Budget **2010 11**

FOR A MORE EFFICIENT AND BETTER FUNDED HEALTH-CARE SYSTEM

Finances Québec

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2010-2011 Budget
For a More Efficient and Better Funded Health-Care System

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INTRODUCTION

Over the past 40 years, Quebecers have developed one of the best health-care systems in the world. They are deeply attached to it and want to see it preserved.

— With public and private spending totalling $38.1 billion in 2009, health care represents the most important sector of our economy, accounting for more than 12% Québec's gross domestic product.

— What is more, some 6 million persons, or nearly 80% of the population, receive health care in the course of a year.

The government has made health care its highest priority. This is borne out by the fact that an additional $10 billion has been allocated to the public health-care system since 2003, more than the additional amounts allocated for all of the government's other missions.

This strong growth in public funding makes for better access to health care and improves the quality of services, but it also exerts strong pressure on the government's other missions.

— Accounting for 31% of program spending in 1980, health-care spending now amounts to 45%, or $28 billion in 2010-2011.

— If nothing is done to alter this trend, health-care spending could account for two thirds of program spending within twenty years, at a time when we will be facing unprecedented growth in demand for health care due to demographic changes.

Concerned by this question, several stakeholders in civil society have focused their attention on the challenge of funding health-care services in Québec.

— The current budgetary context and the more long-term outlook compel us to re-examine the initiatives stemming from their efforts as we seek to introduce new sources of revenue and innovative financing formulas in the health-care sector.

In this Budget, the government is therefore opting to ensure funding for our public health-care system and act in a structuring manner to improve performance, thereby confirming its determination to take the necessary steps in that regard.

As regards performance, the available resources must enable us to do more, but especially, to ensure funding for the right service at the right place.

— In this area, the government is counting on improvement of key processes, more effective governance and structures, as well as better performance in the organization of services and information technologies.

As regards funding, new and innovative contributions must be found to ensure durable funding, while also maintaining the government's other missions.

— A health contribution will be progressively introduced beginning July 1, 2010. It will be limited to $25 per adult in 2010, and then progressively increased to $200 in 2012.

— In the coming months, the government will work with its partners to study the results in other jurisdictions that have successfully implemented a health deductible. In that respect, the *Canada Health Act* should not impede the search for solutions that will ensure long-term funding for our health-care system.

Moreover, this Budget marks a pivotal step toward better information and greater transparency in respect of the health-care system. For the first time, the government is making the health accounts public. These accounts are a tool that can be used to assess the health-care system's performance and make more enlightened choices concerning ways to maintain an adequate level of funding.

1. FUNDING QUÉBEC'S HEALTH-CARE SYSTEM: A TIME FOR A DECISION

Over the past 40 years, Quebecers have progressively built what is today considered one of the best health-care systems in the world.

We are all deeply attached to it, and preserving it is a vital concern. This is why the government, which has long made health care its highest priority, devotes considerable resources each year to:

- continually improve the overall health of Quebecers;
- ensure that each citizen has access to the best possible services under the best possible conditions.

1.1 Health-care services Quebecers depend on

In Québec, some 6 million people, or nearly 80% of the population, receive health-care services in the course of a year.

- There were more than 46 million visits to a doctor, 3.8 million visits to emergency rooms, 5.3 million medical consultations in institutions and 476 972 surgeries, including 296 869 out-patient surgeries, in 2008-2009.

These simple statistics amply illustrate the extent of the resources—human, financial and material—that must be mobilized to keep our health-care system operating.

❑ Resources demonstrating this commitment

The health-care sector employs more than 400 000 people. Of this number, approximately 276 000 were employed in the public system in 2008. At that time, they represented nearly 7% of Québec's labour force.

The sums invested in health care by and for Quebecers totalled $38.1 billion in 2009. Of this amount, $27.2 billion came from public funding, while the remainder, $10.9 billion, was provided by the private sector.

- Accounting for more than 12% of our gross domestic product (GDP), health care is the largest sector of our economy.

Public health-care spending primarily consists of transfers to health-care institutions, payments for medical services, special program funding and drug costs. However, it also includes spending on social programs, such as youth and adult psychosocial services, services for seniors losing their autonomy (extended care) and home support services.

Private health-care spending is attributable, in large part, to dental care and eye care not covered by health insurance, drugs consumed outside health-care institutions, contributions by individuals in residential and extended care facilities, ambulance services and certain services offered in private clinics.

TABLE 1

Total health-care spending in Québec in 2009P

	($M)	(%)
Public health-care spending[1]		
Hospitals	9 597	25.2
Other institutions	3 950	10.4
Physicians	4 553	11.9
Other professionals	315	0.8
Drugs	3 359	8.8
Capital expenditures[2]	1 736	4.6
Public health[3]	1 448	3.8
Administration	559	1.5
Other health-care spending	1 678	4.4
Subtotal – public sector expenditure	**27 195**	**71.4**
Private health-care spending	**10 908**	**28.6**
TOTAL SPENDING	**38 103**	**100.0**

P: Projections.
1 The projections of the Canadian Institute for Health Information exclude the social services sector and cover the calendar year, whereas the government's fiscal year runs from April 1 of one year to March 31 of the following year. This explains the differences between public sector health-care spending according to the Institute and according to the ministère de la Santé et des Services sociaux.
2 Capital expenditures are based on the full cost accounting method or the cash accounting method.
3 This item includes, among other things, health inspections, health promotion activities and community mental health programs.
Source: Canadian Institute for Health Information.

The Québec health-care system: key dates	
1960	Adoption of the *Hospital Insurance Act*, which rendered hospital care free of charge in Québec beginning January 1, 1961.
1971	Adoption of the *Act respecting health services and social services*, with the objective of creating the health-care system and the health insurance plan, the latter of which established the principle of universal access to health care and social services.
1984	Assent to the *Canada Health Act*, which fixed the conditions that provinces and territories must comply with in order to be eligible for the Canada Health Transfer.
1992	Regionalization of the system through the establishment of regional health and social services boards charged with the mission of organizing the services in their territories and allocating budgets to the institutions.
1997	Establishment of the basic prescription drug insurance plan, a mixed universal plan based on a partnership between the government and private insurers.
2003	Adoption of the *Act respecting local health and social services network development agencies*. This Act entrusts the agencies with responsibility for implementing a new mode of organizing services in each region based on local services networks.
2004	Introduction of local health services and social services networks, with the objective of better coordinating services so as to render them more accessible.
2005	Adoption of the *Act respecting the Health and Welfare Commissioner*, with the objective of improving access to services for citizens.
2006	In response to the decision of the Supreme Court in the Chaoulli-Zeliotis case, implementation of a public access mechanism for certain medical procedures, together with limited access to private insurance coverage for three surgeries: hip replacement, knee replacement and cataract surgery.
2009	Tabling before the National Assembly of Bill 67 creating the Institut national d'excellence en santé et services sociaux, in line with the government's determination to improve the performance of the public health-care system.

1.2 A priority mission for the government

In Québec, health-care spending is the largest expenditure item for the government. With a budget of $28 billion in 2010-2011, the ministère de la Santé et des Services sociaux accounts for nearly 45% of program spending.

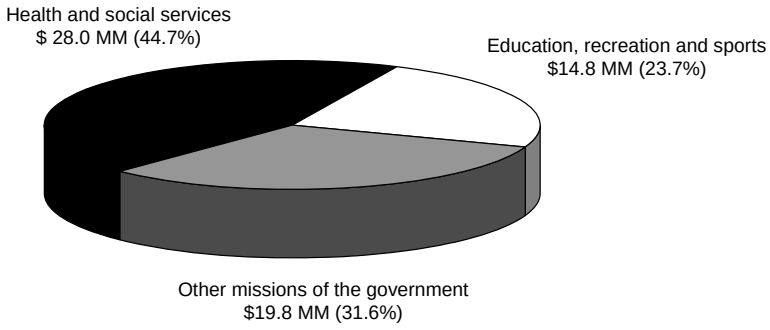
— By comparison, spending on education at $14.8 billion is the second largest expenditure item for the government.

As for remuneration, $18.9 billion is allocated to the ministère de la Santé et des Services sociaux in 2010-2011.

— Of that amount, $16.7 billion will be paid in salaries to health-care professionals and other personnel working in health and social services institutions.

CHART 1

Program spending in 2010-2011: $62.6 billion[P]
(billions of dollars and percent)



P: Projections.
Source: Secrétariat du Conseil du trésor, *2010-2011 Expenditure Budget.*

❑ Funding based primarily on general taxation

Primarily because its funding system is largely based on general taxation, Québec's health-care system is essentially built on a principle socialization of health-related risks.

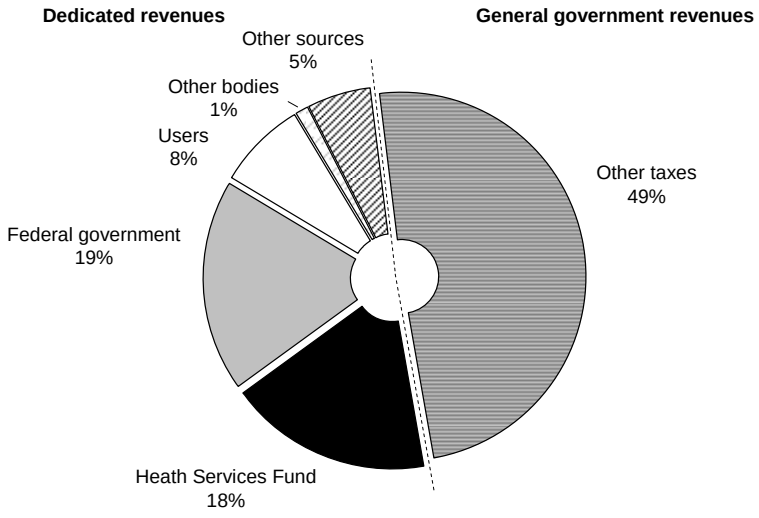
Thus, in 2010-2011, nearly one half of the funding for health-care spending, that is, 49%, comes from the government's general revenues.[1] These expenditures are paid out of the Consolidated Revenue Fund.

As regards sources of funding specifically dedicated to health, only 8% comes directly from user contributions, primarily in the form of fee-based services.

— The greater part comes from contributions from the Health Services Fund (18%) and the contribution from the federal government (19%).

CHART 2

Sources of funding for health and social services, 2010-2011P
(percent)



P: Projections.

1 See the box "Total spending for health and social services and sources of funding" in this document, p. 14.

❑ A sustained government effort since 2003-2004

Even though Québec is one of the provinces exercising the strictest control over health-care spending, it is rising faster than other governmental spending.

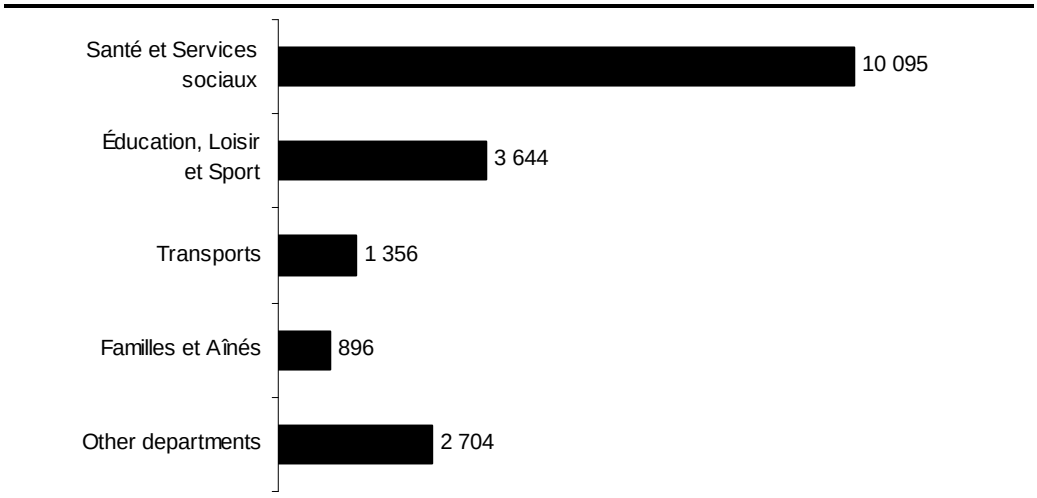
— From 2003-2004 to 2010-2011, health-care spending grew at an annual rate of 5.8%.

— This is much higher than for other government spending, which grew at an annual rate of 3.6% during the same period.

Thus, 54% of the total increase in the government's program spending has gone toward public funding of Québec's health-care system since 2003-2004, that is, more the $10 billion out of some $19 billion that has been added for all program spending.

CHART 3

Breakdown of the increase in program spending, 2003-2004 to 2010-2011P
(millions of dollars)



P: Preliminary results for 2009-2010 and projections for 2010-2011.
Source: Secrétariat du Conseil du trésor, *2010-2011 Expenditure Budget*.

1.3 Strong pressure on the government's other missions

This situation is nothing new, since as far back as 1980, the growth in health-care spending exceeded that for all of the government's other missions. Between 1980 and 2010, health care's share of program spending grew from 31% to 45%.

— The substantial investments in recent years in the health-care sector were made possible by disciplined spending management in the government's other missions.

— Moreover, balancing these elements was made possible by the favourable economic context at that time.

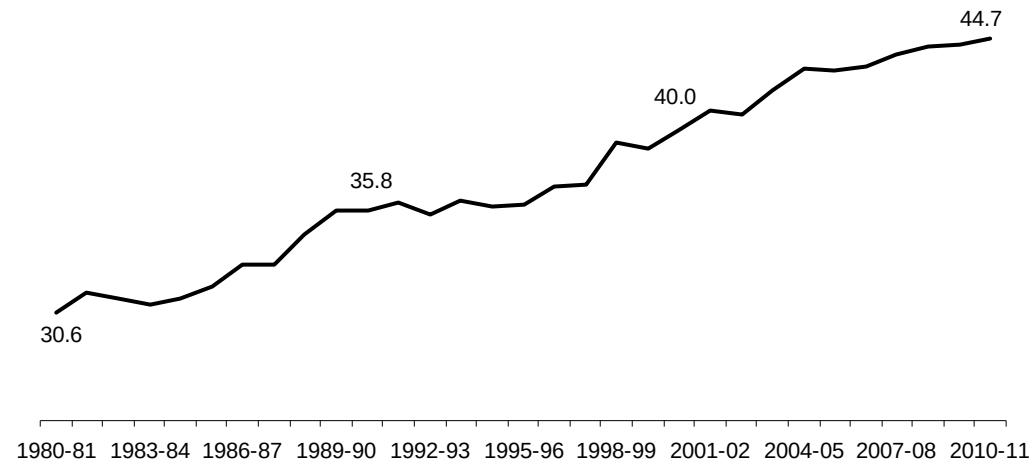
However, all indications are that the upward pressure exerted by health-care spending on the government's program spending will continue in the coming years.

If nothing is done to alter this trend, health-care spending could total nearly two thirds of program spending by 2030, when we will be facing unprecedented growth in demand for health care due to demographic changes

— In other words, for each dollar invested in public services, $0.67 would be devoted to health-care spending.

CHART 4

Health-care spending's share of program spending, 1980-1981 to 2010-2011P
(percent)



P: Preliminary results for 2009-2010 and projections for 2010-2011.
Source: Secrétariat du Conseil du trésor, expenditure budgets.

1.4 A status quo that is becoming impossible to maintain in the present context

In contrast to other government missions, health-care spending is subject to pressures that are unique. In addition to higher costs due to the rising cost of living, there are two major factors behind the steep rise in health-care spending:

— technological advancements, which help to improve the quality of services, but generate ever higher costs;

— demographic trends toward a growing and aging population, with an increasing impact on the demand for services and the types of services required.

The health-care system must therefore cope with a strong demand for new and ever more costly technologies, as well as constantly increasing needs, particularly for residential services and home care.

Thus, the current budgetary context and the expected changes in Québec's demographic composition make it even more difficult to maintain the status quo in public funding of health-care spending.

— This is why steps must be taken to ensure funding for health care, while also maintaining the government's other missions.

❑ Ongoing progress in medical and surgical practices, new technologies and drugs

While the introduction of new medical and surgical practices makes it possible to reduce the duration of certain procedures, the wider range of possible diagnoses opens the door to new clienteles and new treatments which, just a few years ago, were inaccessible.

Furthermore, improvements in technologies help to reduce the cost of certain treatments. On the other hand, increased productivity resulting from the use of new technologies makes it possible to treat more patients and to treat diseases that were once incurable.

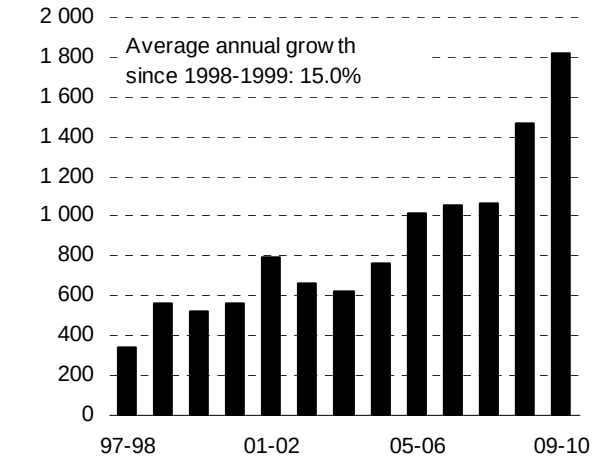
— Between 1998-1999 and 2009-2010, government-funded investments in infrastructures and equipment in the health-care network grew at a sustained annual rate of 15% on average.

Drugs and medical supplies are the fastest growing item in health-care spending, due to the ever rising cost of new drugs and the sharp increase in their consumption.

— Costs under the public prescription drug insurance plan grew at 10.7% annually between 1998-1999 and 2009-2010, a rate that will require considerable funding over the long term.

CHART 5

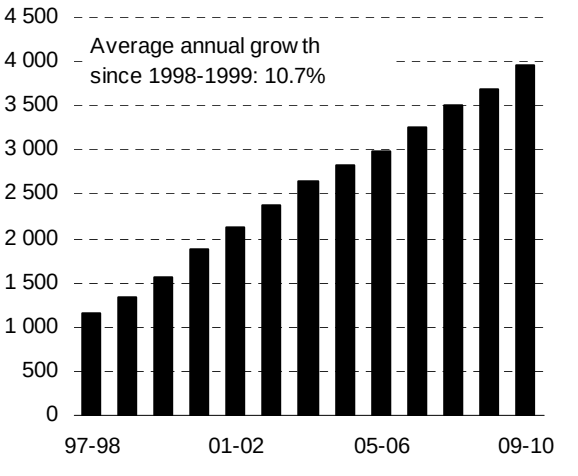
Investments in health-care infrastructures and equipment[P]
(millions of dollars)



P: Preliminary results for 2008-2009 and 2009-2010.
Source: Secrétariat du Conseil du trésor.

CHART 6

Total costs under the Québec public prescription drug insurance plan[P]
(millions of dollars)



P: Preliminary results for 2009-2010.
Source: Ministère de la Santé et des Services sociaux.

❑ The impact of demographic changes on health-care funding

In coming years, the expected aging of the population will exert even greater extra pressure on health-care spending, due to the sharp increase in the number of seniors.

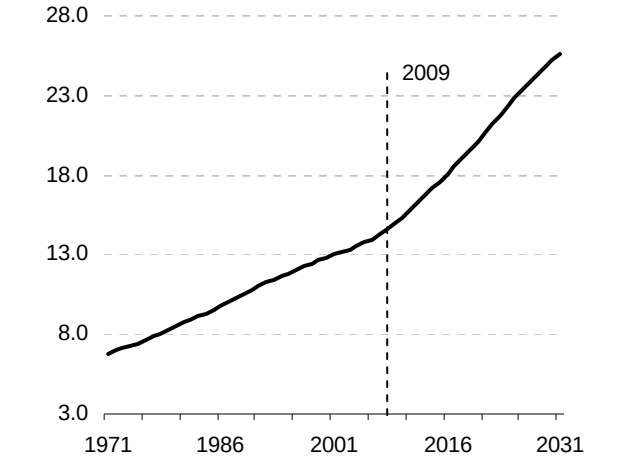
— The percentage of individuals age 65 and over should increase very rapidly, from 15.4% in 2010 to 25.6% in 2031. Health-care spending for seniors is considerably higher than for the rest of the population. In 2007, the average cost per person per year was $10 094 for those age 65 and over, compared to $1 633 per person for those under 65.[2]

Furthermore, the dwindling pool of potential workers beginning in 2014 will reduce the government's ability to fund the health-care system, a trend just the opposite of what will be observed in Ontario and the United States. Between 2010 and 2030, the labour pool in Québec will contract by 3.3%, whereas it will grow by 10.0% in the United States and 12.3% in Ontario.

— As a result, the number of workers in Québec for each person age 65 and over will fall from 4.5 in 2010 to 3.7 in 2016, compared to 9.4 in 1971. The shrinking of the working-age population will lead to reduction in the economic growth on which the government's revenues and its ability to fund public services depend.

CHART 7

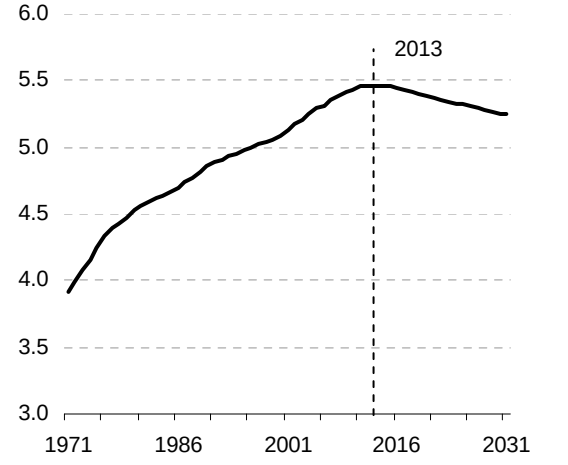
Percentage of the population 65 and over
(percent of total population)



Source: Institut de la statistique du Québec (2009).

CHART 8

Potential labour pool
(population age 15 to 64, millions of people)



Source: Institut de la statistique du Québec (2009).

[2] Canadian Institute for Health Information and Institut de la statistique du Québec.

❑ Growing costs that exceed our collective wealth

Not only does health-care spending exert strong pressure on the government's other mission, but it is growing faster than our collective wealth, a trend that is unsustainable in the long term.

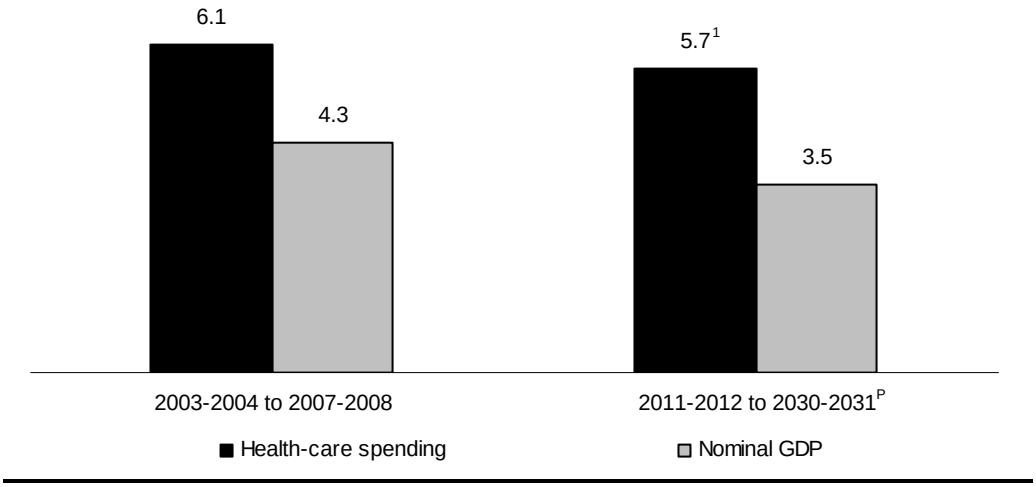
— Between 2003-2004 and 2007-2008, before the Québec economy was hit by the recession, annual growth in health-care expenses averaged 6.1%, whereas the economy grew at 4.3%.

The projected average annual growth in the economy for the next twenty years is 3.5%, and efforts will have to be made to restore balance in public finances. It is clear that the past rate of growth in health-care spending cannot be maintained without an improvement in the network's performance and identification of measures to ensure its funding.

— The government has no choice but to take the necessary steps to ensure durable funding for the health-care system, as well as to maintain sound public finances.

CHART 9

Growth in health-care spending and the economy
(average annual growth in percent)



P: Projections.
1 Projected growth in health-care spending based on the average estimate of the Task Force on the Funding of the Health System (the Castonguay Report, 2008).

1.5 Choosing to act now

Given the ever widening gap between government revenues and rising health-care costs, there is no way to maintain sound public finances and reduce the debt burden without tackling the far-reaching challenge of funding our public health-care system.

— We must ensure funding for our health-care system and the government's other missions, and do so with a view to durably restoring budget balance by 2013-2014.

❑ Relying on a balanced and innovative approach

The government is relying on a balanced and innovative approach in the measures to be chosen in order to ensure adequate funding for the health-care system, while also maintaining sound public finances over the long term.

Thus, until budget balance is restored by 2013-2014, the government has chosen to:

— reduce to 5% the annual growth in funding for total health-care spending, while also maintaining the government's other missions;

— implement, as of 2010-2011, new and innovative sources of funding to achieve this objective, subject to the taxpayers' ability to pay.

In that respect, the government is announcing the creation of a fund for financing health-care institutions.

Over the longer term, the government intends to protect the quality and the accessibility of health-care services by seeking to strike a balance between funding for rising health-care costs and the growth of our collective wealth.

TABLE 2

Total spending for health care[1] and sources of funding, 2009-2010 to 2013-2014[P]

(millions of dollars and percent)

	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Total spending for health and social services					
Program spending	– 26 980	– 27 967	– 28 985	– 30 034	– 31 121
% change	*5.3*	*3.7*	*3.6*	*3.6*	*3.6*
Other health-care spending	– 4 523	– 4 976	– 5 612	– 6 285	– 6 998
% change	*5.0*	*10.0*	*12.8*	*12.0*	*11.3*
Total, health and social services spending	**– 31 503**	**– 32 943**	**– 34 597**	**– 36 319**	**– 38 119**
% change	***5.3***	***4.6[2]***	***5.0***	***5.0***	***5.0***
Sources of funding					
Other taxes from the Consolidated Revenue Fund[3]	15 677	16 277	16 972	17 550	18 171
Sources of funding dedicated to health care	15 826	16 486	17 050	17 774	18 503
New contributions required to fund health-care institutions and maintain the growth in health-care spending at 5%	—	180	575	995	1 445
Total sources of funding	**31 503**	**32 943**	**34 597**	**36 319**	**38 119**
% change	***5.3***	***4.6[2]***	***5.0***	***5.0***	***5.0***

P: Preliminary results for 2009-2010 and projections for subsequent years.
1 Total spending of the ministère de la Santé et des Services sociaux and health and social services institutions.
2 Total health-care spending for the 2009-2010 fiscal year includes an exceptional amount of $126 million attributable to the costs of the A (H1N1) flu pandemic. When this amount is excluded, growth in health-care spending for 2010-2011 is 5%.
3 For the purposes of the health accounts, the deficits of the establishments in the health and social services network are covered by the other taxes from the Consolidate Revenue Fund.

Total spending for health and social services and sources of funding

Total spending for health[1] and social services and sources of funding – 2007-2008 to 2013-2014

(millions of dollars)

	Actual data		Preliminary data	Projections			
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
TOTAL HEALTH AND SOCIAL SERVICES SPENDING							
Program spending funded by the Consolidated Revenue Fund	– 24 054	– 25 622	– 26 980	– 27 967	– 28 985	– 30 034	– 31 121
% change		*6.5*	*5.3*	*3.7*	*3.6*	*3.6*	*3.6*
Spending by users and others							
– Current spending	– 4 169	– 4 307	– 4 523	– 4 796	– 5 037	– 5 290	– 5 553
% change		*3.3*	*5.0*	*6.0*	*5.0*	*5.0*	*5.0*
– Impact of the health contribution	—	—	—	– 180	– 575	– 945	– 945
– Other contributions to be identified	—	—	—	—	—	– 50	– 500
	– 4 169	– 4 307	– 4 523	– 4 976	– 5 612	– 6 285	– 6 998
% change		*3.3*	*5.0*	*10.0*	*12.8*	*12.0*	*11.3*
Total health-care spending	**– 28 223**	**– 29 929**	**– 31 503**	**– 32 943**	**– 34 597**	**– 36 319**	**– 38 119**
% change		***6.0***	***5.3***	***4.6[2]***	***5.0***	***5.0***	***5.0***
SOURCES OF FUNDING							
1. Dedicated government revenues							
Health Services Fund	5 404	5 631	5 647	5 843	6 022	6 266	6 497
Contributions from the federal government							
– Health transfers	3 925	3 740	4 148	4 264	4 504	4 791	5 098
– Notional portion of the special Québec abatement related to the Canada Health Transfer	1 714	1 916	1 726	1 887	1 966	2 042	2 112
– Others	83	83	83	83	—	—	—
Subtotal	**11 126**	**11 370**	**11 604**	**12 077**	**12 492**	**13 099**	**13 707**
% change		***2.2***	***2.1***	***4.1***	***3.4***	***4.9***	***4.6***
2. User fees							
Contributions from users	2 308	2 438	2 509	2 602	2 690	2 760	2 832
Contributions from other bodies	303	329	339	377	389	398	408
Own-source revenues from other sources	1 468	1 335	1 374	1 430	1 479	1 517	1 556
Subtotal	**4 079**	**4 102**	**4 222**	**4 409**	**4 558**	**4 675**	**4 796**
% change		***0.6***	**2.9**	***4.4***	***3.4***	***2.6***	***2.6***
3. Other taxes from the Consolidated Revenue Fund[3]	**13 018**	**14 457**	**15 677**	**16 277**	**16 972**	**17 550**	**18 171**
% change		***11.1***	***8.4***	***3.8***	***4.3***	***3.4***	***3.5***
4. Fund for financing health-care institutions							
Introduction of a health contribution on July 1, 2010	**—**	**—**	**—**	**180**	**575**	**945**	**945**
Other contributions to be identified	**—**	**—**	**—**	**—**	**—**	**50**	**500**
Total sources of funding	**28 223**	**29 929**	**31 503**	**32 943**	**34 597**	**36 319**	**38 119**
% change		***6.0***	***5.3***	***4.6[2]***	***5.0***	***5.0***	***5.0***

1 Total spending of the ministère de la Santé et des Services sociaux and health and social services institutions.
2 Total health-care spending for the 2009-2010 fiscal year includes an exceptional amount of $126 million attributable to the costs of the A (H1N1) flu pandemic. When this amount is excluded, growth in health-care spending for 2010-2011 is 5%.
3 For the purposes of the health accounts, the deficits of the establishments in the health and social services network are covered by the other taxes from the Consolidate Revenue Fund.

2. ENCOURAGING BETTER PERFORMANCE BY THE HEALTH-CARE SYSTEM

Over the coming years, substantial efforts will be required to preserve the values underlying our health-care system.

— We have to accept that the investments we will be able to devote to our health-care system must be compatible with our ability to create wealth.

Thus, the injection of additional resources in our health-care system, while necessary, cannot in itself guarantee maintenance of the quality and accessibility of our health-care services over the long term.

The choice of services, methods of allocating resources to institutions, remuneration of personnel and streamlining of rules and structures are the keys to better management of our health-care system.

To improve the health-care system's performance, the ministère de la Santé et des Services sociaux will focus its efforts on three areas of intervention:

— a global approach to optimization of key processes that will be applied in each institution;

— rationalizing technological and computer infrastructures and implementing promising new technologies. The implementation of the e-health file will be accelerated;

— a review of governance in the network, particularly the links between the ministère de la Santé et des Services sociaux, the health-care agencies and the institutions, with a view to improving efficiency.

In the coming months, the Minister of Health and Social Services will provide more information on the implementation of these elements.

Our public health-care system's performance: shortcomings that have been noted repeatedly

Just as with the issues of health-care funding, concerns have been repeatedly raised in the past about our health-care system's performance.

Advisory Committee on the Economy and Public Finances (pre-budget consultations – 2009-2010):

"*The introduction of approaches that take into account the characteristics of the population reduces iniquities between institutions and regions. However, with a few rare exceptions, these approaches offer no incentive to bolster the institutions' performance.*"

Task Force on the Funding of the Health System (Castonguay Report – 2008):

"… Québec citizens do not have easy access to their health-care system's services. It is also found that, in terms of productivity, the Québec health-care system is positioned poorly in relation to what is observed in several other jurisdictions."

Comité de travail sur la pérennité du système de santé et de services sociaux au Québec (Ménard Report – 2005):

"Labour shortages and increasing needs on the part of the population have made a situation that was already difficult even worse. Despite the progress made, major problems persist: overcrowding in emergency rooms, as well as lengthy and growing waiting lists for surgery and cancer treatment."

Commission d'étude sur les services de santé et les services sociaux (Clair Commission – 2000):

"The culture of our network is based on a hierarchical, bureaucratic and compartmentalized approach whereby each new client represents a new problem. A culture of excellence needs to be developed, one that is based on results and in which objectives and the means to attain them are established through governance."

2.1 Instituting a "Lean Health Care" approach to performance

In line with efforts to maintain a strong public health-care system, improvements to performance and productivity must be encouraged through financial incentives. Such incentives have a "bandwagon" effect, encouraging imitation by means of example, without calling into question pre-existing structure.

Going beyond experimentation and pilot projects, support for performance improvement initiatives must stimulate a genuine migration toward more effective and efficient management.

— Encouraging and facilitating the exporting of such persuasive experiments creates a ripple effect which then helps to instil a veritable culture of performance in the organization of services.

To that end, a global approach to optimization of key processes (the Lean approach) will be instituted in all the institutions. The emphasis will thus be placed on revising key work processes in the institutions and identifying processes potentially capable of generating performance gains.

In that regard, a team will be set up at the ministère de la Santé et des Services sociaux in order to monitor the initiatives introduced and see to the transfer of expertise throughout the network.

Ongoing improvement as an aid to performance in England: doing more with the resources available

The Lean approach aims at ongoing improvement of processes by repeatedly applying five basic principles:

- clearly identify the product or service required by the client by putting yourself in the client's place and adopting his or her point of view;
- perfectly understand the production process so as to eliminate any unnecessary aspects or stages;
- improve the flow of production by ensuring that it remains client-oriented;
- place the client at the centre of the process, instead of the producers of goods and services;
- strive for perfection by ongoing improvement of processes.

Upon completion of this cycle, the time and money saved are reinvested in improving the quality of services.

The National Health Service of Great Britain began applying this approach several years ago.

Using this approach, Bolton Hospitals NHS Trust restructured its entire hip fracture treatment process. As a result, lead time from emergency room admission to operation was reduced by 38%.[3]

3 The National Health Service Confederation, *What is productivity?*, 2006.

2.2 Relying on better governance, more efficient structures

The incentive for better performance can also come from organizational structures and resource allocation methods that are in line with a results-based logic. If the additional sums are coherent with the objectives pursued, applying them will lead to the expected results.

Human resources are the driving force in any organization. They must be aware of their importance in the organization and be able to assess the impact they have on the health-care system's performance, whatever their duties or level of responsibility.

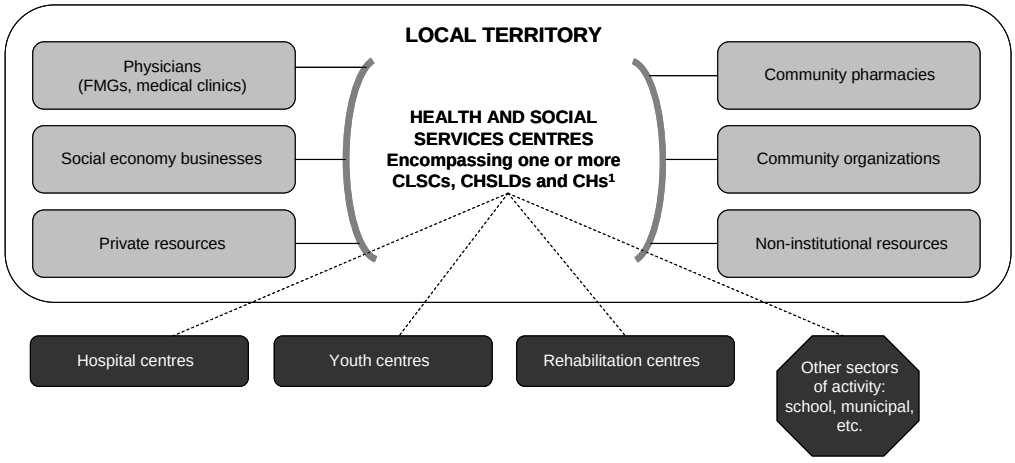
— Formulation of coordination mechanisms and consolidation of structures, if they are applied according to a results-based logic, help to maximize the contribution of organizations and leaders to improving the system's performance.

— To give managers and professionals in the system the means to exercise strong leadership, the first step is to define objectives and establish clear lines of governance.

Thus, better governance is inconceivable unless all the stakeholders are involved and collaborate toward the success of such an approach.

FIGURE 1

Organization of the health and social services network



1 It would not be possible for a health and social services centre to include a hospital centre due to the absence of such a service structure in its territory or the complexity of integrating or consolidating those services.

Source: Ministère de la Santé et des Services sociaux.

2.3 Organizing information services and technologies differently

When used judiciously, technological innovations offer exceptional possibilities for improving productivity.

- Ever more sophisticated medical equipment reduces the unit costs of treatment to a remarkable degree.
- Electronic exchange of information, in addition to improving the quality of interventions in a decentralized system, also generates considerable savings.
- Access to reliable data makes it possible to carry out research and determine best practices.

Ensuring quality and continuity in care can only be facilitated by effective technological infrastructures and modern equipment, provided the right choices are made.

In that respect, parallel measures will be taken in two separate areas related to information technologies:

- rationalizing technological and computer infrastructures;
- implementing promising new technologies.

In addition, the efforts to implement the e-health file will continue. The information to be included in it will be a great aid in guiding citizens through the health-care system. Thus, the information that health-care professionals require in order to provide care and services will be more accessible where and when it is needed.

3. A NEW FINANCIAL CONTRIBUTION FOR MAINTAINING ACCESSIBILITY

In the current context of public finances, the government is implementing an additional approach to health-care funding in order to guarantee the sustainability of our public health-care system for present and future generations.

Among the possible options for dedicating new sources of revenue to funding health care, the government is introducing a health contribution.

The sums thereby collected would be primarily invested in improving the supply of health-care services by means of a fund dedicated to that goal. Being thus made available to health-care institutions, they will guarantee:

- continuing development of front-line services;
- support for training and development in the profession of specialized nurse practitioner, as well as for the integration of that profession into the clinical setting;
- improvement of the system's performance, in particular by supporting promising projects designed for that purpose.

Management details for the fund will be spelled out at a later date.

Moreover, the government will study the advisability of introducing a health deductible in order to orient citizens in their consumption of services and ensure the funding of the health-care system.

Sweden, an example of success

Control of health-care expenses is an ongoing concern in Sweden. To tackle this problem, three initiatives have been introduced over the years, with undeniable success. The weight of health-care expenses in the Swedish economy is now less than in comparable countries in the Organization for Economic Cooperation and Development due to:

- an increase in user participation in the cost of health-care services;
- a reorientation of a hospital-based system toward a system based on primary and home care;
- a change in the health-care system's management rules involving greater reliance on managerial techniques prevailing in the competitive sector in order to raise the level of productivity in the health-care system.

Moreover, Sweden has a significant advantage when it comes to determining costs in the health-care system: its role as a leader in the use of medical data bases for the purpose of formulating codes of good practices. Some fifty "national quality files" have thus been established in areas such as heart surgery, hip prosthesis operations and strokes.

Source: Alain Vasselle and Bernard Cazeau, *Réformer la protection sociale : les leçons du modèle Suédois,* [information report produced on behalf of the Mission d'évaluation et de contrôle de la sécurité sociale and the Commission des affaires sociales, nº 377 (2006-2007)], on the website of the Sénat de France, [http://www.senat.fr/rap/r06-377/r06-3777.html].

3.1 Introduction of a health contribution beginning July 1, 2010

In the interests of upholding the principles of universality, accessibility and comprehensiveness in the public health-care system, the government must mobilize all Quebecers to address the issue of funding for quality health care that is accessible to all.

In this context, the government is announcing the introduction, beginning July 1, 2010, of a health contribution levied on individuals at the time they file their income tax return and payable in spring 2011. In 2012-2013, the health contribution will allow approximately $945 million to be allocated to the funding of health care, via a fund dedicated to health.

❑ A contribution per adult of $25 in 2010, $100 in 2011 and $200 in 2012

Unlike a tax on income or a surtax, the health contribution is a general contribution of $25 per adult in 2010,[4] $100 in 2011 and $200 in 2012.

The health contribution is a simple and effective way to provide substantial funding for the health-care institutions, but without demanding an excessive effort on the part of each taxpayer.

[4] The health contribution will be $50 in 2010. However, since it will not begin to apply until July 2010, this equals $25 for 2010.

An exemption for low-income households

Households whose family income is below the exemption thresholds provided for in the Québec public prescription drug insurance plan will be exempted from paying the health contribution. These income thresholds correspond to the income of seniors receiving the maximum guaranteed income supplement paid by the federal government.

- For example, for 2009, the income thresholds of the public prescription drug insurance plan are as follows:
  - $14 040 for a person living alone;
  - $22 750 for a couple without children or a single-parent family with one child;
  - $25 790 for a couple with one child or a single-parent family with more than one child;
  - $28 595 for a couple with more than one child.

TABLE 3

Parameters of the health contribution
(dollars per adult)

	2010	2011	2012
Maximum health contribution, per adult	25	100	200
Income thresholds above which the health contribution becomes payable[1]			
– Person living alone	14 320	14 605	14 895
– Couple without children or single-parent family with one child	23 205	23 670	24 145
– Couple with one child or single-parent family with two children	26 305	26 830	27 365
– Couple with more than one child	29 165	29 750	30 345

1 The thresholds are given for purposes of illustration. Actual data will be available later.

Nearly 3.2 million households will pay the health contribution, thereby generating annual revenues of more than $945 million in 2012-2013.

TABLE 4

Financial impact of the health contribution[P]
(millions of dollars)

	Full year	2010-2011	2011-2012	2012-2013
Health contribution	945	180	575	945

P: Projections.

The sums collected by the government by means of the health contribution will make it possible to cover a part of the widening gap between the growth in health-care spending and growth in revenues currently used to fund such spending. They will be paid to the institutions based on their performance and could be used to continue developing front-line services and provide support for promising projects designed to improve the system's performance.

❑ A fund for financing health and social services institutions

In order to dedicate the sums levied exclusively to health-care services, the government is announcing the creation of a fund dedicated exclusively to financing health and social services institutions.

— In that respect, the government's omnibus bill, tabled in June 2010, will establish, among other things, the fund for financing health-care institutions.

Administrative responsibility for the fund will be entrusted to the Minister of Health and Social Services, who will see that the sums placed at the Minister's disposal serve, among other purposes, to:

— strengthen front-line services, which are the key to ensuring access to medical services and global health management for each individual throughout his or her lifetime;

— support training and development in the profession of specialized nurse practitioner, as well as for the integration of that profession into the clinical setting;

— support promising initiatives designed to improve the health-care system's performance, whether in respect of services offered or governance and structures.

Moreover, the fund will be consolidated with the government's financial statements and will report annually on the used of the amounts in its annual report and in the health accounts.

— Management details for the fund will be spelled out when the bill is tabled.

TABLE 5

Fund for financing health and social services institutions, 2010-2011 to 2013-2014[P]
(millions of dollars)

	2010-2011	2011-2012	2012-2013	2013-2014
Introduction of a health contribution on July 1, 2010	180	575	945	945
Other contributions to be identified	—	—	50	500
TOTAL	**180**	**575**	**995**	**1 445**

P: Projections.

3.2 A health deductible to orient citizens in their consumption of services

Inspired by the proposals formulated in 2008 by the Task Force on the Funding of the Health System (the Castonguay Report), the government will study the advisability of introducing a health deductible within a few year in order to orient citizens in their consumption of health-care services.

— This form of funding with an orienting effect is used with great success in several European countries.

In the coming months, the government will work with its partners to study the results in other jurisdictions that have implemented a deductible. The government will seek to draw upon the systems that have proven most effective and adapt them to the context of Québec.

❑ A deductible offering advantages

In the present context, the introduction of a health deductible would offer undeniable advantages.

— It would encourage citizens to take responsibility for their use of health-care services and for their own health.

— It would orient users of the system in the direction considered the most appropriate by public health-care authorities, by adjusting the amount charged depending on where the service is consumed.

Task Force on the Funding of the Health System: illustration of the health deductible

According to the Task Force on the Funding of the Health System (the Castonguay Report), the health deductible could be, for example, a $25 charge per medical visit. It would apply to each visit to a physician for medical services paid for on a fee-for-service basis in a health-care institution and at a given date.

Only one deductible would be charged to a patient for each visit to a physician, even if the physician performs more than one medical act. However, two deductibles would be charged for a visit to a given health-care institution if the patient consults two physicians each of whom performs a medical act.

In order to maintain the progressivity of Quebec's tax and transfer systems, the deductible would be capped and could not exceed, for example, 1% of family income above the exemption threshold for the contribution to the Québec public prescription drug insurance plan.

For the sake of simplification, the health deductible would be paid when the income tax return is filed. For that purpose, each household would receive a statement at the end of the year from the Régie de l'assurance maladie du Québec indicating all the health-care services received during the year, and the total number of medical visits subject to the $25 deductible. The total amount to be entered in the income tax return would also be indicated and explained.

Illustration of the calculation of a $25 health deductible based on type of household, family income and number of medical visits during a single taxation year - 2012
(dollars)

	Person living alone		Couple with two children[1]	
Calculation of a health deductible	10 medical visits	20 medical visits	10 medical visits	20 medical visits
1. Amount to be reported ($25 per visit)	250.00	500.00	250.00	500.00
2. Employment income	35 000	35 000	60 000	60 000
Deduction for workers	*– 1 070*	*– 1 070*	*– 2 140*	*– 2 140*
3. Net income (line 275)	33 930	33 930	57 860	57 860
Exemption from the health deductible[2]	*– 14 895*	*– 14 895*	*– 30 345*	*– 30 345*
4. Income subject to the deductible	19 035	19 035	27 515	27 515
5. Contribution rate	1%	1%	1%	1%
6. Maximum annual deductible based on the 1% ceiling	190.35	190.35	275.15	275.15
DEDUCTIBLE PAYABLE (line 1 or line 6, whichever is less)	**190.35**	**190.35**	**250.00**	**275.15**

1 Each spouse earns 50% of the employment income.
2 The deductions that will be used for the 2012 health deductible are the same as those for the contribution to the Québec public prescription drug insurance plan for the 2012 taxation year.

❑ A deductible health would not hinder access to health care

Unlike user fees, a health deductible would not hinder access to health care and would make it possible to exempt the most disadvantaged. It would not infringe on the right to health care or the principle of equality between citizens. It would not be collected at the service outlet, but instead the following year through the income tax return.

This approach would not call into question the principles of accessibility and solidarity that characterize our health-care system. Funding of the system, to which each citizen would contribute according to his or her means, would remain public.

❑ The health deductible and the *Canada Health Act*

Québec is of the opinion that a health deductible would not restrict the accessibility of the health-care system. What is sought is an orienting effect, not a moderating effect: the purpose is to encourage delivery of the right care at the right place.

Furthermore, such a health deductible might also interest other provinces faced with major challenges in respect of funding health-care services.

The principles of the *Canada Health Act*

The *Canada Health Act* came into force on April 1, 1984. It establishes the conditions that the provinces and territories must comply with to be eligible for the Canada Health Transfer.

Insured health services, as defined by the Act, include all necessary hospital and medical services provided by a physician and medically necessary surgical-dental services which can only be provided suitably at a hospital.

The government pays the full amount of its contribution when a province or territory complies with the following principles:

- Public administration: the plan must be administered and operated on a non-profit basis by a public authority responsible to the government of a province and subject to audit of its accounts and financial transactions.
- Comprehensiveness: the plan must insure all insured health services provided by hospitals, medical practitioners or dentists and, where the law of the province so permits, similar or additional services rendered by other health-care practitioners.
- Universality: one hundred percent of the insured persons of a province are entitled to the insured health services provided for by the plan on uniform terms and conditions.
- Portability: when a person settles in another province, the province of origin must assume the costs of the insured health services during the minimum period of residence or waiting period imposed by the new province of residence, a period which must not exceed three months.
- Accessibility: the plan must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to these services by insured persons; the plan must also provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists and for the payment of amounts to hospitals in respect of the cost of insured health services.

4. HEALTH ACCOUNTS: FOR BETTER INFORMATION AND GREATER TRANSPARENCY

In the interests of better information and greater transparency concerning the results of the funding provided in order to offer quality health services, the government is announcing the introduction of health accounts.

Health accounts are not a health fund or a new budget mechanism. They are simply an instrument, a tool, designed, among other purposes, to make the population more aware of:

- the repercussions that consumption of health-care services have on cost trends in our public health-care system;
- the choices facing us as a society in order to preserve the quality and accessibility of health-care services.

Health accounts will not lead to any additional user contribution to funding health-care services. They will enable us to make choices regarding ways to maintain an adequate level of funding.

They will therefore make it possible for both the population and political and government decision-makers to assess the repercussions of resource allocation on the health-care system's performance and results.

❑ Specific objectives

First proposed by the Comité de travail sur la pérennité du système de santé et de services sociaux (the Ménard Report), the concept of health accounts was again taken up in 2006 in the government working paper *Guaranteeing Access*, and still again in 2008 by the Task Force on the Funding of the Health System (the Castonguay Report).

Based on the recommendations put forward by this working groups, health accounts are designed to:

- improve transparency concerning the amounts allocated to the health and social services sector;
- increase public awareness of the trends in health-care spending and the pressure it exerts on the government's other missions;
- constitute a baseline for public discussion of the issues and the choices to be made in order to ensure the sustainability of health-care funding.

4.1 Improving information and transparency, raising public awareness

Health accounts, rendered public for the first time in context of the 2010-2011 Budget, take the form of an informational document that presents the Québec government's health and social services spending, the revenues devoted thereto and a set of indicator's related to the network's performance.

— Thus, being made public each year, they contain financial information making it possible to understand the impact of the level of resources allocated to the health-care system and make the necessary adjustments.

❑ Better information in order to make the right choices

As regards financial information, establishing the connection between health-care spending and the resources devoted thereto will make it possible to identify trends and issues affecting the level and growth of costs and the various contributions ensuring the system's viability.

— Health accounts will also provide a picture of the personnel working in the health-care system, as well as the structure of services and the makeup of service outlets.

— Indicators for the volume and type of care will enable the public to be informed about the resources invested and their effects on the services offered.

This is an unprecedented move toward transparency on the government's part to illustrate the dynamics surrounding funding and performance in the Québec public health-care system.

4.2 An move toward transparency for greater accountability

The health accounts will be made public in the fall of each year by the Minister of Health and Social Services and will present the most recent information possible.

This information comes in addition to other mechanisms designed for the purpose of evaluating and ascertaining performance in health care.

The Health and Welfare Commissioner, whose function was created in 2004, has the mission of informing the public debate and the government decision-making process so as to contribute to improving the health and welfare of Quebecers.

Also, the Institut national d'excellence en santé et en services sociaux, soon to be established, will have the mission of:

— assessing the clinical advantages and the costs of the technologies, medications and interventions used in health and personal social services;

— drawing up recommendations and developing clinical practice guides to ensure optimal use of those technologies, medications and interventions, in order to update and distribute them;

— determining service performance evaluation criteria in its recommendations and guides and making recommendations to the Minister of Health and Social Services with a view to updating certain lists of medications.

CONCLUSION

Maintaining a public health-care system that is responsive the population's changing needs is daunting challenge. Québec is no exception in this regard, since most of the major advanced economies are facing the same challenge.

❑ Opting for performance and better funding

The government is choosing to act now to improve the funding of our public health-care system. This is a shared responsibility between the government and users.

— At the individual level, each citizen must adopt a healthy lifestyle and act responsibly in the consumption of health-care services.

— At the collective level, we must be sure to make the right choices to develop a more effective system, one that makes better use of the considerable resources available to us, subject to our ability to pay.

The government's approach is simple:

— reducing to 5% the annual growth in funding for total health-care spending, while also maintaining the government's other missions;

— implementing, as of 2010-2011, new and innovative sources of funding to achieve this objective, subject to the taxpayers' ability to pay.

Over a longer period, the government intends to protect the quality and accessibility of health-care services by striking a balance between rising health-care expenses and the growth of our collective wealth.

— Our success in that regard depends on the measures we are prepared to take as of now to improve the performance of the health-care system.

❑ Health accounts: making the right decisions

Health accounts, as presented in this document, are a first step toward better information and greater transparency in respect of our health-care system. They will thus lead to more enlightened decision-making concerning ways to maintain an adequate level of financing.

In this way, they will offer both the population and political and government decision-makers the opportunity to assess the impact of resource allocation on the system's performance and results.

APPENDIX 1: HEALTH ACCOUNTS

Health Accounts, 2007-2008 to 2009-2010

TABLE OF CONTENTS

FOREWORD

The report on revenue and expenditures in the health and social services system is an annual publication that presents the highlights of the financial and social health performance of the ministère de la Santé et des Services sociaux, including revenues, expenses, resources and results.

❑ Objectives of the report

This report is essentially designed to contribute to advancing the debate on health-care funding by:

— improving transparency in respect of the sums devoted to the health and social services sector;

— raising public awareness of the trends in health-care spending and the revenues allocated to it, as well as the pressure it on funding for the government's other missions;

— constituting a basis of discussion for the public debate on the issues and the choices to be made in order to ensure the sustainability of health-care funding.

The report will also enable the Minister of Heath and Social Services to determine how well the department has fulfilled its objectives (public health, quality of services, performance indicators, productivity, etc.) in regard to the sums invested.

1. FINANCIAL REVIEW OF THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

1.1 Growth in revenue and expenditure

This section presents a table summarizing the trends in total expenditure of the ministère de la Santé et des Services sociaux and sources of funding.

TABLE 6

Total expenditure of the ministère de la Santé et des Services sociaux and sources of funding[1] – 2007-2008 to 2009-2010

(millions of dollars)

	2007-2008	2008-2009	2009-2010[P]	Average annual change[2] (%)
Total spending for health and social services				
Program spending funded by the Consolidated Revenue Fund	– 24 054	– 25 622	– 26 980	5.9
Spending assumed by users and others	– 4 169	– 4 307	– 4 523	4.2
Total, health and social services spending	**– 28 223**	**– 29 929**	**– 31 503**	**5.7**
% change		***6.0***	***5.3***	
Sources of funding				
Health Services Fund	5 404	5 631	5 647	2.2
Contributions from the federal government	5 722	5 739	5 957	2.0
Contributions from users	2 308	2 438	2 509	4.3
Contributions from other departments and bodies	303	329	339	5.6
Own-source revenues from other sources	1 468	1 335	1 374	– 3.3
Subtotal	**15 205**	**15 472**	**15 826**	**2.0**
% change		***1.8***	***2.3***	
Other taxes from the Consolidated Revenue Fund[3]	13 018	14 457	15 677	9.7
% change		*11.1*	*8.4*	
TOTAL SOURCES OF FUNDING	**28 223**	**29 929**	**31 503**	**5.7**

P: Preliminary results.

1 These data were compiled from documents produced by the ministère de la Santé et des Services sociaux, the public accounts and financial statements of all the bodies included within the Health and Social Services mission's reporting entity. They include, among others, amounts related to user contributions prescription drug insurance and interest on debt service.

2 Average annual change from 2008-2009 to 2009-2010.

3 For the purposes of the health accounts, the deficits of the establishments in the health and social services network are covered by the other taxes from the Consolidate Revenue Fund.

1.2 Expenditure items

This section presents the trends in expenditure items over the past three years, with respective contributions and different factors explaining growth

❑ Spending according to budgetary programs

The table below summarizes spending by budget program using the nomenclature in the expenditure budget.

TABLE 7

Total spending by budgetary program
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Department and Québec-wide operations	**364**	**374**	**477**	**14.5**
Regional operations				
Health and social services agencies	95	101	103	4.1
Health and social services institutions	14 271	15 031	15 600	4.6
Community organizations and other bodies	393	425	438	5.6
Other activities	2 151	2 303	2 402	5.7
Debt service	646	772	743	7.2
Subtotal – Regional operations	**17 556**	**18 632**	**19 286**	**4.8**
Office des personnes handicapées du Québec	12	13	13	4.1
Régie de l'assurance maladie du Québec[2]	7 962	8 649	9 391	8.6
Other net expenses from transfers between bodies	2 329	2 261	2 336	0.2
TOTAL EXPENDITURE	**28 223**	**29 929**	**31 503**	**5.7**
As a % of GDP	***9.5***	***9.9***	***10.5***	

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.
2 Includes the deductible and the co-insurance under the public prescription drug insurance plan.

❑ Spending by category of expenditure

This section presents the trends in spending in each major category of expenditure.

TABLEAU 8

Total spending by category of expenditure
(millions of dollars)

	2007-2008	2008-2009	% change
Salaries	16 552	17 582	6.2
Operations	6 447	6 940	7.6
Capital	380	486	27.9
Interest	381	350	– 8.1
Support	3 824	3 896	1.9
Other	639	675	5.6
TOTAL EXPENDITURE	**28 223**	**29 929**	**6.0**
As a % of GDP	***9.5***	***9.9***	

1.3 Sources of funding

This section described the trends in the respective shares for dedicated new revenues, federal transfers, users and the Consolidated Revenue Fund allocated to health-care funding.

❑ Health Services Fund

TABLE 9

Health Services Fund
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Contributions from employers	5 203	5 454	5 475	2.6
Contributions from individuals	201	177	172	– 7.5
Health Services Fund	**5 404**	**5 631**	**5 647**	**2.2**
As a % of total expenditure	***19.1***	***18.8***	***17.9***	

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.

❑ Contributions by the federal government

The federal government contributes to health care primarily by means of the Canada Health Transfer. To be entitled to the full cash amount, provinces must comply with the conditions fixed by the *Canada Health Act*.

The table below presents the trends in federal government contributions over the past three years.

TABLE 10

Contributions from the federal government
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Health transfers				
Canada Health Transfer in cash	3 601	3 583	4 015	5.6
Wait Times Reduction Fund[2]	—	—	58	
Wait Times ReductionTrust	281	—	—	
Patient Wait Times Guarantee Trust	42	42	43	1.2
Human Papillomavirus Immunization Trust	—	46	24	
Interest from trusts	—	68	8	
Subtotal	**3 925**	**3 740**	**4 148**	**2.8**
Notional portion of the special Québec abatement related to the Canada Health Transfer[3]	1 714	1 916	1 726	0.3
Agreement respecting the federal *Youth Criminal Justice Act*	37	37	37	
Agreement respecting participation by persons with disabilities in the labour force	46	46	46	
Contributions from the federal government	**5 722**	**5 739**	**5 957**	**2.0**
As a % of total expenditure	***20.3***	***19.2***	***18.9***	

Note: The amounts have been rounded off, so they may not add up to the total indicated.
P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.
2 The Wait Times Reduction Fund is a transfer under Part V.1 of the *Federal-Provincial Fiscal Arrangements Act*. It is granted on a per-resident basis.
3 The notional portion of the special abatement related to the Canada Health Transfer corresponds to 62% of the special Québec abatement of 16.5%. The remaining 38% is related to the Canada Social Transfer. These revenues are collected by Québec via the personal income tax. They are added here to the federal transfers for purposes of illustration.

❑ User contributions

This table presents the various user contributions in respect of funding for health-care services.

TABLE 11

Summary of user contributions
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Public prescription drug insurance plan				
Premium	707	778	749	2.9
Deductible and co-insurance	643	679	730	6.6
Subtotal – Public prescription drug insurance plan	**1 350**	**1 457**	**1 479**	**4.7**
Contribution from accommodated adults	662	682	680	1.4
Supplement for private and semi-private rooms	66	63	70	3.0
Parental contribution and tax benefit for children placed with foster families	50	50	51	1.0
Other user contributions	180	186	229	10.6
User contributions	**2 308**	**2 438**	**2 509**	**4.3**
As a % of total expenditure	***8.2***	***8.1***	***8.0***	

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.

❑ Contributions from other bodies

This subsection presents the various financial contributions from other bodies.

TABLE 12

Contributions from other bodies
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Contribution from the Commission de la santé et de la sécurité du travail, the Société d'assurance automobile du Québec, the ministère de la Sécurité publique and the ministère du Revenu du Québec	266	296	307	7.4
Reciprocal agreements with the other provinces (Régie de l'assurance maladie du Québec)	37	33	32	– 7.0
Contributions from other bodies	**303**	**329**	**339**	**5.8**

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.

TABLE 13

Contributions from other bodies paid into specified purpose accounts
(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Loto-Québec (pathological gamblers)	22	22	22	—
Loto-Québec (seniors losing their autonomy)	30	30	30	—
TOTAL	**52**	**52**	**52**	**—**

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.

❑ Other taxes from the Consolidated Revenue Fund

This table shows the trends in the contribution by the Québec government to funding health-care services from the taxes in the Consolidated Revenue Fund.

TABLE 14

Contributions by the Québec government from the taxes in the Consolidated Revenue Fund

(millions of dollars)

	2007-2008	2008-2009	2009-2010P	Average annual change[1] (%)
Other taxes from the Consolidated Revenue Fund	13 018	14 457	15 677	9.7
As a % of total expenditure	*46.1*	*48.3*	*49.8*	

P: Preliminary results.
1 Average annual change from 2008-2009 to 2009-2010.

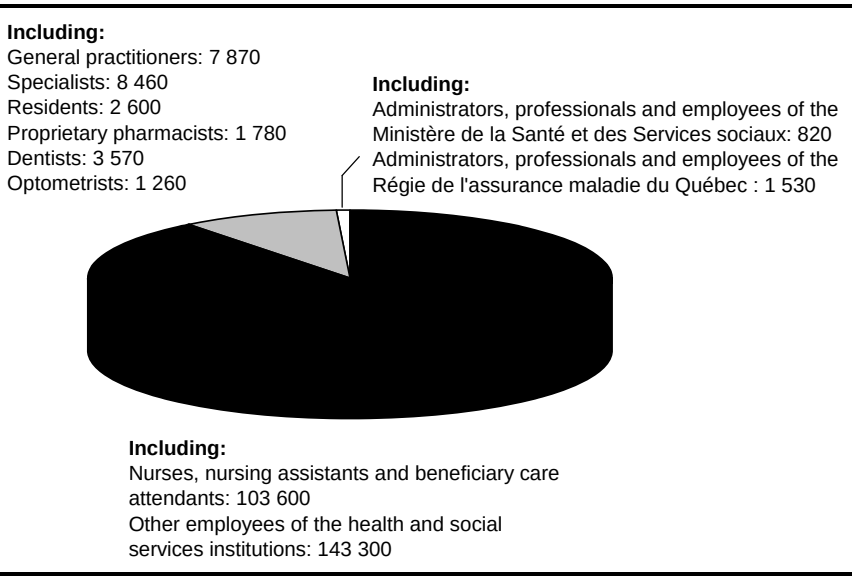
2. RESULTS AND PERFORMANCE INDICATORS

2.1 Portrait of the personnel and the institutions

❑ Personnel of the network

CHART 10

Personnel of the health and social services network, 2008-2009
(number)



❑ Institutions

In 2008-2009, the health and social services network was composed of 294 institutions, of which 191 were public and 103 were private. These institutions are corporations endowed with legal capacities and responsibilities. They hold a permit from the Minister of Health and Social Services to provide services corresponding to the five major missions defined by the *Act respecting health services and social services*. These institutions administer 1 740 facilities or sites where health care and social services are offered to the population of Québec.

This table summarizes the trends affecting the health and social services institutions.

TABLE 15

Institutions
(number)

	2007-2008	2008-2009
Private institutions	**103**	**103**
Public institutions		
Health and social services centres	95	95
Hospital centres	28	27
Residential and long-term care centres	7	8
Child and youth protection centres and rehabilitation centres designated as youth centres	16	16
Rehabilitation centres	41	41
Centres assuming all five missions for the northern regions	4	4
Subtotal	**191**	**191**
Total number of institutions	**294**	**294**

2.2 Volume and type of care

This section summarizes the trends affecting the volume and type of care provided.

TABLE 16

Volume of care provided by program and by service

Programs	Services	Measurement units	Volumes
Physical health	Days of stay of clienteles admitted	Days of stay	4 438 701
	Surgeries	Number of surgeries	476 972
	Emergency room	Visits	3 795 044
	Medical consultations at institutions	Visits	5 329 821
	Deliveries	Number of deliveries	80 680
Loss of autonomy related to aging	Accommodation	Days of stay	13 964 530
Home-support services (all programs)	Home nursing care	Users	234 061
Physical impairment	Adjustment / rehabilitation	Hours of service delivered	2 392 707
Intellectual impairment	Intermediate resources	Paid days	1 696 367
	Residential resources, ongoing residential assistance	Days of stay	400 432
	Adjustment and support for the patient, family and friends	Users	29 521
Young persons with adjustment problems	Case management	Cases reported	69 673
	Psychosocial services	Users	118 021
Mental health	Hospitalization	Days of stay	855 384
	Accommodation	Days of stay	284 360
	Front-line ambulatory services	Users	63 093

Source: Ministère de la Santé et des Services sociaux, *États financiers 2008-2009*.

3. SOURCES OF FUNDING FOR CERTAIN ACTIVITIES

❑ Public prescription drug insurance plan

The following table presents the trends affecting contributions from persons insured and from the government compared to costs.

TABLE 17

Premiums and costs under the Québec public prescription drug insurance plan
(millions of dollars)

	2007-2008	2008-2009
Premiums – Adherents and individuals 65 years of age or over	707	778
Contributions from members (deductible and co-insurance)	643	679
Total, premiums and insurance	**1 350**	**1 457**
Cost to the government	2 155	2 222
TOTAL COST OF THE PLAN	**3 505**	**3 679**
% of the premiums and contributions in the total cost of the plan	***38.5***	***39.6***

This table explains the origin of the shortfall between contributions from adherents and persons age 65 and over in relation to the total costs of the plan.

TABLE 18

Cost of the public prescription drug insurance plan, 2008-2009

(millions of dollars)

		Funding			
	Costs	User contributions	Premiums	Contribution from the government	Share paid by insured persons (%)
Recipients of last-resort financial assistance	**652**	**—**	**—**	**652**	**—**
Persons age 65 and over					
Receiving the maximum guaranteed income supplement	109	—	—	109	—
Receiving 94% to 99% of the guaranteed income supplement	81	—	—	81	—
Receiving a partial guaranteed income supplement	962	178	112	672	30
No guaranteed income supplement	1 048	280	268	500	52
Subtotal	**2 200**	**458**	**380**	**1 362**	**38**
Adherents					
Under age 18	47	—	—	47	—
Students age 18 and over	11	—	—	11	—
Age 18 to 64	769	221	398	150	81
Subtotal	**827**	**221**	**398**	**208**	**75**
TOTAL	**3 679**	**679**	**778**	**2 222**	**40**

❑ Accommodation of adults

The following table presents the trends affecting user and government contributions for accommodation services.

TABLE 19

Contributions and costs of accommodation services
(millions of dollars)

	2007-2008	2008-2009	2009-2010P
Contributions from adults accommodated in public institutions	562	573	587
Cost to the government	1 079	1 123	1 164
TOTAL COST OF ACCOMMODATION SERVICES	**1 641**	**1 696**	**1 751**
% assume by users	***34.2%***	***33.8%***	***33.5%***

P: Preliminary results.

❑ Ambulance services

Ambulance services cost nearly $393 million, out of which $365 million is assumed by the government and is thus borne by all taxpayers. The government assumes 93% of the costs related to ambulance services. The contribution by users total totals $28 million.

TABLE 20

Ambulance services, 2008-2009
(millions of dollars)

	Contributions	(%)
Contributions from the government		
Ministère de la Santé et des Services sociaux	302	76.8
Transportation between health-care institutions[1]	53	13.6
Persons age 65 and over[1]	0	0.0
Ministère de l'Emploi et de la Solidarité sociale for income security beneficiaries	10	2.5
Subtotal	**365**	**92.9**
Contributions from users and other bodies		
Commission de la santé et de la sécurité au travail	0	0.0
Société de l'assurance automobile du Québec	4	1.0
Individuals	22	5.6
Others[2]	2	0.5
Subtotal	**28**	**7.1**
TOTAL	**393**	**100.0**

1 Costs assumed by health-care institutions.
2 Includes, among other things, contributions from the federal government, including the Solicitor General of Canada, National Defence, war veterans and Health and Welfare.

In cases where fees are charged, the contribution from users covers only 23.2% of operating costs. The average amount billed for each trip by ambulance is $153.66, whereas the average real cost is $661.93, which explains why the government assumes the greatest part of the costs.

This reflects, among other thing, the fact that ambulance services for income security beneficiaries and persons age 65 and over, regardless of their income, is free of charge.

Currently, a uniform fee of $125 is charged throughout Québec for picking up a patient, with an additional charge of $1.75 per kilometre travelled.

APPENDIX 2: TOTAL SPENDING OF THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX AND SOURCES OF FUNDING, 2008-2009

TABLE 21

Total spending, 2008-2009 – Health and social services
(millions of dollars)

		Breakdown of bodies receiving funding			
	Total	**Departments and bodies**	**Régie de l'assurance maladie**	**Health Services Fund[1]**	**Institutions in the network**
HEALTH AND SOCIAL SERVICES SPENDING					
Program spending					
– Québec-wide operations	374	374	—	—	—
– Regional operations					
▪ Agencies	101	101	—	—	—
▪ Institutions	15 031	15 031	—	—	—
▪ Community and other organizations	425	425	—	—	—
▪ Other activities	2 303	2 303	—	—	—
▪ Debt service	772	772	—	—	—
– Office des personnes handicapées	13	13	—	—	—
– Régie de l'assurance maladie	6 603	6 603	—	—	—
Subtotal	**25 622**	**25 622**	**—**	**—**	**—**
Régie de l'assurance maladie					
– Health insurance plan	4 356	—	4 356	—	—
– Public prescription drug insurance plan	3 679	—	3 000	679	—
– Others	471	—	471	—	—
– Administrative expenses	143	—	143	—	—
Subtotal	**8 649**	**—**	**7 970**	**679**	**—**
Transfers between bodies	**– 4 342**	**– 23 540**	**—**	**17**	**19 181**
TOTAL HEALTH AND SOCIAL SERVICES SPENDING	**29 929**	**2 082**	**7 970**	**696**	**19 181**

1 Including the costs assumed by users for the deductible and co-insurance under the public prescription drug insurance plan.

TABLE 22

Sources of funding 2008-2009, Health and social services

(millions of dollars)

		Breakdown of bodies receiving funding					
	Total	**Departments and bodies**	**Régie de l'assurance maladie**	**Prescription drug insurance fund[1]**	**Institutions in the network**	**Health Services Fund**	**Consolidated Revenue Fund**
SOURCES OF FUNDING FOR HEALTH-CARE SPENDING							
Health Services Fund							
– Contributions from employers	5 454	—	—	—	—	5 454	—
– Contributions from individuals	177	—	—	—	—	177	—
Subtotal	**5 631**	**—**	**—**	**—**	**—**	**5 631**	**—**
Percentage of funding	*18.8%*						
Contributions from the federal governement							
– Health transfers							
▪ Canada Health Transfer in cash	3 583	—	—	—	—	—	3 583
▪ Patient Wait Times Guarantee Trust	42	—	—	—	—	—	42
▪ Human Papillomavirus Immunization Trust	46	—	—	—	—	—	46
▪ Interest from trusts	68	—	—	—	—	—	68
– Notional portion of the special Québec abatement related to the Canada Health Transfer	1 916	—	—	—	—	—	1 916
– Agreement respecting the federal *Youth Criminal Justice Act*	37	37	—	—	—	—	—
– Agreement respecting participation by persons with disabilities in the labour force	46	46	—	—	—	—	—
Subtotal	**5 739**	**83**	**—**	**—**	**—**	**—**	**5 657**
Percentage of funding	*19.2%*						
Contribution from users							
– Prescription drug insurance							
▪ Primiums	778	—	—	778	—	—	—
▪ Deductible and co-insurance	679	—	—	679	—	—	—
– Adults accommodated in public and private institutions	682	—	—	—	682	—	—
– Supplement for private and semi-private rooms	63	—	—	—	63	—	—
– Tax benefit for children placed with foster families	50	—	—	—	50	—	—
– Others	186	9	—	—	177	—	—
Subtotal	**2 438**	**9**	**—**	**1 457**	**972**	**—**	**—**
Percentage of funding	*8.1%*						

TABLEAU 22 (cont.)

Sources of funding 2008-2009, Health and social services

(millions of dollars)

		Breakdown of bodies receiving funding					
	Total	Departments and bodies	Régie de l'assurance maladie	Prescription drug insurance fund[1]	Institutions in the network	Health Services Fund	Consolidated Revenue Fund
Contributions from other bodies							
– CSST, SAAQ, ministère de la Sécurité publique, ministère du Revenu du Québec	296	115	115	—	66	—	—
– Other provinces (reciprocal agreements)	33	—	33	—	—	—	—
Subtotal	**329**	**115**	**148**	**—**	**66**	**—**	**—**
Percentage of funding	*1.0%*						
Other revenues							
– Bodies (Québec residential centres, Urgences-santé, Héma-Québec, Institut national de santé publique du Québec)	17	17	—	—	—	—	—
– Miscellaneous (commercial services, donations, etc.)	1 318	4	10	—	1 304	—	—
Subtotal	**1 335**	**21**	**10**	**—**	**1 304**	**—**	**—**
Proportion du financement	*4.5%*						
Total, sources of funding for health-care spending	**15 472**	**228**	**158**	**1 457**	**2 342**	**5 631**	**5 656**
Percentage of funding	*51.7%*						
Other taxes from the Consolidated Revenue Fund	**14 457**	**—**	**—**	**—**	**—**	**—**	**14 457**
Percentage of funding	*48.3%*						
TOTAL SOURCES OF REVENUE	**29 929**	**228**	**158**	**1 457**	**2 342**	**5 631**	**20 113**

Note: The amounts have been rounded off, so they may not add up to the total indicated.

1 Including the costs assumed by users for the deductible and co-insurance under the public prescription drug insurance plan.