicated, obtaining a positive result is conditional on an appropriate regulatory environment favourable to the development of its full potential and the elimination of undesirable practices.

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A new paradigm

Our system of hospital and medical care is a monopoly. It has all the attributes of a monopoly with its own culture. A culture that is closed to external pressures, impervious to real change, adaptation and innovation, and which favours inefficiency. To break this monopoly, it is necessary to introduce change that is capable of engendering a new model.

Presently, with the exception of radiology, doctors must either participate in the public system or be disengaged. This impenetrable divide must disappear or else the monopoly which exists in our system will remain intact. But is it possible without the private system somehow cannabilizing the public one?

The coexistence of public and private services in the OECD countries shows that it is possible to establish a healthy equilibrium between the two by means of an appropriate framework. In these systems, generally, the doctors must fulfill well-defined responsibilities within the framework of the public system as a prerequisite to permitting them to provide private services. These conditions can take the form of a minimum number of hours of care per week or per month.

They can also consist of a limit on the amount of revenue in the private sector. Numerous examples show that it is possible to establish efficient control while at the same time avoiding the introduction of heavy bureaucratic controls. Obviously, ethical standards would be necessary to avoid possible conflict of interest and to ensure equitable treatment for all. Such standards are within the jurisdiction of the College of Physicians.

Finally, given the current context, it seems to me that physicians should re-evaluate the nature of their relationships with the government. In the current and foreseeable state of affairs, in order to obtain better practice conditions and a level of remuneration competitive with the outside, they have to resort to means of applying pressure which are difficult to reconcile with their mission and their professional status. Furthermore, physicians place the government in an impossible position when they lobby for increases in remuneration which exceed the level that the State can provide to the public and para-public sectors. Would it not be more appropriate on their part to plead for greater professional freedom and to obtain access to new sources of revenue?

Lastly, even if the relationship of nurses with the government is not exactly of the same kind, it seems to me that a re-evaluation of these relationships would be

entirely justified. Society recognizes more and more that the proper functioning of our institutions rests to a large extent on nurses – 24 hours a day and 365 days a year.

Canada Health Act

The need to modernize the Canada Health Act is urgent.

Just like our health care program, the Canada Health Act that sets out its framework needs to be adapted and clarified. In its current formulation, the Act restricts, if not prohibits, the changes that are required.

The Act forbids the imposition of user fees and even provides for harsh penalties in this regard. While the federal government funds less than one-quarter of our health care system, it maintains the prohibition that was introduced at a time when it covered half of the costs of the health care system. The punitive nature of the law is completely contrary to the spirit of cooperation which should exist between levels of government in an area which is so crucial. This is a legacy of days gone by when Ottawa wanted to impose its own way of seeing things on the majority of areas of provincial jurisdiction.

The need to modernize the Canada Health Act is urgent. Quebec, which has proven itself to be a pioneer in areas of social policy, should take the initiative. It would respond to the wishes of its population and would be supported by more than one province.

New Directions

The future of our health care system is a fundamental issue. If the necessary changes are not made, our system cannot survive. That is a certainty from which we cannot escape.

The monopoly of our health care system is imbued with a culture that is absolutely resistant to change. This monopoly must be broken to make way for innovation, dynamism and performance which alone are capable of protecting the universal character of our health care system. The chronic crisis situation has lasted long enough. Adversaries to change, who are increasingly rare, can no longer ignore what is done elsewhere and can no longer hide behind the spectre of two-tier medicine.

The following proposals, which are inspired by the example of the European countries and which are in no way revolutionary, would allow us to save our health care system and its essential universal character.

1. The allocation to the Régie de l'assurance maladie of the functions of purchasing health care and evaluating the performance of institutions.

2. The accelerated development of medical clinics in areas where the needs are greatest and according to the model which offers the best guarantees from the point of view of quality, cost of services and the adaptation to the environment that is being served.

3. The optimization of the use of hospital equipment.

4. A coverage plan for long term care for the aged so as to concentrate

the resources on priority services and on the greatest needs including, for vulnerable persons, a caregiver assistance program.

5. The abolition of the prohibition regarding private health insurance.

6. The abolition of the divide between public and private.

7. Review of the Canada Health Act.

These proposals, which constitute a genuine program, aim essentially to protect the universal character of our health system while at the same time reducing the growth in public sector costs to an acceptable level. Those who are successful in breaking the shackles which are strangling our health system and straining our public finances will render an immense service to Quebecers.

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A widely respected public servant, politician and corporate leader whose career has spanned more than four decades, Claude Castonguay developed the blueprint for a new Quebec health and social welfare program between 1966 and 1970 -- at the peak of the Quiet Revolution.

After being elected to the Quebec National Assembly in 1970, Castonguay became Quebec's minister of health and social affairs, and assumed responsibility for implementing the program he developed.

He served as Chief Executive Officer of the Laurentian Group Corporation from 1982 to 1989, and as chairman of the Conference Board of Canada from 1989 to 1990. Castonguay was named a Companion of the Order of Canada in 1974 and an Officer of the Ordre du Quebec in 1991. He served in Canada's Senate from 1990 to 1992.

Castonguay has received Honorary Doctor of Laws from Bishop's University, McGill University, University of Toronto, University of Manitoba, Laurentian University, Concordia University, University of Western Ontario, and York University.

Canadian Health Care Consensus Group

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