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QUEBEC'S HEALTH REVIEW (THE CLAIR COMMISSION)

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QUEBEC'S HEALTH REVIEW (THE CLAIR COMMISSION)

HIGHLIGHTS

The first part of this paper summarizes key elements of the analysis of Quebec's health-care system contained in the report of the Clair Commission, handed down on 17 January 2001, as well as its main recommendations. This summary is followed by a brief account of the reaction to the report on the part of stakeholders, commentators and the government.

The Commission's report concentrated primarily on the reform of the delivery of primary health-care services and on issues relating to the funding of the health-care system. Among its 36 recommendations and 59 proposals are a number of innovative suggestions, including:

- the reorganization of the delivery of primary health-care services by encouraging the formation of group family practices made up of 6-10 physicians that would provide care to a roster of patients 24 hours a day, 7 days a week; and
- the creation of a dedicated "loss of autonomy" insurance fund financed by taxpayers that would be used to pay for an expansion of homecare and institutional services to the growing number of elderly persons.

PART I – SUMMARY OF THE CLAIR COMMISSION REPORT

On 17 January 2001, the commission appointed by the Quebec Government in June 2000 to study the province's provision of health and social services – known as the Clair Commission (after its chair, Michel Clair) – handed down its final report and recommendations, entitled *The Emerging Solutions*. In public hearings held across the province, the Commission received 212 submissions, and heard testimony from 124 representatives of various

organizations. In addition, it delegated the responsibility of hearing from the public at large to regional health bodies which received a further 550 submissions and heard directly from 6,000 individuals. The regional health bodies then reported their findings directly to the commission. Finally, the Commission sponsored an extensive public opinion survey and organized four thematic conferences where it heard from more than 30 expert witnesses from Quebec, across Canada and abroad.

The report contains 36 broad recommendations, supported by 59 proposals for their implementation. These deal with the two main themes on which the Commission concentrated, i.e., the way health services are organized and delivered, and public funding. However, they also touch on issues of human resource management and planning as well as on the overall governance of the health-care system.

A. Towards a New Vision for the Next Decade

In their introduction, the commissioners note that the problems confronted by the health-care system in the province of Quebec mirror those faced by countries around the world. These are framed by a central imperative: as scientific and medical advances expand the possibilities for intervention, and these entail growing costs, decisions must be made at all levels of society. Decision-makers are confronted by the need to choose how to spend limited resources, while ordinary citizens must decide which is more important: social solidarity and fairness, or the expansion of individual control.

Drawing on a report from the World Health Organization, the commission report insists on the fact that all health-care systems must recognize the inevitability of some degree of rationing, and that it is up to the state to put in place the procedures that will allow decisions to be made on what services should be provided. An unavoidable aspect of this process involves the need to establish a balance between those services provided to the population as a whole, and clinical treatment administered to individual patients. For its part, the Commission clearly opts to seek ways of making health promotion and prevention a priority.

B. The Organization of Health-Care Delivery

In the spirit of this basic orientation, the Commission tackles the organization of the delivery of health services in the second chapter of the report. It notes that the structure of health-care delivery in Quebec is still stuck in the 1970s, with an overemphasis on individual professional practices, the autonomy of each health-care establishment and a general approach based on "silos" that allows each component of the system to function independently of the others. According to the Commission, the many changes that have taken place in the organization of the health system in recent years – including the closing of hospitals and a reduction in the length of hospital stays – have mainly been done in reaction to events rather than flowing from a new vision that is truly adapted to the changing circumstances.

The Commission begins the process of outlining its own vision by re-evaluating the role of the family doctor. The core of its approach in this area is to encourage the formation of group practices composed of 6-10 physicians that would be able to provide comprehensive primary care to patients 24 hours a day, 7 days a week. This expansion of front-line service would be further facilitated by giving a greater role to nurse practitioners, as well as by using the existing structure of community-based health centres (CLSCs – Centres locaux de services communautaires) to coordinate the activities of these group practices, and to supplement them with a variety of specialized services. Moreover, the Commission suggests that electronic medical files be established in order to ensure the continuity of service required.

The Commission's recommendations with regard to the organization of service delivery are structured thematically. Selected highlights follow.

1. Prevention

In the Commission's view, prevention constitutes the central element of health policy and it is up to the Government as a whole, and not simply the Ministry of Health and Social Services, to assume overall responsibility for the health of the population. The Commission recognizes that results in health prevention become visible in the medium rather than in the short term, and that priorities must be set that take into account three important dimensions of the problem:

- different risk factors contribute to a number of different health problems (e.g., tobacco consumption increases the risk for heart diseases, cancer and respiratory illness);

- the first years of life are critical; and
- an integrated approach is required.

2. Primary Care

The Commission recommends that Quebec's current twin components, i.e., doctors' practices and the network of CLSCs, be recognized as the foundation of primary health-care delivery. It sees the possibility for a coordination of services based on cooperation between the two levels, rather than through their forced marriage. The CLSCs would concentrate on the social dimension, while group medical practices would be at the centre of the delivery of medical services. Concretely, the CLSCs would develop a common set of services that would be offered across the province and, in particular, they would be responsible for the provision of basic "psychosocial" care. The CLSCs would contract with group family practices, made up of 6-10 GPs as well as nurses, with each doctor being responsible for approximately 1,000-1,800 people. Patients would still be able to choose their own family doctor but would sign an agreement to stay with them for a period of approximately six months, after which it would be possible to change physicians. Doctors would be paid using a mixed formula that would combine payment for each patient registered with the doctor's practice, payment for the doctor's participation in outside programs, and contractual fees as well as fee-for-service. The Commission proposes that this system be instituted gradually, on a voluntary basis, with a target of about 75% of the population being enrolled in group practices within five years.

3. Services for People With Special Needs

One of the more innovative recommendations of the Commission report concerns the establishment of a dedicated fund for financing an integrated network of services for older people experiencing a loss of autonomy.(1) The Commission based its recommendations in this area on the recognition that elderly persons experiencing a loss of autonomy require a complex, specialized and integrated set of services that would allow the most appropriate form of care to be delivered regardless of location. The responsibility for ensuring the coordinated provision of these services would fall to the CLSCs in collaboration with group family practices, which

(1) The funding proposal will be discussed below in the section on public funding.

would contract with the CLSC to take charge of patient care. A special budget for these services would be assigned at a regional level, with the objective of increasing the availability and quality both of homecare and of institutional services across the province.

4. The Coordination of Specialized Services

The Commission recommends the formalizing of a hierarchical structure for specialized hospital services, divided amongst local, regional and teaching hospitals, each with an increasing level of specialization. As well, in keeping with its intention to allow medically necessary services to be provided in a variety of settings, the Commission proposes to allow specialized private practices to affiliate with hospitals. It hopes that the provision of certain procedures outside a hospital setting would improve access and shorten waiting lists. These services would be offered under the supervision of hospital staff, and patients would incur no additional charges. Given the innovative character of this recommendation, the Commission suggests that it be implemented gradually following a series of pilot projects.

5. Granting Greater Responsibility to Doctors and Nurses

The Commission recommends that nurse practioners be trained and gradually integrated into the system.

C. Human Resources

The third chapter of the report deals with human resource issues. The Commission laments the fact that, despite their centrality to the overall functioning of the system, human resource issues have never been accorded strategic importance. It notes that the management approach that had been widely adopted in the health sector was largely based on a conflictual industrial relations model that does not allow for either the public interest or client needs to be fully respected. It therefore calls for a thorough reorganization of work procedures involving both unions and management, with the aim of counteracting the demoralization that has become endemic. To this end, it proposes that each establishment inaugurate a project designed to link management, professional and other staff in coordinating their efforts to

improve client service. The Commission also identified the need to find ways to base promotion on both merit and seniority rather than exclusively on the latter.

D. Public Funding

The fourth chapter deals with the funding of the system. The Commission notes that there has been a drift from conceiving of health care as a set of insured services towards the idea of an individual right to service. It believes that this has been accompanied by growing confusion over what is and what is not insured by the public system to the point that no one can any longer identify who is supposed to provide what to whom, how quickly and in what location. Only experts are able to decipher the costs of various services, and no one really knows who decides which services are to be covered, where the money comes from, and where it all goes.

The Commission reaffirms the social importance of the five principles of the *Canada Health Act* (*CHA*) but points out that they must be reinterpreted according to contemporary realities. While rejecting a two-tier system, and insisting that public funding remain the foundation of the system, the Commission also calls for a paradigm shift that would replace a conformist culture with an innovative and entrepreneurial one, and that would foster partnerships between public, private and third-sector institutions.

To preserve the province's ability to provide health services over the long term in the face of growing expenses, the Commission recommends that the Government set out the maximum level of public expenditure it considers acceptable and provide triennial budget provisions for the health-care network.

The Commission states clearly that public finances should remain the main source of funding for insured services, but it also recommends that other forms of collective insurance be explored to pay for an expansion of service and that a special fund be created to deal with the needs of an aging population, paid for through a "loss of autonomy" tax on the whole population. While recognizing that recent increases in federal transfer payments to the provinces have improved the funding situation in the health-care sector, the Commission nonetheless feels that these contributions are not enough.

It therefore calls on the Quebec Government to seek additional funding at a level five or six times the amount that has already been allocated by the federal government. This would be invested over a period of five to six years in the renewal of medical equipment, the

deployment of information technology, the reorganization of primary care and new infrastructure. In order to break down funding "silos," the Commission proposes instead to base the allocation of resources on a "population" basis that would allow for an integrated approach to service delivery, and to replace a hierarchical and bureaucratic model with one based on contractual links between the different elements of the system.

The Commission notes that the basket of insured services has not kept pace with demographic, epidemiological and technological changes. Despite the widespread desire to avoid a two-tier system, the Commission notes that there already are many grey areas fostered by the lack of resources. It questions the logic of not insuring homecare services even when these are cost effective, or of insisting on the provision of services through hospital emergency wards when these cost more than they would in a less intensive setting.

Although it did not have a mandate to reinterpret the five principles of the *CHA* itself, the Commission nonetheless highlights the inequities produced by the way in which these are currently understood and suggests that the need to review them is urgent. The Commission recommends that the government establish, through legislation, a credible body – composed of scientific experts, medical specialists, ethicists and respected citizens – that could continuously reassess the basket of insured services as well as make proposals concerning the adoption of new technologies and new treatments.

The Commission noted that there are currently no mechanisms in place to allow for a systematic monitoring of the various cost drivers affecting the system, and calls on the government to develop a plan of action in this regard. It points out that many of its own recommendations could have a positive impact on controlling costs, including the implementation of electronic records and a "smart card" that would give all health-care providers access to a patient's medical records. Furthermore, the Commission recommends that various partnership programs be initiated with the private sector, both for-profit and non-profit, noting that the level of private participation is higher in many countries with publicly financed systems than in Canada and not nearly as controversial as it is here.

The Commission calls for the implementation of a "corvée" that would mobilize funding from the private sector, unions, health-care professionals, the public at large, philanthropic foundations, and the federal and provincial governments in a major investment program in health-care technology and infrastructure. It also suggests that certain support

services in the hospital sector (laundry, food services) be progressively transformed into mixed ownership corporations, in which the unions would be invited to invest. Finally, it recommends that the government create a Quebec Techmed Foundation in order to foster investment in medical technology. It would be seeded with $100 million in government funds, but would seek a further $500 million from various private sources; these would be given generous tax incentives to invest.

As mentioned earlier, one of the report's innovative recommendations calls for the creation of a dedicated insurance fund, financed by a special tax, to cover long-term loss of autonomy. According to the Commission, this would enable the system to simultaneously meet a number of objectives: allow an equitable system of homecare and institutional care to be established across the province; reduce the costs and inconvenience associated with long-term hospitalization; and support and supplement the work of non-professional caregivers. The Commission insists that this fund must be separate from general provincial revenues, and it therefore recommends that the fund be administered by a body such as the Quebec Pension Fund.

E. Governance

The final chapter of the Commission's report deals with the question of the governance of the health-care system at the provincial, regional and local levels. The Commission notes that there is widespread dissatisfaction across the network with the functioning based on "silos" and the ensuing "turf wars." At the same time, in view of the system's complexity, the Commission believed that the most appropriate course of action was to suggest making only the most urgent changes. It recommends that the Ministry of Health and Social Services concentrate on working out the strategic orientation for health policy and on monitoring the results, while divesting itself of the responsibility for administering the delivery of health services. It suggests that the Government consider reducing the size of the current ministry and look into establishing a new body to coordinate the actual delivery of health services. As well, the Commission reaffirms the validity of maintaining three levels of governance (provincial, regional and local) and suggests that the number of regional bodies (18) remain the same. It recommends that these regional bodies have the responsibility for setting up "Citizen Forums" to advise them on issues relating to regional health delivery.

PART II – THE CLAIR COMMISSION: THE REACTION SO FAR

It is no doubt true, as Carol Néron remarks in her commentary in *Le Quotidien* (January 19), that it will take a number of weeks for people to digest the full impact of the 59 recommendations and proposals contained in the Commission's 400-page report. However, the initial round of reactions – coming mainly from stakeholders, the press and the government – has seen more praise than criticism for the Commission's efforts.

In general, the Commission's central recommendation to create group family practices that would be able to provide care 24 hours a day, 7 days a week, has received the most favourable reaction. Its other innovative proposal – to create a special fund to pay for care for an aging population experiencing a loss of autonomy – has attracted criticism from those who worry that it entails an additional tax for the already overburdened Quebec taxpayer. Finally, commentators seem to be divided as to the degree of openness to the private sector that is reflected in the Commission's report.

One further concern that was voiced, amongst others, by Yves Lamontagne (*Le Devoir*, January 18), president of the Collège des médecins du Québec, was that whatever its merits, the timing of the report – coinciding as it did with the resignation of former Quebec Premier Lucien Bouchard – may limit its impact. This also contributed to diminishing the scale of public reaction to the report, according to Carol Néron.

Some reports, however, have begun to fill in certain of the details concerning key Commission recommendations, notably its proposal for a loss-of-autonomy tax. In its report, the Commission did not attempt to specify either the size of the fund that would be required, or the amount that each taxpayer could expect to have to pay. In an interview with *La Presse* (January 18), Guy Morneau – the president of the Régie des Rentes (Quebec Pension Fund), who initiated the idea for the loss of autonomy fund – suggested that it would cost individual taxpayers about $135 a year, and that at its peak in 2035 the fund would need about $21 billion in capital.

A. Selected Reactions

1. Stakeholders

As might be expected, given the important role the report assigns to the institutions on whose behalf it speaks, the association representing Quebec's community-based health centres (CLSCs) believed that the Commission had adopted most of its suggestions. They remained concerned, however, that the level of funding would not be adequate to allow the CLSCs to fulfill their mandate (*Le Devoir*, January 18). The Federation of General Practioners of Quebec expressed great satisfaction with the report's emphasis on reforming front-line services. However, its president, Renald Dutil, also voiced his concern with regard to what he called the Commission's "weak and timid" funding proposals (*La Presse*, January 18).

The vice-president of the Quebec Hospital Association, Daniel Adam, said that hospitals looked forward to being freed from caring for flu patients and elderly persons who were tying up emergency wards and acute care beds, and also had praise for the Commission's recommendations that promotion in the health-care sector not be exclusively based on levels of seniority (*La Presse*, January 20).

Reaction on the union side was much more critical. The Vice-President of the Confédération des syndicats nationaux (CSN) lamented the fact that the Commission downplayed the need for massive reinvestment in the health-care system, while other unions also criticized the Commission's reliance on further taxation measures to fund its proposals (*Le Devoir*, January 18).

Louis Roy, President of the Féderation de la santé et des services sociaux, affiliated to the CSN, was highly critical of two aspects of the report. In the first place, he saw the overarching thrust of the report as heading in the direction of an increased privatization of the system. His second criticism concerned the tone adopted by the report towards its unionized workers, which he termed "paternalistic" and biased in favour of the employers (*La Presse*, January 25).

2. Other Reactions

Editorial reaction in the Quebec press was initially mixed, with most French-language papers commenting favourably on the report, while the English-language *Montreal*

Gazette adopted a largely critical stance. For example, Jean-Robert Sansfaçon of *Le Devoir* concluded his editorial (January 18) by saying that the report constituted a new starting point that should be followed up without delay if the health-care system is to be saved. The *Gazette*, for its part, said that despite a number of useful suggestions the report merely proposed tinkering with the system rather than revolutionizing it, notably by "getting the private sector more involved" (January 18).

The opposition in Quebec City was also critical of the report. The health critic for the Liberal Party of Quebec, Jean-Marc Fournier, saw the report as leading to an unwise increase in taxation and a progressive disengagement of the government from key sectors of the system (*Le Soleil*, January 18).

Finally, in an early commentary from academic circles, Antonia Maioni of McGill University, in a paper prepared for the Canadian Policy Research Networks, suggests that the report is a "determined attempt to think outside the box in policy terms" in which the Commissioners try to "make feasible suggestions that avoid ideological sparring or quick-fix solutions." She is concerned, however, that the Commission did not fully weigh all the consequences of its more contentious proposals, especially because "it remains unclear from the evidence presented in the report that these proposals are entirely compatible with ensuring the improvement and longevity of a publicly-funded health-care system."

3. The Government's Response

On 26 February 2001, Health Minister Pauline Marois indicated that the government intended to move forward with the creation of group family practices as recommended by the Clair Commission. She noted that a number of pilot projects were already under way that demonstrated the viability of this system. Its initial phases would be funded using $140 million provided by the federal government over the next four years. Minister Marois also stated that she had already recommended to Cabinet that the Commission's proposal for a "loss of autonomy" fund be studied in detail, thereby enabling measures to be adopted quickly that would respond to the long-term needs of an aging population.(2)

(2) Sources: Ministry of Health Press Release, 26 February 2001 (c6725), and reports from Radio-Canada.