

Report on the progress made

*regarding the bilateral agreement entered into during the
federal-provincial-territorial
meeting of the first ministers on health,
september 2004*



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Message from the Quebec Minister of Health and Social Services

At the end of the federal-provincial-territorial meeting of the First Ministers on Health, held in Ottawa between September 13 and 15, 2004, the premiers of Quebec and the other Canadian provinces signed a bilateral agreement entitled "*Asymmetrical Federalism That Respects Quebec's Jurisdiction*". This *asymmetrical agreement* in particular recognizes the desire of the Quebec government to carry out its own responsibilities with respect to planning, organizing and managing the Quebec healthcare system.

After reminding the audience that on the whole Quebec adheres to the general objectives and principles drawn up by the Prime Minister and the provincial and territorial premiers in their news release of September 2004 entitled "A Ten-Year Plan to Strengthen Health Care", the bilateral agreement specifies that Quebec will apply its own plan for reducing wait times based on its own set objectives, standards and criteria, especially with respect to human resource management in health care, family and community care reform, home care, strategies for increased access to medication, and health and prevention promotional strategies regarding chronic diseases. The agreement lastly sets out that the Quebec Government itself will report the results of its efforts to Quebeckers in order to reduce wait times and, more broadly, the progress made thus far in attaining its objectives.

This report responds to this commitment. One year after signing the *Asymmetrical Agreement on Health*, the Quebec Government has prepared a progress report. This report provides the reader with an overview of the initiatives taken to reduce wait times, and overall improve access to health care. On behalf of the premier and other members of the Quebec government, I am pleased that Quebeckers will be able to find out more about their health care system and see the efforts being made to continue to meet their needs.

Philippe Couillard
Minister, Health and Social Services

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1. Reduced Wait Times and Improved Access to Services

As with other governments in Canada, Quebec, on the whole, adheres to the general principles for reducing wait times and improving the access time to quality health care and services, as stated by the Prime Minister and provincial and territorial premiers at the Conference on Health Care in September 2004. Quebec's priorities involve specialized treatments and services in the following areas: cancer, heart, medical imaging, joint replacement and sight restoration.

In order to provide coherent information on the progress made especially in reducing wait times, Quebec has been taking part since the fall of 2004 in a provincial-territorial task force mandated during the conference of provincial and territorial deputy health ministers. This task force's studies have shown that improving access and reducing wait times will require the cooperation and participation of service providers (doctors, nurses and other healthcare professionals) and network managers. Unless we change our way of doing things, injecting more money will not enable us to reach the desired objectives. All parties in the chain of services to patients must be involved: from community services to the ultra-sophisticated services provided by university centres to health prevention and promotion.

Quebec's commitment to improve access to services has posed specifically two sizeable challenges to our healthcare system:

- To better manage wait times, i.e., to develop and implement the tools for better service access management in order to assure services to patients based on their needs;
- To reduce these wait times, when they are unacceptable, which involves first defining limits based on clinical evidence and priorities.

Before September 2004, Quebec had already taken on these two challenges by investing in information technology. Major efforts were made, especially in 2004, concerning access to services in the tertiary cardiac and radio-oncology sectors. In January 2004, the Ministère de la Santé et des Services Sociaux completed in each institution in Quebec offering tertiary cardiac services, the deployment of the standardized service access management system (known as SGAS, système de gestion de l'accès aux services). In September 2004, an equivalent system specifically for radio-oncology was set up in institutions offering radio-oncology services. By combining investments in information technology with investments in high-tech to upgrade tertiary cardiac and radio-oncology treatment equipment, the Quebec healthcare network now had the means to optimize the use of costly resources while assuring equal access for patients awaiting these services. This occurred through each institution adopting a common list of priorities for service requests based on a morbidity and mortality risk scale defined by a consensus of experts in each area of specialization. In addition to considerably improving wait time management, the systems in place for tertiary cardiac and radio-oncology services help generate quality standardized information management. For these

two sectors, additional investments will be required to make these service access management systems fully operational.

For the other priority sectors of activity, such as medical imaging, sight restoration and joint replacement, the Ministère does not yet have an SGAS type standardized service access management system to allow the complete follow-up of patients waiting for services based on their needs. However, in surgical sectors, such as joint replacement and sight restoration (cataract surgery), we can still regularly follow changes in patient wait times. To make up for the shortcomings in the current information collection system, the Ministère will ask regional agencies and institutions to carry out an analysis in order to grant priority to patients classed as having waited longer than the set time limit. This operation will first apply to joint replacement services. As well, work and services must be organized, certain practices standardized, waiting lists regularly analyzed, methods of patient preparation and check-out reviewed, while still maintaining a high level of service quality and safety.

2004-2006 Results and Actions:

Tertiary Cardiac Services

- A marked reduction in tertiary cardiac waiting lists¹: diagnostic catheterization and angioplasty dropped from 1,544 people waiting in 2002 to 916 people waiting in 2005, i.e., a decrease of 40.6%, and, for heart surgery, from 702 people waiting in 2002 to 456 in 2005, i.e., a decrease of 35%.
- Network enhancements: A grant of \$18.4 million was announced to add three cardiac operating rooms at the Montreal Heart Institute in May 2005 and to upgrade over 2004-2005 two hemodynamics rooms, for a total investment of \$22 million in tertiary cardiology at the Montreal Heart Institute.

Radio-Oncology

- Wait times beyond four weeks have considerably decreased in the radio-oncology sector. While on June 3, 2005, there were 201 cancer patients waiting for treatment for more than one month, there were only 94 come September 23, 2005. More generally, the number of people waiting for radio-oncology treatments has gradually dropped week by week since June 2005.
- Wait times over eight weeks for the same type of treatments also have substantially decreased since March 2003. They dropped from 206 for all types of cancer on March 31, 2003, to 21 cases on September 30, 2005. We should point out that no breast cancer patients to date have waited longer than eight weeks to receive the required radiotherapy treatments. The number of prostate cancer patients waiting longer than eight weeks has also greatly decreased.

¹ Based on the results available as of March 31, 2005.

- Inter-institutional service corridors were set up for patients waiting longer than eight weeks, which enabled in 2004-2005 some 300 patients to be treated within the maximum wait times.
- Three million dollars were injected in May 2005 to allow overtime work in radio-oncology centres in order to bring wait times down to under four weeks.
- Prostate radium therapy has been developed at the Centre Hospitalier Universitaire de Montréal, allowing the treatment of 100 more patients a year.
- Seven investment projects are currently underway in seven radio-oncology centres. These projects will increase the radiotherapy equipment inventory by 15 accelerators and enable to treat at least 6,000 patients from now until 2007-2008.

Medical Imaging

- Magnetic resonance: In 2005-2006, including the 13 MRIs currently in operation, Quebec will have 50 machines in its public network.
- Cat scans: Also in 2005-2006, including the three scanners being set up, Quebec will have 101 machines.
- Positron Emission Tomography (PET): Again in 2005-2006, including the one currently in use, Quebec will have four machines.

Sight Restoration and Joint Replacement

- Changes in annual activity volumes:
 - The number of patients undergoing cataract surgery (between 2002-2003 and 2004-2005) has increased by 16.5%, i.e., by 9,358 patients;
 - The number of patients undergoing knee replacement has increased during the same period by 23%, i.e., by 959 patients;
 - Lastly, the number of patients undergoing hip replacement has increased between 2002-2003 and 2004-2005 by 9.6%, i.e., by 377 patients.

- Changes in waiting lists on an annual basis. Based on the last available report dated June 25, 2005, we noticed, compared with the same period the previous year, a decrease of 1.4% (i.e., 238 fewer patients) for cataract surgery, a decrease of 0.2% (three fewer patients) for hip replacements and an increase by 9.6% (299 more patients waiting) for knee replacements.
- The Ministère will initiate, between now and December 2005, a process to clarify the content of waiting lists, starting with hip and knee replacements. In all institutions with patients waiting longer than nine months for one of these surgeries, additional information will be required to specify the status of the patients waiting. This operation will allow us to determine the actual number of patients waiting who require one of these operations and are available to be operated upon. This clarification work will also allow to reduce as much as possible the number of patients, whose wait for hip or knee replacement has truly exceeded the set limits based on the prevailing situation in Quebec institutions and a patient priority and removal plan. This effort will be a major step in managing patients awaiting service based on their actual needs. In order for this process to be a success, all network parties, including doctors in the specialties concerned, must be willing to give their full support to it. The new data collected this way will help us to update and enhance the information currently available on the Ministère's Web site.

Summary Table

Tertiary Cardiology: Waiting List	
<ul style="list-style-type: none"> • Diagnostic catheterization and angioplasty • Heart surgery 	<p>Decrease of 40.6% since 2002 in the number of patients waiting (628 fewer patients)</p> <p>Decrease of 35% since 2002 in the number of patients waiting (246 fewer patients)</p>
Tertiary Cardiology: Enhancements	
<ul style="list-style-type: none"> • Diagnostic catheterization and angioplasty • Heart surgery 	<p>Upgrading of two hemodynamic rooms at the Montreal Heart Institute in 2004-2005</p> <p>Announcement in May 2005 of the addition of three heart operating rooms at the Montreal Heart Institute</p>
Radio-Oncology: Waiting List	
<ul style="list-style-type: none"> • Waits longer than eight weeks • Waits longer than four weeks 	<p>85% drop (i.e., 175 fewer) in the number of patients waiting for more than eight weeks between March 2003 and September 2005. For breast and prostate cancer, no case exceeds an eight-week waiting period. Gradual drop in waits of more than four weeks. In September 2005, there were only 94 patients waiting.</p>
Radio-Oncology: Enhancements	
<ul style="list-style-type: none"> • Enhanced capacity 	<p>Fifteen treatment machines (accelerators) are currently being set up and will allow to treat 6,000 more patients a year between now and 2007-2008</p>
Medical Imaging	
<ul style="list-style-type: none"> • Magnetic Resonance • CAT Scan <p>Positron Emission Tomography</p>	<p>Thirteen new machines are being set up, which will bring the total to 50 in the Quebec public network</p> <p>Three new machines are being set up, which will bring the total to 101 in the public network</p> <p>One machine is currently being set up, which will bring the total to four in the public network</p>
Surgery	
<ul style="list-style-type: none"> • Cataract surgery • Knee Replacement • Hip Replacement 	<p>A 16.5% increase (9,358 more) in the number of patients operated over the past two years</p> <p>A 23% increase (959 more) in the number of patients operated over the past two years</p> <p>A 9.6% increase (377 more) in the number of patients operated over the past two years</p>

2. HUMAN RESOURCES IN THE HEALTHCARE SECTOR

The increase in the aging population, which is larger in Quebec than elsewhere in Canada, has meant an increased demand for health and social services. At the same time, the health and social services network has seen a decrease in the number of young people interested in working in the network and thus replacing those retiring. Over the past few years, the Quebec Government has been working to fill the current and anticipated labour shortages in order to ensure that accessible quality health and social services are maintained for the public.

Skilled labour must be available for these changes to take place in the health and social services network. The advances made over the past few years have enabled us to better respond to the needs of the population, due in large part to changes in practices of men and women who, within the health and social services network, have been able to benefit from new knowledge and technological developments, while remaining committed to the people who need their help.

In particular, the situation of nursing staff has positively developed over the past two years. For example, there are 903 more nurses working than the estimated number two years ago. The increase in number of students registering in health and social service training programs and higher numbers of graduates are primarily responsible for this positive change. Reviewing work organization methods means better use of the skills of nurses, nursing assistants, reception centre attendants, externs and clerks and has also reduced the demand for nurses by 2,600 over the past five years. Lastly, the increase in the number of full-time jobs and hours worked by nurses has represented over the past five years the equivalent of nearly 3,600 more jobs.

Work carried out by institutions to ensure adequate management regarding work attendance has meant that we can count on an available labour force equivalent to 660 employees and save approximately \$17.4 million.

Over the past twelve months, work has been carried out jointly between the Quebec College of Physicians, the Quebec Order of Nurses, the Quebec General Practitioners Federation and the Ministère de la Santé et des Services Sociaux to put in place the regulations required for introducing new professional practices, such as nurse practitioners specialized in cardiology, in neonatology or in nephrology. Introducing these new practices will foster accessibility to Quebec's health services.

Moreover, major steps have been taken to accelerate the evaluation and promote the integration of healthcare graduates trained abroad. Since 2000, through the implementation of the "Recruitment Health Quebec" program, the result of a partnership between the Ministère de la Santé et des Services Sociaux and the Ministère de l'Immigration et des Communautés culturelles, 500 French nurses were recruited to help fill the gaps we face in nursing staff. As well, upgrading training support programs have been set up for immigrants who have been trained in health care.

In the pharmacy sector, which also suffers from major staff shortages, students registering in the training programs have increased from 262 in 1999 to 312 in 2004, and then to 360 in September 2005. Investments have enabled us to set up a hospital pharmacy career program. Lastly, an action plan will introduce narcotic cabinets into health care units, which will promote a more judicious use by nurses, and thus reduce risks of errors and the costs associated with the use of medication.

Lastly, to meet the requirements of the new service organization, the government adopted on December 18, 2003, Bill 30, An Act Respecting Bargaining Units in the Social Affairs Sector and Amending the Act Respecting the Process of Negotiation of the Collective Agreements in the Public and Parapublic Sectors. The provisions of this Bill in particular reduce the number of collective agreements in an institution, which makes it easier to more effectively manage employees. Overall, adopting Bill 30 will allow institutions to be more flexible in managing human resources and to better assign the available health-care workers based on priorities.

Other actions have been made over the past few months to improve the coordination and concerted action of the government in order to address the labour shortages in the health and social services sector. To this effect, the government is developing a renewal strategy for employees in this sector, which shall be tabled this fall.

Medical Staff

Since the late nineties, Quebec has, among other things, been affected by a shortage in medical manpower. This shortage was, in part, due to a significant drop in medical school registrations and, in part, due to the implementation of a retirement program. Medical federations believe that this shortage amounts to respectively 800 general practitioners and 1,000 specialists. To fill this gap, Quebec is focused on four areas in its medical staff plan, namely:

- Triennial Policy for Registrations in Doctoral Medical Training Programs and Registration Policy for Post-Doctoral Medical Training Programs
- Recruitment Health Quebec
- Regional plans for staffing general practitioners and specialists
- Decentralized training

The first two items will increase the number of doctors; the last two will better allocate medical employees by trying to prevent service shortages.

1. Triennial Policy for Registrations in Doctoral Medical Training Programs and Registration Policy for Post-Doctoral Medical Training Programs

- Medical student registrations for Quebec have increased. They grew from 716 in 2004-2005 to 748 in 2005-2006, i.e., an increase of 32 places. Since 1998-1999, authorized registrations have increased by 84%. A satellite campus was set up in Trois-Rivières, under the aegis of the Université de Montréal's Faculty of Medicine, and a similar project was set up for Sagamie by the Faculty of Medicine at the University of Sherbrooke.

2. Recruitment Health Quebec—Doctors

- Recruitment Health Quebec currently is actively sponsoring 108 people; 14 candidates are doing their evaluation internship as required by the Quebec College of Physicians. The remaining candidates are being evaluated as to their eligibility for a limited licence from the Quebec College of Physicians or are in the process of writing exams. Twelve candidates have received their limited licence to practise.

- Recruitment Health Quebec, along with the Ministère de l'Immigration et des Communautés culturelles, support Quebec graduates from outside Canada and the United States wishing to obtain a regular medical practice licence. For the past two years, workshops for preparing students for entry exams to Quebec College of Physicians were organized. These workshops have paid off, given that, in 2002-2003 only two Quebec candidates who graduated outside Canada or the United States gained residency, while, in 2005-2006 this number climbed to 58.

3. Regional Medical Staffing Plans (RMSP)

- The purpose of regional medical staffing plans (RMSP) is to assure greater equity in terms of access to medical services by attempting to fix any inequities for medical service access between the different administrative regions. The idea of equity refers in this context to two principles:
 - Assuring the people in each region has equitable access to services
 - Fostering the sending of doctors to the regions so that these services can be offered in the patients' region
- Each year, the RMSP sets recruiting objectives for general practitioners and specialists for each region in Quebec. The 2006 RMSP for general practitioners and specialists should be released in October 2005.
- For 2005, closely managing the objectives helped increase recruiting of physicians for the regions with major doctor shortages (remote and intermediate regions).
- Regarding general practitioners, the overall rate reached in the medical staffing plans jumped from 70% in 2004 to 86% in 2005.

The main challenge will be to appropriately assign new doctors to different parts of Quebec to make sure that we respond as best as possible to the needs of the public. Therefore, the medical staffing plans have been designed to promote the recruiting of physicians at institutions that are not as well staffed by also limiting the recruiting of doctors in better staffed institutions. Last year, representatives from the recently created integrated university service networks (IUSN) contributed to this process. The IUSN must indeed propose a deployment plan for new doctors who will be starting their practice over the next few years, taking into account the needs of the people in the territory under their responsibility. This latest contribution should help to better organize medical services in different parts of Quebec and thus support complementary services between institutions.

4. Decentralized Training

Decentralized medical training has been recognized as being one of the best ways of recruiting doctors, since it enables medical residents to have an enriching experience by practicing medicine outside the major urban centres. In its decision of February 25, 2004, the Conseil des ministres recommended continuing and increasing the distribution of residence positions so that a significant percentage of all training internships are done by residents of the outlying regions, i.e., 10 and 15% in specialized programs and between 30 and 35% in general practitioner programs.

To act upon this recommendation, an internship plan for the next five years has been adopted with the faculties of medicine and a program was developed to support the faculties and the institutions in developing new internships in different areas.

The number of months in decentralized training in the regions has increased from 2,088 in 2004-2005 to 3,242 in 2005-2006, i.e., a 55% increase. Decentralized medical training has taken and will take several different forms: in family medicine units (Baie-Comeau, Trois-Rivières, Maria, etc.); in developing satellite campuses (Trois-Rivières and Sagamie) and in internships in healthcare institutions located more than 50 kilometres from a faculty of medicine.

3. HOME AND PALLIATIVE CARE

Orientations and Implementation

The *Home Support Policy* “*Home is the Option of Choice*” was made public on February 21, 2003. This policy was designed for various clientele requiring home care services, regardless of the reason for or circumstances of their disabilities or disorders, as well as for their families and loved ones. These services enable people whose health requires it to stay at home or return home after receiving care in an institution.

Thus, handicapped people (physical or intellectual disability, developmental problems), people with diminishing autonomy due to aging, people with a serious mental health disorder, people with physical health problems (chronic diseases, post-operative or hospitalized patients, palliative care), their families and their loved ones are eligible for various home support services based on a needs evaluation. These services strongly vary in nature and intensity. Depending on the needs, they are offered for a limited time (short term) or an undetermined time (long term).

This policy is applied horizontally and complements the action plans and policies for different clientele. It also falls within the framework of the reorganization of front-line services as being a priority and a means of solving problems, including those related to the inefficient use of certain resources (unnecessarily going to the emergency room, use of short-term beds for clients with other types of needs, etc.). Home support services make up 80% of the front-line services offered by the Centres de Santé et de Services Sociaux (CSSS).

Several conditions essential for implementing the *Home Support Policy* have been met since 2003, including:

- Adopting a means for allocating financial resources based on population
- Introducing changes to the ways of organizing services and management practices (especially appointing those in charge of coordinating services for all users requiring long-term services, integrated network work)
- Accountability based on results
- Implementing Centres de Santé et de Services Sociaux

Investments Allocated Since 2004 and Results Obtained

For the 2004-2005 budget year, the additional amount allocated for home support was \$61 million, which represents 30% of the \$200 million allocated this year for new public services. Of the \$61 million, the lion's share — \$50 million — was allotted to senior citizens who have lost autonomy.

The additional amounts granted for home care helped a larger number of people. Thus, in 2004-2005 157,637 senior citizens who had lost autonomy received services versus 153,714 the previous year.

The 2005-2010 action plan for services to senior citizens who have lost autonomy should be made public soon. This action plan emphasizes community services: the only way to adequately serve all senior citizens who have lost autonomy. Maintaining the current model, still too focused on public or private accommodation in hospital centres for long-term care, mobilizes resources for people living in these centers, while leaving other people at home without sufficient services.

During 2005-2006, this action plan will materialize in the form of regional implementation plans through agencies.

\$50 million has been set aside to implement the 2005-2010 Action Plan concerning services for seniors who have lost autonomy and the 2005-2010 Mental Health Action Plan.

Innovative Projects: Maintaining People's Living Environment

Moreover, since July 2004, innovative projects have been implemented to enable people who have lost major autonomy to maintain their living environment instead of being sent to institutional accommodation.

These projects carried out with partners such as local housing authorities, community organizations or home service co-ops enable people who have lost autonomy to continue living in a familiar place, whether a studio, an apartment or a room. This approach enables people to stay as long as possible in a living environment similar to their home and to be with their loved ones, thus preventing the breakdown of their social ties. In all cases, health and social services are provided by an institution in the health and social services network and the other services, such as accommodation, are taken care of by another partner.

Between July 2004 and June 2005, 31 projects of this type were authorized by the Ministère. These projects, carried out for an approximate recurrent and annual cost of \$12 million, except for accommodation services, offer services to 500 senior citizens who have lost autonomy.

Palliative Care at the End of Life

In June 2004, the Ministère de la Santé et des Services Sociaux made public a Policy on Palliative Care at the End of Life, which will be implemented over the next few years.

This policy sets out guidelines, which will help structure action in the area of end-of-life services for all clientele. In addition to describing the context and the main issues that Quebec society must face, it proposes solutions and concrete measures for improving end-of-life services for everyone, whether adults or children. Three guidelines underlying a partnership with the user, the family and those involved in the planning and provision the services were used as guides in defining these solutions and measures. These are:

- Needs and choices of users
- Maintaining users in their natural living environment
- Supporting the family and loved ones

Thus, this policy promotes continuous access to quality services (medical, nursing and pharmaceutical), whether at the person's home, in an institution or in palliative care. To do so, the objectives were set by regional agencies in order to increase the number of people at home at the end of life and to offer these people more services. It will also promote access to palliative care beds, especially in Quebec.

4. REFORM OF PRIMARY CARE

Local Health and Social Services Networks

In December 2003, the Quebec Government adopted the Local Health and Social Services Networks Act. This Act gave agencies the responsibility of setting up a new way of organizing the services in each region, based on local service networks. The purpose of the 95 local service networks created throughout Quebec in June 2004 was to bring services to the public, providing better accessibility, coordination and continuity.

At the heart of each of these local service networks there is a new institution called “centre de santé et de services sociaux” (CSSS), created from the merging of local community service centres, long-term care centres and shelters, and in most cases, a hospital. The CSSS serves as basis for the local service network to ensure accessibility, continuity and quality of the services for a given local population.

With the creation of the local service networks, different parties providing health and social services to a local population will now collectively share in the responsibility for this population. This population responsibility assumes that the network mobilizes to, on the one hand, improve the health of the entire population through public health activities, such as promotion and prevention, and, on the other hand, improve access, continuity and quality of services, especially for more vulnerable clientele: senior citizens who have lost autonomy, people with mental health problems, people with chronic diseases, youth at risk, and people requiring palliative care. The network requires a hierarchy of services to guarantee better complementarity between first-line, second-line and third-line services through a common referral system between service providers.

This reform comes specifically with three major levers that will make it easier to attain the objectives.

Family Medicine Groups

Quebec laid the foundations for a new front-line care organization by implementing the first family medicine groups (FMG). There are currently 104 FMGs in Quebec: 71 are the result of private clinic doctor groups, 17 were accredited in public institutions and 17 others are mixed (private clinic associations and public institutions).

The 2005-2010 strategic plan of the Ministère de la Santé et des Services Sociaux calls for the creation of 300 FMGs, which in the end will enable the registration of a family doctor for approximately 70% of the Quebec population. As of September 26, 2005, 1,128 doctors and at least 185 nurses worked in FMGs. Thirty-two family medicine group projects are currently being prepared.

In all cases, the FMG service offerings include medical activities with or without appointments, in a doctor's office or at home for people whose condition requires it, during clinic business hours on weekdays and without appointments on weekends. A response adapted to the people on the list whose health condition is fragile and those who live at home but have seriously lost autonomy is assured outside the regular opening hours of FMGs. This service offering is made possible through Info-Santé and requires 24-hour medical supervision, seven days a week, taken care of by FMG members, in cooperation with health care and social services network professionals.

As of September 17, 2005, 637,674 patients were registered at an FMG (electronic registration at the RAMQ), with a potential estimate of registrations at 104 FMGs of nearly 1,550,000 people.

A formal evaluation process was started by the Ministère in different regions. Benefits were reported by clients, stakeholders and partners regarding, in particular, accessibility to and quality of the services offered. Thus, the regions saw an increase in the business hours of certain FMGs in their territory while others noted an increase in the number of service hours without appointments or an increase in the number of days of services offered per year, including holidays. Other benefits were seen in client follow up—though, among other things, the integration of nurses—in accessibility to second-line services and even in adapting services to patient needs, 24 hours, seven days a week.

Implementing FMGs in Quebec therefore contributes to the reform of primary health care by a service organization promoting accessibility, continuity and taking care of the clientele of a family doctor. This medical group practice model is based on interdisciplinary work and complementary care for each formal or informal partner and contributes to the hierarchy of health care by establishing robust front-line medical services.

Network Clinics (NC)

In order to reflect the specific characteristics of the Montreal region in terms of the organization of front-line services, the Ministère de la Santé et des Services Sociaux worked with the Quebec Federation of General Practitioners, the Agence de développement de réseaux locaux de services de santé et de services sociaux de Montréal (ADRLSSS), the Département régional de médecine générale de Montréal and the Montreal Association of General Practitioners to design a medical clinic model that would meet the characteristics of medical practice in urban centres and the need of offering citizens access to more comprehensive medical services during extended hours. This practice model has taken the form of network clinics.

The goal of these clinics is, on the one hand, to assure accessibility to medical services without an appointment outside the emergency room of a hospital every day of the year as well as weeknights, and, on the other hand, to coordinate operations between the doctors in a specific territory who look after the medical needs of their clients, and the Centre de santé et de services sociaux (CSSS) to assure the accessibility and continuity of the health and social services offered to the people. A network clinic could be a well-established clinic, a group of clinics or even the medical team or a CLSC or FMG, or a family medicine unit that serves a population of approximately 50,000 people. The network clinic offers services to the public and coordinates and liaises between the CSSS and doctors in the area. The development agency for local health and social service networks assumes the costs of liaison staff (mainly nurses), clerical staff, and computer support expenses for services without appointments. The Ministère de la Santé et des Services Sociaux pays doctors an additional amount of \$80 for every four hours of services without appointments given outside business hours (between 6:00 p.m. and 10:00 p.m. in the evenings and 8:00 a.m. and 4:00 p.m. on weekends and holidays).

The network clinic provides access to a complete range of front-line medical services, including consultations with or without appointments, 365 days a year, 12 hours a day weekdays and eight hours a day on weekends and holidays. The network clinic must offer or draw up agreements to offer basic emergency diagnostic services (lab, simple x-rays and ultrasound). The network clinic also ensures that medical monitoring services are available outside business hours for vulnerable clients by guaranteeing access to a doctor at all times. Eight clinics are currently open in the Montreal region; seven more should be up and running by March 31, 2006.

5. PHARMACEUTICAL PRODUCTS

Symposium on Optimal Drug Use

In May 2004, at the initiative of the Ministère de la Santé et des Services Sociaux, a symposium on optimal drug use was held with the goal of bringing together all parties involved in the optimal use of drugs to make everyone aware of the problems, to share and exchange ideas and to make it easier to find concrete solutions and foster their application in each of the areas represented.

During this symposium, several topics were discussed, including therapeutic management programs, user responsibility, new technologies for improving care and strategies for increasing optimal use.

Approximately 300 people attended this symposium (healthcare professionals, university employees, network managers, managers from various public agencies, representatives from professional orders, unions, social groups and the industry, and members of the Assemblée Nationale).

Awareness Campaign on Optimal Drug Use

A three-year information campaign on the proper use of drugs was launched by the Ministère de la Santé et des Services Sociaux in September 2004. It responds to the commitment made by the Ministère de la Santé et des Services Sociaux during the Symposium on Optimal Drug Use. Its objective is to promote the adoption and maintenance of good attitudes regarding optimal drug use.

This campaign is the first of its kind in Quebec and aims to be a major prevention initiative that will empower citizens to use medication correctly. Health prevention is incidentally a major issue discussed at the Forum des générations².

A sum of \$1.3 million was invested in the first year of the campaign and an annual amount of approximately \$1.5 million is expected for the second and third years.

² Between October 12 and 14, 2004, the Forum des Générations enabled the Quebec Government to come together with other elected representatives and leaders of Quebec society to find concrete, structured, long-term solutions to the two challenges facing Quebec and threatening the equity between generations, i.e., declining demographics and the government's finances.

Drug Policy

In December 2004, the Quebec Government tabled a draft drug policy at that Assemblée Nationale. This policy involved four areas:

- accessibility to medication
- establishing a fair and reasonable price for medication
- the optimal use of medication
- maintaining a dynamic pharmaceutical industry in Quebec

The aim of the drug policy is to provide Quebec with a common vision and strategy that will ensure medication is accessible to everyone, that medication is used optimally and that we have a business environment where business practices, the prices paid and industrial development contribute to the success of this strategy.

This policy was developed with the cooperation of the stakeholders. Three of the four areas were primarily inspired by work from different committees or the opinion of several experts. Thus, a Tripartite Committee on Drug Pricing (Régie de l'assurance maladie du Québec, Ministère de la Santé et des Services Sociaux and the Conseil du médicament) was set up to study the issue of drug prices, access to the market, the business practices of pharmaceutical companies and wholesaler mark-up. The proposals presented regarding optimal use resulted from certain conclusions made during the Symposium on Optimal Drug Use. Lastly, the Ministère de la Santé et des Services Sociaux consulted the Ministère du Développement économique, de l'Innovation et de l'Exportation and manufacturers of innovative and generic drugs to develop the fourth area.

After the draft policy was tabled, 84 briefs were tabled at the Commission des Affaires Sociales of the Assemblée Nationale and hearings were held between April 20 and September 1, 2005.

Draft legislation should be tabled this fall to implement the provisions of the policy that require legislative amendments. Following its adoption, the final version of the drug policy will be published.

Moreover, this policy can be used to review the current issues in order to find an acceptable balance between the increasing needs and collective ability to fill them. In the long run, the drug policy will be used to guide the actions of the Ministère and of other concerned parties, while maintaining a dynamic pharmaceutical industry in Quebec. The proposed solutions are based on optimizing available resources.

6. PUBLIC HEALTH—PREVENTION AND PROMOTION

A number of public health measures have been put in place to better identify the scope of and prevent healthcare problems. These measures concern the management of public health throughout Quebec, the management of the blood system and follow-up or prevention of different types of problems (chronic diseases, infectious diseases, developmental and social projects in children and youth).

Public Health Management

As provided for in the *Public Health Act* and the *2003-2012 National Public Health Program*, all regions of Quebec have developed their regional public health action plan. Most of the Centres de santé et de services sociaux have also developed their own local public health action plan. Regional and local public health problems are key issues for ensuring consistent actions and public health services offered throughout Quebec. Moreover, in April 2005, the National Director of Public Health, in accordance with the *Public Health Act*, published the first provincial report on the state of health of the Quebec population.

Blood System Management

Regarding blood system management, the transfusion accident and incident reporting process was combined and nearly 90% of institutions running a blood bank are part of this new process. As well, the integrated information system on transfusion and blood surveillance activities for computerizing transfusion activities was set up in 85 institutions with a blood bank. This system makes it easier to monitor all transfusion activities from donor to recipient and to systematically generate data on monitoring recipients, on transfusion reactions and on the use of blood products. Along these lines, we should point out that, through this system, Quebec is currently providing 80% of the Canadian data on transfusion accident and incident monitoring.

The Fight Against Smoking and Chronic Diseases

The fight against chronic disease first comes through the many preventive measures against smoking. In June, 2005, the *Tobacco Act* was revised to introduce measures that would further limit the use of tobacco. Centres have since been set up to help people quit smoking. Most regions have these free services and, over the past year, have been able to work with approximately 4,000 smokers, which represents a 40% increase versus the previous year. As well, the Quebec Breast Cancer Screening Program was consolidated and now reaches nearly one in two women between the ages of 50 and 69. Work has also been done on improving the quality assurance process for this program.

Infectious Diseases

The Provincial Table on the Prevention of Hospital-Acquired Infections was set up to develop and carry out an integrated action plan to fight against hospital-acquired infections. Hospitals also received financial support, which enabled them to purchase equipment and carry out property projects directly related to infection prevention. General and specialized care institutions have added resources to reach the ratio recommended by the Quebec Committee on Hospital-Acquired Infections, that is of one nurse assigned to the prevention of hospital-acquired infections for 133 short-term beds. As well, a *Clostridium difficile* monitoring system was put in place. To complement the actions for preventing infectious diseases, a public health version was developed by the department during the year to fight against the influenza pandemic. Work is underway to be ready to face the pandemic if it should happen in Quebec.

Development and Social Problems in Children and Youth

Preventive services for vulnerable families (low income, low education levels, young mothers) were consolidated last year. These services primarily aim at the healthy development of children and preventing abuse and negligence. Integrated perinatal and early childhood services, which both help families during pregnancy and early childhood (between 0 and 5 years) and carry out interventions designed to improve the quality of the environments of these families, were implemented in almost three-quarters of the local territories in Quebec. In 2004-2005, these services helped 61% of low-income, low-educated pregnant women and mothers aged 20 or more and 88% of young pregnant women and mothers under 20 years of age.

Furthermore, ten of the 16 development agencies for local health and social services networks in Quebec have an action plan to deploy the *École en santé* approach, the result of work between the healthcare and education sectors. This approach involves planning the overall health promotion and prevention actions so that the school, family and community can work together on the main factors influencing the health, well-being and success in school of young people. Provincial mechanisms and tools were put in place to support the implementation of this approach.

Campaign on Promoting Healthy Life Styles

In the fall of 2004, the Quebec Government launched its promotional campaign on healthy lifestyles, targeting the general population, and, more specifically, young families. From the view of public health prevention, actions were carried out to encourage the population to eat healthfully and regularly exercise. Run by five government departments, this campaign proved to be strong in mobilizing many different partners in order to promote interactions between different sectors.

Specifically, regarding the Ministère de la Santé et des Services Sociaux, the campaign on promoting healthy life styles is in line with the objectives of the 2004-2012 Provincial Public Health Program.

7. Reporting and Accountability

Commissioner on Health and Well-Being

Following public consultations held during the winter of 2004, Bill 38 on the Commissioner of Health and Well-Being was adopted by the Assemblée nationale in the spring of 2005, and then sanctioned on June 17.

Reporting to the Ministère de la Santé et des Services sociaux, the Commissioner of Health and Well-Being must assess and evaluate the results of the health and social service system and report on it to the population. The Commissioner shall also focus on two major issues facing Quebec's socio-health system: quality, accessibility, integration, insurability and funding of services, ethics related to health and well-being, medication and technologies as well as the determining factors for health and well-being. He also reports to the Quebec population regarding his assessment of changes in the system for these issues.

The purpose of the process for appointing the Commissioner of Health and Well-Being is to provide him with strong authority and greater independence in carrying out his duties. A nominating committee will be set up to recommend people to be nominated as Commissioner to the Quebec Government. This committee will be made up of seven members of the Parliamentary Commission on Social Affairs, including three from the opposition parties. As well, five experts from sectors related to health and well-being will be appointed after consulting with representative organizations. These five members will come from the following areas of expertise: medicine, nursing, social work, technology evaluation and ethics. The last two members of the nominating committee will represent the point of view of users and the population in general respectively.

The process for appointing a Commissioner of Health and Well-Being has reached the step of setting up a nominating committee. The Act provides that this committee has six months to make recommendations to the Quebec Government. Appointing the Commissioner will result in abolishing the Conseil de la santé et du bien-être and the Conseil médical du Québec. The staff in these organizations will support the Commissioner in carrying out his work.

Implementing a Commissioner of Health and Well-Being will ensure the population of Quebec of closer and more impartial follow-up of the results, progress made and priority issues regarding its health and social services.

A New Management Framework Based on Results in the Health and Social Services Network

The *Public Administration Act* adopted in 2000 recommends a new results-oriented management mode. These results are measured using indicators, which are essential for results-based management, not only for the actual measurement of the results and performance assessment, but also for making decisions, developing and reviewing the strategic plan and action plans, allocating resources, improving services and service provision methods and developing the organization.

This new management framework obliges the Ministère to produce a multi-annual strategic plan, an annual expense management plan and an annual management report. These three documents are tabled before the Assemblée Nationale.

The report of the Ministère each year before of the Assemblée Nationale must be based on reliable and credible information and enable to assess the results in light of the stated intentions. More than ever, in particular due to the expenses involved, the Quebec health and social services system must assess its objectives and report on progress made in this respect.

It is especially from this perspective that the governance of the health and social services network was modified in 2001. Major changes have been made to the *Act Respecting Health Services and Social Services* to institute results-oriented management within the health and social services network. These legislative changes oblige the regional agencies to prepare management and accountability agreements with the Ministère and to produce an annual management report. For their part, institutions must enter into a management and accountability agreement and produce an annual management report.

Management and Accountability Agreements

Management and accountability agreements, whose content builds on items in the departmental strategic plan, annually sets service production targets, which are incumbent upon regional agencies and institutions in the socio-health network, determine their accountability in attaining these targets along with the obligation from the Ministère to support the agencies and institutions in this process, especially through the required financial, technological and human resources.

Thus, the Ministère signed management and accountability agreements during the summer of 2005 with the agencies. These agreements set out, based on the performance indicators identified for the services in each of the service programs and support programs, commitments to maintain during 2005-2006. These agreements are based on management and accountability agreements signed with these agencies for 2004-2005, agreements for which the Ministère required a report over the past few months.

8. ABORIGINAL HEALTH

First, keep in mind, for all Aboriginal communities in Quebec, financing for health and social services is mainly under the responsibility of the federal government. The Ministère however does participate in discussions with Aboriginal communities to ensure a better link with its network in organizing health care services and in certain projects where it can contribute in terms of training Aboriginals.

Moreover, since 1976, the Cree, Naskapi and Inuit Aboriginal communities have had their own system for planning, organizing and providing health and social services, which is partially funded by Quebec.

On March 31, 2005, after two years of discussion, the Quebec Government signed a specific agreement with the Cree Nation in Quebec worth \$152 million to give effect to the implementation of Chapter 14 of *The James Bay and Northern Quebec Agreement* regarding the provision of health and social services.

This agreement, a complement to *The Order in Council Respecting the Publication of the Agreement Concerning a New Relationship Between the Government of Quebec and the Crees of Quebec*—known as the “*Paix des Braves*”—signed in February 2002, provided a stable and predictable financing formula for the region. It is supported by a strategic plan developed by the Cree Council on Health and Social Services for James Bay, which defines the implementation means and the resources required for an integrated service organization. This approach fosters the development and management by the Crees of a health and social services organization that is better adapted to the specific needs of the Aboriginal people living in each of the nine Cree villages.

Thus, a decentralized, more concentrated service organization in each village will enable the Cree to have better means for preventing and for acting on health problems deemed priorities and resulting from, among other things, changes in their life style over the past 30 years. Compared with the rest of the population, Cree are more likely to have from Type 2 and gestational diabetes, tooth decay, obesity, cardiovascular disease and arthritis. Most of these problems are primarily attributable to the gradual disappearance of traditional life styles, reduced daily exercise, changes to diet related to the transformation of their habitat and the problems in finding a fresh, nutritious alternative source of food at affordable prices, given the major expenses in shipping food to these remote and isolated regions.

The agreement signed with the Cree enabled them to kick off projects designed by the communities themselves and to ensure that the services provided have the holistic approach desired by the Cree, i.e., based on an approach that takes into account the global nature of the needs of the members of their community (social, spiritual, health, work, housing and other needs).

As for the Inuit, many different projects are currently ongoing with the Nunavik Regional Board of Health to evaluate their needs. Specific attention is being paid to priority prevention programs, especially regarding the organization of youth services, including youth protection and services of people with mental health problems. A major issue involves optimizing the use of the currently available resources in institutions and organizing them so that they meet the needs of these populations as adequately as possible given that they are spread out in isolated and hard-to-access villages.

The Ministère de la Santé et des Services Sociaux has also financed an on-site study conducted in cooperation with the Nunavik Public Health Board, which aims to better identify the health of the Inuit population and especially to understand under which conditions prevention, awareness and educational activities can count on the development of community approaches so that the services offered have been adapted to the culture.

CONCLUSION

This overview of the measures put forth in Quebec for the health sector over the past year accurately illustrates the progress made and work carried out. Moreover, we must point out that this report purposely does not mention other measures and initiatives made in the Quebec health and social services sector, since it is limited mainly to the sectors identified under the agreement of the First Ministers entered into during the Federal-Provincial-Territorial Conference on Health held in September 2004. This document therefore has been prepared in this context as providing additional information to the public. It does not replace other regular and recurrent reporting methods, in particular that of the Ministère's annual management report.

We should also mention that regarding reducing wait times, the main objective of the conference on health in September 2004, major improvements have been made in terms of accessibility and productivity in the sectors of tertiary cardiology and radio-oncology, which have not only been accomplished through major investments in high-tech and human resources, but also through setting up a management program for waiting patients based on needs. To attain these results, we had to obtain the cooperation of clinicians from the specialties concerned in order to develop the necessary tools to share and exchange quality information on the actual needs of patients. As we have mentioned, we would like to see the same degree of success in other priority sectors by improving our knowledge of wait list content. We also plan to focus on the organization of work and services, standardize certain practices, carry out regular analyses of wait lists and review the methods for preparing and releasing patients while providing a high level of service quality and safety. Initially, and in the short term, we will focus our efforts on joint replacement, i.e., hip and knee replacements, and then gradually work on all services.

Lastly, the presentation of all these results in this report show that the Quebec Government has met its reporting commitment to the general public.



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