

The Reform of Health and Social Services in Quebec



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Introduction

Quebec is undergoing a healthcare revolution (Levine 2005). With the passage of Bill 25 in 2003 and Bill 83 in 2005, the Government of Quebec introduced potentially profound reforms to the province's healthcare system. In this paper I examine these changes and identify some of the strategic levers that support them and increase the probability of their success.

The Reforms

Quebec's healthcare reform has four main objectives:

- Improving the population's health and well-being
- Distributing services equitably

- Facilitating the use of services
- Managing vulnerable patients' care

Two principles guide the reforms: population-based responsibility and the hierarchical provision of services.

Population-Based Responsibility

Quebec is divided into 17 healthcare regions. Each one has an agency responsible for ensuring the health and well-being of its population and for managing the primary and secondary health and social services delivered in its jurisdiction (regional or national organizations provide tertiary care and specialized services). Each regional agency is also responsible for ensuring patient access to care, no matter where that care is delivered.

Hierarchical Provision of Services

The Quebec system distinguishes between primary and secondary care services and the more specialized services offered in regional or tertiary care centres. This distinction is essential for determining which services will be provided close to the population being served and which will be provided in more resource-intensive specialized centres. It also underlies the concept of corridors of service, which are defined so that local, region-based centres can directly access more complex services without the random shopping around by physicians that presently occurs.

Structural Changes

Adhering to the principles of population-based responsibility and the hierarchical provision of services, the Quebec government created a new organizational form: the Health and Social Services Centre (HSSC). While variations exist, especially in Montreal, the basic HSSC structure entails the merger of one or more local community service centres, long-term care facilities and an acute care hospital. Across the province there are 95 HSSCs, each responsible for a specific territory and population (there are 12 centres on the island of Montreal – see <http://www.cmis.mtl.rtss.qc.ca>).

Bill 25 changed the mandate of regional health boards from being planning organizations to assuming responsibility for managing, coordinating and delivering healthcare in their regions. Each new regional health agency (e.g., Montreal Health and Social Service Agency) has a board nominated by the provincial minister of health and a president and chief executive officer (CEO) appointed by an order in council. The first mandate of these agencies was to determine the HSSCs that were needed in their regions and to make recommendations to the minister of health.

The mandate of each HSSC reflected their new responsibilities:

- To evaluate the health and well-being of their populations and determine their healthcare service needs
- To coordinate the use of healthcare services by their populations
- To manage the healthcare services they offered
- To develop integrated local care networks

Figure 1 illustrates the local care network form (Ministère de la santé et des services sociaux 2004). These networks connect care providers as well as other health and social service partners (e.g., local pharmacies, schools, community groups and social clubs). They are the cornerstone of efforts to ensure access to, and continuity of, services.

Strategic Levers

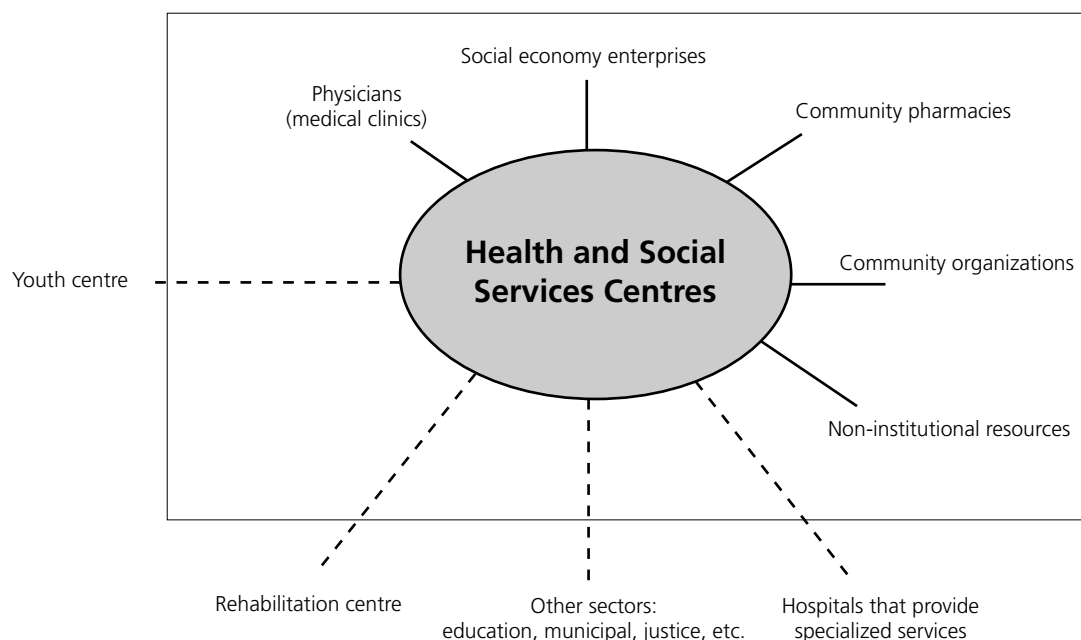
Between 2004 and 2006, Quebec's HSSCs established a new organizational structure by integrating activities and developing an appropriate management model. In Montreal, we designated the following criteria as essential for a high-performing healthcare system:

- Timely access to the different levels of care required
- Continuity in the provision of services
- Optimal use of available human, technological and financial resources
- Application of evidence-based practices, both clinical and managerial

Managed care (with its constituent elements) and performance measurement are our main strategic levers necessary for accomplishing these goals.

Managed Care

Montreal's approach to managed care was informed by models from Kaiser Permanente (2005); the United States Veterans Health Administration (Petzel 2006; Jha et al.,

Figure 1. Integrated local care networks

2003); the Puget Sound Project (Davis 2006, 2007; The Commonwealth Fund 2006; Puget Sound Center); primary care trusts in England (British Medical Association 2006; Roland et al. 2005; National Health Service); and primary care teams in Barcelona, Spain (Deuxième Colloque 2006). It has three major components:

- A population-based model
- A chronic care model
- Service management redeployment

Population-Based Model

Knowing the state of health of a given population is an essential part of a population-based model. Significant effort was therefore made to help each of Montreal's HSSCs learn about their populations. Using Statistics Canada census data as well as information obtained through local sources (e.g., <http://www.cmis.mtl.rtss.qc.ca>), the agency's public health team prepared a portrait of each HSSC population in the region. These portraits provide data on

socio-economic status, education level, and service consumption, as well as information on housing, immigration, and community organizations. Lifestyle data are also available for each area, including, for example, tobacco consumption, levels of physical activity and obesity rates. The data also define at-risk populations and highlight critical social issues such as homelessness and prostitution. These data are updated every two years and health-improvement targets are set for each HSSC and the Montreal agency as a whole. This information is also used to ensure equitable funding according to the specific needs of each population.

Chronic Care Model

Ed Wagner's Chronic Care Model (Wagner 1995, 1998; Wagner et al. 1996a, 1996b; Wagner et al. 1999) was adopted in order to manage the care of chronically ill patients and those at risk of developing a chronic illness. This model comprises four main components:

1. Chronic care protocols for each disease and involvement of family physicians in their application and follow-up
2. Patient self-management through education and support networks necessary to accomplish that goal
3. Multidisciplinary primary care teams or access to such teams by family physicians, including seamless access to secondary and tertiary services as well as all corridors of service for diagnosis and treatment
4. Information systems that support electronic medical records, chronic disease registers and diagnostic and treatment decision-support tools

The Montreal agency also established a close working relationship with the research team at the University of Montreal involved in chronic disease treatment. The agency also created a consortium that includes the CEOs of the 12 HSSCs and the agency's public health team. Four projects are now being examined for possible implementation.

Service Management Redeployment

Under the new integrated approach, it is necessary to ensure that the management of primary- and secondary-level services falls as much as possible under each HSSC's jurisdiction and that each centre also coordinates access to tertiary and other specialized services.

In this respect, the first major reorganization of services undertaken by the Montreal agency dealt with the provision of primary mental health services (Trépannier 2006). Almost 95% of the \$325 million spent annually on mental health in Montreal is managed by five psychiatric hospitals and four psychiatry departments based in teaching hospitals. The plan currently being executed involves the transfer of \$48 million worth of mental health services to the city's 12 HSSCs. Primary mental health services will thereupon

be offered in collaboration with primary care physicians in each territory. Similar reorganizations are being implemented for long-term care admissions, rehabilitation and subacute care services, public health programs and services for the intellectually handicapped.

Montreal's regional agency has also joined with its hospitals to study whether the implementation of a citywide laboratory service with a single dedicated specimen transport system and a single information system would improve accessibility and lower costs. Under such an arrangement, specialized analyses would be regrouped while ensuring hospitals' capacity to undertake immediate diagnostic work.

Performance Measurement

Performance measurement, which includes the ability to adjust practices when targets are not reached, is a second critical strategic lever for developing and maintaining a high-performing health system. This is true at the levels of both population health and professional activity. An example of the latter is the Quality and Outcomes Framework used by the United Kingdom's (UK's) health system and the British Medical Association to measure and pay physicians for the work they do (Department of Health 2004). Under this system, physicians are awarded points for achieving clinical and operational targets and are then remunerated for the points accumulated. These measurements help to orient the model of managed care in the UK and to maintain a certain uniformity of practice.

In addition to clinical performance measurements, there are the administrative measurements designed to ensure, for example, timely access, appropriate surgical wait times and emergency room efficiency. These measurements allow for better allocation of resources to services that require more support. Likewise, quality measurements – at both the clinical and administrative levels

– must also become part of an organization’s culture. Such measurements, which include patient satisfaction, are critical for ensuring standards are met and that feedback information can be integrated into reform initiatives.

The Montreal agency signs performance contracts with its regional HSSCs. These contracts are monitored throughout the year to ensure compliance.

Primary Care

Montreal has over 2,000 general practitioners (GPs) operating out of 400 private offices. As increasing numbers of walk-in clinics appeared, many physicians decided to work one or more shifts in these clin-

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ics, which provide little or no follow-up care to the patients they see. As a result, many Montrealers report they do not have a family physician; indeed, it is almost impossible today to find a GP willing to accept new patients. Compounding this problem, GPs’ difficulty accessing timely diagnostic services for their patients or obtaining specialist consultations for them has also led to high degrees of dissatisfaction among both patients and physicians.

In a comparison with Kaiser Permanente, Montreal was found to have twice the number of emergency room visits per capita. To correct this situation and provide the medical support and coverage needed to manage Montrealers’

healthcare needs, a new primary care model was proposed. The Quebec government offered financial incentives to physicians who were willing to create new family medicine groups (FMGs), new organizational forms that exemplify the government’s integrative approach to health services. FMGs register 1,500 patients per full-time equivalent (FTE) physician (between 8 and 12 physicians belong to each one). FMG physicians commit to providing a full array of medical case management services to clients who have chosen to register with them. Services are provided with or without an appointment, seven days a week. FMGs also include extended nursing services totalling 70 hours of availability a week (Émond et al. 2005).

In Montreal, network clinics were also supported by the Montreal agency, which provided financial support to physicians who formed FMGs, agreed to provide services seven days a week and offered as many hours of services for patients with appointments as for those without (Agence de Santé de Montréal 2006).

To date, 33 new FMGs have been established in Montreal, and it is now necessary to move to the next stage in the development of primary care. This involves creating primary care multidisciplinary teams – or integrated network clinics – that will be capable of registering 2,000 patients per FTE physician and ensuring availability of a team of professionals and support staff to manage each patient’s healthcare needs (Jodoin 2007). Within 10 years, it is anticipated that Montreal will have developed 60 such multidisciplinary teams, each covering the healthcare needs of 30,000 people. These teams will sign funding contracts with their local HSSCs. The contracts will also encompass guaranteed access to diagnostic services, specialist consultation, subacute care and rehabilitation services, access to home care and treatments

Figure 2. The programs through which funding is provided

Program Types	Programs
Population programs	Public health
Service programs	General (clinical and assistance) and front-line medical services
Programs designed to address specific problems	<ul style="list-style-type: none"> • Loss of autonomy due to aging • Physical impairment • Intellectual impairment and pervasive developmental disorders • Troubled youth • Addiction • Mental health • Physical health
Support programs	<ul style="list-style-type: none"> • Administration and support for services • Building and equipment management

required by patients that the teams themselves are unable to provide.

Management Contracts

One of the most important elements of healthcare reform in Quebec has been the introduction of management contracts (i.e., accountability agreements) between the health ministry and the province’s regional agencies and the contracts signed between each agency and the organizations providing services in their jurisdictions. This contractualization has legitimized the regional agencies’ authority and has defined the management responsibilities of the partner organizations in terms of clear objectives. Indeed, these mandatory agency–organization contracts, which enable the regional agencies to honour their own management contracts with the provincial government, are the most important health system management tools in Quebec.

Contracts provide a formal method to monitor development on an annual basis and to measure the performance of regional services. In addition, they serve as an agreed-upon checklist of objectives, and it is hoped they eventually will include population-health outcomes. Contracts also provide a more uniform and equitable way for regional authorities to manage provider organiza-

tions, and they can be used to track production levels as well as the extent to which new orientations and policies are implemented.

Contracts can also be used as platforms for discussion between a regional agency and the organizations providing services to it. A contract allows each organization to identify the projects and programs that an agency agrees to support, while allowing an agency to define performance measures.

To succeed, Quebec’s health system reformation – including the development of population-based responsibility – requires a shared and sustained effort. Management contracts, for example, must be regarded as genuinely two-party agreements that benefit both sides. Equal partners make the best agreements and, while the situation does not allow for absolute equality, the contract negotiation process must attempt to provide all opportunities possible for objective exchange and discussion.

Conditions for Success

Equity Funding

Ensuring equitable resource allocation or equity funding requires a population-based funding formula. Each of Quebec’s 17 regions is evaluated using population-based criteria to determine its particular health needs. Funding

is provided through 11 programs (Figure 2) and resource allocation is determined according to each region's population; the services provided to people from outside a region are also considered. Data include socio-economic statistics and historical consumption patterns.

The provincial government's introduction of a new funding formula in 2003 proposed a reduction in funding of \$221 million for Montreal. Other regions, mainly urban areas, likewise saw their funding decrease, while in more rural areas funding increased. In order to implement this new formula gradually, it was decided that all transfers would be made exclusively from new development money and that any regions transferring funds outside of their jurisdictions would have to achieve greater productivity in order to ensure their own development. Given that the long-term collection of population-health data is needed to guarantee equitable funding among a region's HSSCs, all parties agree that it will be a number of years before the formula will be finalized.

Purchasing Access

Access has become one of the most visible measures of a high-performing healthcare system and the one that is most talked about in the media and by government. Wait times for surgery, emergency room consultation, diagnostic tests, specialist consultation and radiation therapy are just some of the issues making the headlines. The Supreme Court of Canada recently ruled that Quebec could not prevent private insurers from offering healthcare services if public institutions were unable to provide timely care in response to medically necessary services. This ruling has led Quebec to offer wait time guarantees and to allow the private purchase of medical services if wait times are not respected.

The most important, yet often least mentioned, form of access is the ability to see a family physician. While one might wait up

to five hours to see a GP for a five-minute consultation, access to one's family physician is frequently much more limited and often requires setting an appointment months in advance. The Kaiser Permanente model ensures a scheduled visit within 48 hours and an urgent scheduled visit the same day. This is achieved through the use of a multi-disciplinary team responsible for a group of patients (although each patient has his or her own family physician on the team). Access to diagnostic services is arranged by the team through a central booking system.

In Montreal, access to family physicians is being addressed by financially supporting the development of the FMGs I discussed earlier. The number of admissions to medical schools has also been increased and new curricula based on a team approach are in development. Recently, negotiated fee-for-service formulas have included bonuses for registering patients, registering and treating vulnerable patients, taking on management tasks and spending time discussing cases with other professionals.

Access to timely surgical intervention is receiving a lot of public and government attention, and the government made new money available to reduce wait times using a two-pronged approach. The first method involved designing a wait list system that ensures such lists are appropriate and centralized. Each hospital named a person responsible for managing its wait list and contacting patients and, when the guaranteed wait time could not be met, helping patients find alternatives. The wait time management program is administered by each regional agency with the support of the hospitals' information systems. The second step involves increasing the number of surgical interventions in those areas where wait times are beyond the norm. Regional agencies are responsible for this initiative. In Montreal, we issued a request for proposals and awarded new surgical volumes

to those hospitals that offered the highest quality, lowest-cost service. We encouraged high volumes and regrouped services such as cataract surgery and hip and knee replacement into high-volume services. These endeavours have proven successful: in some cases wait times have been cut in half, while costs have dropped significantly.

Family physicians frequently complain of lack of access to diagnostic services, a problem that is frustrating for patients as well. Important investments have recently been made in increasing the system's capacity, especially for MRI and CT scans; however,

In an effort to create more efficient, easily accessible, and comfortable healthcare environments, Quebec passed a new law that would allow the creation of private affiliated medical centres

there are many other areas, such as ultrasound, that are not easily accessible. Establishing a strong link between GPs and access to diagnostic services is key to successful healthcare management. As FMGs are established, they are linked to diagnostic centres that must ensure services in a timely manner.

In an effort to create more efficient, easily accessible, and comfortable healthcare environments, Quebec passed a new law that would allow the creation of private affiliated medical centres (Government of Quebec 2006). These are affiliated with hospitals in which the medical centres' physicians are members of the hospitals' medical advisory councils. Each centre will be permitted to

provide services that, under the Canada Health Act, are not allowed outside the organized care system. These private centres will not be allowed to charge patients for interventions but must negotiate a volume of activity from their local HSSCs. Each centre will need to be accredited by its regional agency and its affiliated hospital(s) will be responsible for quality of care.

Conclusion – The Key Ingredients of Success

I have attempted to illuminate some of the levers that the Quebec government and the Montreal Health and Social Service Agency are using to develop a high-performing healthcare system. The reform process began with a system-wide set of changes that reorganized services on a population basis. This step was followed by an integration of services aimed at providing more efficient care delivery. Last, steps were taken to focus on the health and well-being of individuals and communities by giving specific mandates to HSSCs across the province.

The success of these reforms depends upon physicians and other healthcare professionals making a significant cultural shift. It also requires strong health system leadership to promote the vision of this widespread transformation and to guide its implementation.

References

- Agence de Santé de Montréal. 2006. *Cadre de Référence pour l'Implantation des Cliniques-Réseaux*. Retrieved February 28, 2007. <http://www.santemontreal.qc.ca/pdf/cma_cadre.pdf>
- British Medical Association. 2006. *Revision to the GMS Contract 2006/2007: Delivering Investment in General Practice*. London: NHS Employers.
- Commonwealth Fund. 2006. "The Puget Sound Health Alliance: Bringing Together Purchasers, Payers, Providers, and Consumers to Change the System." *States in Action: A Quarterly Look at Innovations in Health Policy*. New York: Author. Retrieved February 28, 2007. <<http://www.cmwf>>

- org/publications/publications_show.htm?doc_id=410531#puget>
- Davis, K. 2006. "President's Message: The Best Health System in the World." *2006 Annual Report of The Commonwealth Fund*. New York: The Commonwealth Fund. Retrieved February 28, 2007. <http://www.cmwf.org/usr_doc/Pres_Message_2006_FINAL_small_file.pdf>
- Davis, K. 2007. "Models for Achieving the Best Health System in the World." Retrieved February 28, 2007. <http://www.cmwf.org/aboutus/aboutus_show.htm?doc_id=444193>
- Department of Health. 2004. *Quality and Outcomes Framework*. London: Author. Retrieved February 28, 2007. <<http://www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf>>
- Deuxième Colloque sur le Modèle Montréalais de Prise en Charge de la Population. November 30–December 1, 2006. Retrieved February 28, 2007. <<http://www.santemontreal.qc.ca/fr/documentation/colloque.html>>
- Émond, J.-G., J. Pettigrew, C. Côté, J. Lalancette, D.L. Sasseville, A. Mageau, A. Munger, C. Plourde and L. Racette. 2005. *Devenir un GMF: Guide d'Accompagnement*. Rev. ed. Quebec: Ministère de la Santé et de Services Sociaux.
- Government of Quebec. 2006. *Projet de Loi no 33: Loi Modifiant la Loi sur les Services de Santé et les Services Sociaux et d'Autres Dispositions Législatives*. Quebec: Éditeur Officiel du Québec. Retrieved February 28, 2007. <<http://www2.publications-duquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2006C43F.PDF>>
- Jha, A.K., J.B. Perlin, K.W. Kizer and R.A. Dudley. 2003. "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care." *New England Journal of Medicine* 348(22): 2218–27.
- Jodoin, Y. 2007. *Cadre de Référence de la Clinique Réseau Intégrée et Relatif au Modèle Montréalais de Prise en Charge – Document de Travail*. Montreal: Agence de Santé de Montréal.
- Kaiser Permanente. November 28, 2005. Papers presented at the conference La Prise en Charge de la Population: Quel Modèle pour Montréal? In *Les Actes: La Prise en Charge de la Population: Quel Modèle pour Montréal? Journée de Réflexion sur la Prise en Charge de la Population Montréalaise, 28 novembre 2005*. Retrieved February 28, 2007. <<http://www.bibliotheque.assnat.qc.ca/01/mono/2006/04/900545.pdf>>
- Levine, D. 2005. "A Healthcare Revolution: Quebec's New Model of Healthcare." *Healthcare Quarterly* 8(4): 38–46.
- Ministère de la santé et des services sociaux. 2004. *L'Intégration des Services de Santé et des Sociaux: Le Projet Organisationnel et Clinique et les Balises Associées à la Mise en Oeuvre des Réseaux Locaux des Services de Santé et de Services Sociaux*. Quebec: Author.
- National Health Service. "Primary Care Trusts." Retrieved February 28, 2007. <<http://www.nhs.uk/England/AuthoritiesTrusts/Pct/Default.aspx>>
- Petzel, D. October 5, 2006. "Health System Transformation." Paper presented at the GRÉAS conference, Montreal. Retrieved February 28, 2007. <<http://www.greas.ca/publication/pdf/robertpetzel.pdf>>
- Puget Sound Center. Retrieved February 28, 2007. <<http://www.pugetsoundcenter.org>>
- Puget Sound Health Alliance. Retrieved February 28, 2007. <<http://www.pugetsoundhealthalliance.org/index.html>>
- Roland, M., R. McDonald and B. Sibbald. 2005. *Outpatient Services and Primary Care: A Scooping Review of Research into Strategies for Improving Outpatient Effectiveness and Efficiency*. Manchester: National Primary Care Research and Development Centre and Centre for Public Policy and Management of the University of Manchester.
- Trépannier, J. 2006. *Cadre de Référence: Mise en place des Équipes de Santé Mentale de 1re Ligne dans les CSSS – Plan de Mise en Oeuvre à Montréal, Phase 1*. Montreal: Agence de Santé de Montréal. Retrieved February 28, 2007. <<http://www.santemontreal.qc.ca/fr/documentation/nouveaute.asp>>
- Wagner, E.H. 1995. "Population-Based Management of Diabetes Care." *Patient Education and Counseling*. 26(1–3): 225–30.
- Wagner, E.H. 1998. "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" *Effective Clinical Practice* 1(1): 2–4.
- Wagner, E.H., B.T. Austin and M. Von Korff. 1996a. "Improving Outcomes in Chronic Illness." *Managed Care Quarterly* 4(2): 12–25.
- Wagner, E.H., B.T. Austin and M. Von Korff. 1996b. "Organizing Care for Patients with Chronic Illness." *Milbank Quarterly* 74(4): 511–44.
- Wagner, E.H., C. Davis, J. Schaefer, M. Von Korff and B. Austin. 1999. "A Survey of Leading Chronic Disease Management Programs: Are They Consistent with the Literature?" *Managed Care Quarterly* 7(3): 56–66.