

**Keynote Address**

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at the IRPP conference

**“Careful Consideration: Decision Making in the Health Care System”**

***\*Check against delivery***

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I would like to talk about what I have learned from my experience in government – especially the most recent experience – about how health reform can succeed or fail depending on the way it is done.

Given the fact that reform is a change not only in structure but also in culture – the hardest thing to change in our society – when you embark on health care reform, or any public reform, the first thing to do is to set the bar of expectations at the right level, because you will probably always fall short of expectations. This is particularly true in health care, where expectations are infinite, and so is need.

I have studied previous attempts at health care reform, both in Quebec and elsewhere in Canada, and looked at the determining factors that predict its success or failure. I have come to some conclusions I'd like to share with you. First, reform has to be swift and introduced at a rapid pace. The longer it drags on, the more room it gives interest groups to raise new issues, which then reverberate through the columnists and become very important issues for debate. This basically stops reform in its course. Second, it will fail if it doesn't include service providers -- not only physicians, but also nurses and other health professionals.

From the time of the design of the reform until its implementation, it has to be carried out in a period of increased funding. If you carry it out in a period of budgetary freeze or decreased spending, the perception will be that you are doing it only for budgetary or financial reasons, and this will quite rapidly destroy support for the reform. And when you speak about finances, you have to be careful that the effects of your reform are taken into account in the way you allocate funds. For example, in the mid-1990s, one of my predecessors, Mr. Rochon, significantly and rapidly reduced the hospital sector, which was very important and necessary. But, unfortunately, there were no funds in the community for these patients when they came out of the hospital and the whole thing became problematic.

Another thing is that when you carry out reform in the health care system -- which is basically a combination of interest groups (and very powerful lobbies) -- you have to decide from the start how many foes you want to face at one time. There are certain foes that it is better to leave alone for a while and come back to later when reform has been introduced. And perhaps my physician colleagues are among the foes you want to leave alone for awhile. It's kind of funny, but it's also true.

Another of my predecessors, Mr. Coté, carried out a regionalization of the Quebec health care system at the beginning of the 1990s, and he also tried at the same time to change the way doctors practice in hospitals, something the doctors were quite efficient in raising public opinion against. So he only accomplished half of his reform.

The reform has to be presented to the people first and foremost as a process that is intended to improve the quality and accessibility of services, not just to control spending. In my opinion, the budgetary effects of the structural reforms of the health care system, at least in the short-term, have been grossly overrated. I don't think you can achieve significant spending control with structural reform in the short term -- maybe in the medium and long terms. You may in fact need to spend more in the short term to buy change and carry out the reforms you want to implement.

In terms of implementing change, you have to start with a plan and a strategy, but parallel to the type of reform that we undertook in Quebec when we came into office. Of course, situations arise that make you move rapidly in a kind of emergency context. The best example here in Toronto was of course the SARS crisis. And in Quebec more recently there was the C.Difficile problem, which may be a less publicized problem outside of Quebec as well.

Let me be a physician for a while and ask: What is the diagnosis for our health care system? I think various polls show that people in general are quite happy with the quality of care they get. In Quebec, when questioned on the quality of care they received in hospital or at the doctor's office, 90-95 percent of people will say that they are satisfied or very satisfied with the care. We are doing also well in population health. I'll come back to that later. We have excellent health indicators both in Canada and in Quebec, something for which the rest of the world envies us. But, Canadians and Quebecers are not so satisfied with access to care and services, and continuity in care. Our organizations are too rigid, we have insufficient accountability, and our funding is unstable and unpredictable.

Let's deal with the easiest of them all — the funding. If you look around the OECD countries and the provinces in Canada, you will see a constant figure: health care spending will increase year after year, from 5 to 7 percent, sometimes more. This figure is the same all over the world. So, there must be something inescapable about it. And attempting to bringing it under 5 percent, let's say to 3-4 percent, will fail,

resulting in a crisis in the health care system, instability, and rapid cycles of overcorrection and decreased spending. So the challenge for us is to define the acceptable rate of increase for our health care system. I think it is between 5 and 7 percent, and we have to find a way to fill the gap between government income and this level of spending increase.

Of course, citizens, through their taxes, are the only source of income for our health care system. But there has to be a better balance of responsibility and funding between the two orders of government than the one that has prevailed since the drastic cuts in the health care transfers in 1994, which were actually a key to the success of the federal government to control its deficit. This improved balance was at least partially accomplished in Ottawa in September, in a very significant agreement. It was significant in my view mainly for two reasons: The first is the recognition in the new funding accord of an escalator factor, which is 6 percent. So, you always come back to this 5-7 percent figure. I'm very proud of this famous asymmetric accord with Quebec, and I think all Canadians should also be proud of it. I find it hard to understand the negative response to it in the country: It's a quintessential Canadian way of doing things. And what was given to Quebec should have been offered to all the other provinces, because there's no reason why Newfoundland and Alberta and BC cannot manage health care the way they want to or the way they feel is attuned to their priorities and the needs of their residents. So, it's not clear yet how much fresh air the September agreement will bring.

So, starting next year we are getting an additional \$700 million dollars per year, but this year we spent \$20 billion on health care. For how long will it help? Maybe for a few years, but then we'll have to go back to the drawing board, I'm sure. Let me give you a few figures concerning our situation now. In less than two years in Quebec we've increased spending on health care by \$2.2 billion, which is a 12 percent increase. Health care accounts for 42 percent of our program expenses. Seventy percent of our new investments last year were in health care and social services. Meanwhile, education received only 2.7 percent, and all other departments – many of which, such as environment and other government missions, have an impact on health – received 0.5 percent of new investments. So, having secured something of an improvement in funding, we had to take into account other cost drivers.

Demography, pharmaceuticals and technology are certainly the three other major driving costs in our health care system. With respect to demography, the only way to truly control the impact of demographic change

in the long-run is to promote prevention and healthy habits. There's no doubt about that. The problem is that this will only bring benefits in the long-term, and the big challenge with prevention is that it succeeds when nothing happens. So, how do you prove it worked? It's an interesting challenge. The good news though, is that this change in demography is not, in my view, a catastrophe. More and more of our elderly people are healthier, much healthier than those in previous generations; 40 percent of the health care expenses we will all generate, will be generated in the last six months of our life. The other good news is that we only die once. At least for now.

With respect to pharmaceuticals, this is the sector of our health care system with the most rapidly rising costs, which must be integrated into the health care system. We had a disagreement with our colleagues from other provinces when they were attempting to reach a pharmacare agreement with the federal government. Of course we had no objection and we wished them good luck, but we told them that in our view it was not logical to separate pharmacare from the actual running of the health care system, because there is so much interdependence between them. If it is possible to control the rise of pharmaceutical costs, it seems to make sense that we shape controls in a rational way, not disconnected from the health care system overall.

I think each province now has or should have some kind of body that assesses technology and pharmaceuticals in a rational way, an evidence-based way. Over the next weeks I will publish a drug policy that will touch on three themes. First, access: We'll try to reform our current pharmacare program. Second, equitable determination of price: This is important for the innovative industry that we have and benefit from in Quebec. Third, optimal use: I think this is where we can achieve some gains in terms of spending limits and spending control. Not in attempting to control the way doctors prescribe drugs, because patients and citizens react quite negatively to that. We have to be aware of that. And lastly, in Quebec we have quite a dynamic and innovative pharmaceutical industry, which we need to maintain so we can to keep our society prosperous enough to afford these very generous social programs that we have given ourselves.

Governments have two levels of obligation toward the public regarding health care. The first is to provide better health for the population, and in that regard we are doing quite well in Canada. In fact, Canada is one of the best countries in the world in terms of that type of performance. The second is prevention, and here if you look at the population's health, the health care system itself only plays a minor role, around 30 percent,

according to various studies. Other areas like education, social economic levels and environmental protection, play a much more important role in protecting the health of our population.

Our health care system was designed at a time when all of use were much younger and without the chronic health and other types of problems than we have to deal with now. So, first, we need to improve the health of the population. Second, we need to provide better services because, rightly or wrongly, this is what people will use to assess the way their government has performed (and to decide whether to give them another mandate, by the way). And to do that, to give better services to the individual, we have to address the two clear impacts our health care system provides on public opinion, which are emergency rooms and waiting lists. To achieve any success there, we need to change the way we do things.

So, we embarked on that in April 2003 when we were elected, and when the National Assembly was convened the following fall, we did not wait. That is my first principle: don't wait and do it fast. We tabled three bills; two of these three bills have been adopted and are in effect now. The first was Bill 25, creating local health and social services network, which I will describe in more detail later. By the way, in Quebec health and social services are integrated, which is in my view quite and important thing to do. The second one was Bill 30, to reform labour organizations and drastically reduce the number of bargaining units we had in our hospitals. Some institutions had to deal with many bargaining units, like the McGill University Centre, which had to deal with 80. So, we decreased the number of bargaining units from 3,600 to around 1,000, or 4 per institution, and also introduced local bargaining for areas pertaining to work organization, and so on. Of course, you can imagine that this was not very happily accepted by the unions, but we think it had to be done and we paid a political price for that (and for other measures that we took.) The third one, which we hope will soon be adopted, is the creation of a health commissioner, which would increase accountability and report to the people every year on the state of the health care system, both in terms of quality and access.

To go back to Bill 25, this Bill created 95 health and social services networks covering all of Quebec one for each region, which will be responsible for delivering general, medical and social services . Under a single board there will be a CLSC (centre local de services communautaires), a general hospital – very specialized institutions and university centres were excluded from that Bill — and also one or more long-term care institutions. To reflect the trajectory of the patient in the health care sector and also to respect the

changing nature of the hospital with respect to new technologies and new needs, the hospital has to project itself outside of its walls into the community. The notion of responsibility to the population was very much at the centre of the principles that guided this Bill.

There is one GP in private practice on the board of each of the networks of community organizations, specialized institutions, youth centres, rehabilitation centres, university hospitals or specialized regional hospitals. But for us, regionalization is an old story, and I find it hard to understand how you can achieve any progress in a publicly run health care system without at least some degree of regionalization. Delegating more responsibility to the local level was the logical consequence and the natural history of regionalization.

Parallel with this — we were quite busy for a few months — we introduced a new budget allocation system. All of this had to be introduced at the same time. People told me, "Well, you should be careful. You should introduce Bill 25 first, then you should introduce Bill 30, then you should start your new budget allocation method." Well, I told them that this is a recipe for failure and catastrophe. You have to do it all at once, monitoring it as you go. It's quite a risky thing to do though, and you have to make the changes and adjustments as needed. So, the new budget allocation system is population based, with some well-known social, economic, and demographic adjustments, such as dispersion of the population and correction of interregional inequities. You can only do that when you have more funds to allocate to health care, so you allocate a little bit less to regions that have been favoured over time. It's a results-oriented and program-run approach that is going to bring, we think, more accountability and more transparency to the health care sector.

There are other conditions for success that we are also working on. First is the continuing experience with our family medicine groups, which I alluded to a little bit earlier. We now have 87 in Quebec, and I would guess that by the new year we'll be passing the 100 level. In these groups, doctors are paid when they add patients to their list, but then they're also paid on a fee-for-service basis, with a supplement if they see what we call clientèle vulnérable, people with special needs, like the elderly, people with chronic diseases and the mentally ill. Information systems also have to be put in place if the design of the health and social services network is to facilitate care related circulation of information, with all the appropriate confidentiality protections, about patients. This is one of the reasons we're investing a lot of money now. In fact, we are

doing it with Canada Health Infoway and the Canada Institute for Health Information, represented here today, which we very happily joined (something that our predecessors were not that keen on doing). But there's no substitute for a rapid introduction of changes. There is no doubt that the status quo is not acceptable and we have to change our health care system so that it reflects the society that we live in now.

I cannot conclude here without telling you just a little bit about my conception of the role of the private sector in health care. In my opinion – and I've shared it with my federal counterpart and most of my provincial colleagues – there's no need to touch the Canada Health Act, because it is flexible enough to allow some experimentation, mainly for private delivery under a public funding umbrella, for certain types of services – for example, cataract surgery. But it should be said clearly and explicitly, and this is what has been lacking until now: There is no need to make the Canada Health Act more or less flexible. We are also very carefully introducing the P3 formula – private/public partnerships for large infrastructures. No formula is a panacea. We have to be careful and use it with some degree of prudence, but we are learning from Ontario in that regard, and we have a long experience with that. We'll see how successful we are (I say that in a humorous way). In Quebec we remain attached, like the majority of our fellow Canadians, to the values expressed in the Canada Health Act, and in particular, to those of accessibility and universality. And certainly, portability is one area where we need to make a lot of progress.

I'll leave you with this thought I found in one of my readings. When I go home at night I never read any health care files, I read other things, and I encourage you to the same if you work in health care. I found a quote from one gentleman from the 1920s that I've tried to translate as best as I can. It goes as follows: "Our head was made spherical so that our thoughts can change directions." Adaptability and an open mind are vital parts of any approach to health care reform. Thank you.