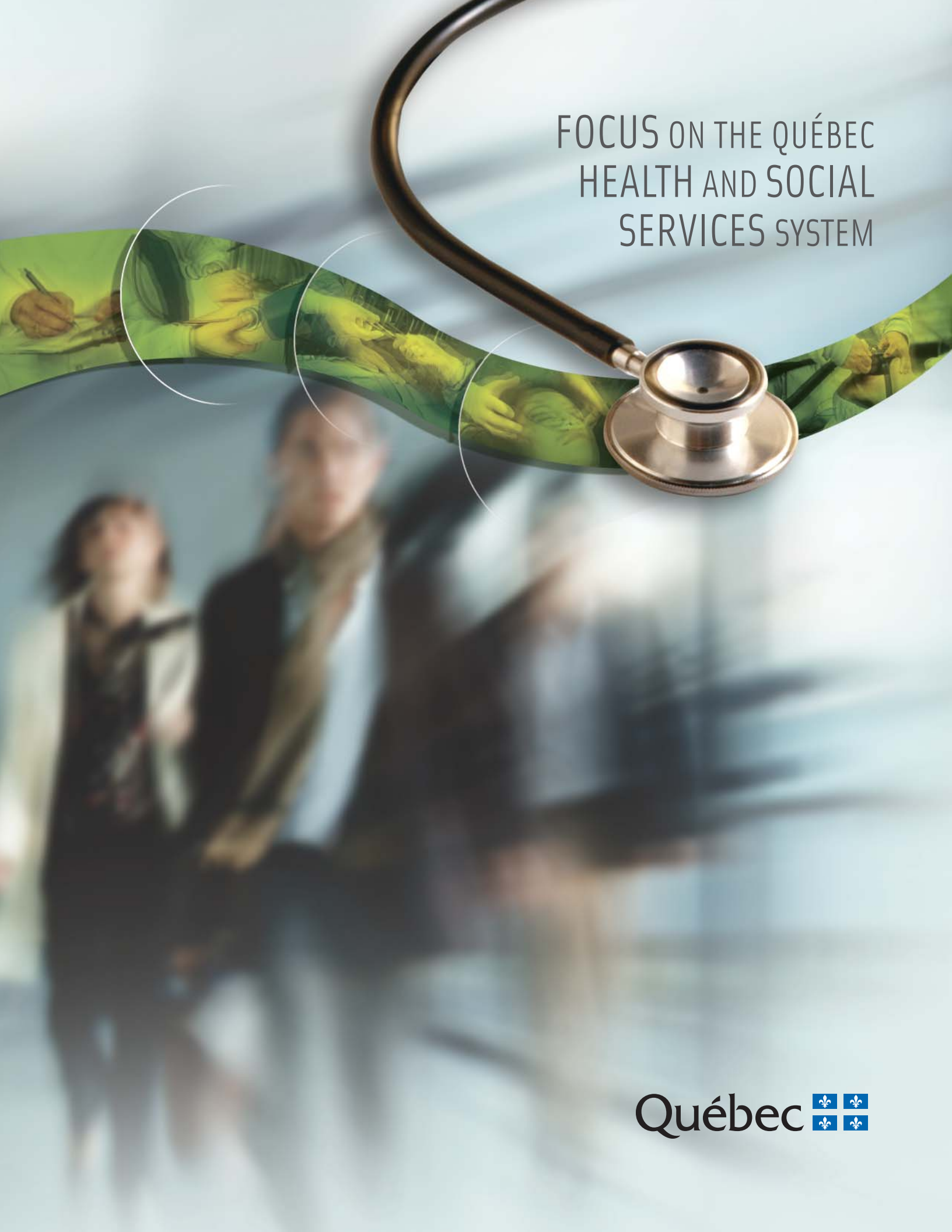

FOCUS ON THE QUÉBEC HEALTH AND SOCIAL SERVICES SYSTEM

Québec

FOCUS ON THE QUÉBEC HEALTH AND SOCIAL SERVICES SYSTEM

April 2009

Santé et Services sociaux Québec

ACKNOWLEDGMENTS

A great number of people contributed to making this document a reality. Convinced that these people will recognize who they are, the author decided not to name each one personally. He did, however, want to make sure that they are aware of how grateful he is and how much he appreciated their contribution.

In drafting the text on the history of the health and social services system, the author drew extensively from papers produced by the Ministère de la Santé et des Services sociaux's (MSSS) Direction des politiques et des orientations stratégiques. Also, the author wanted to point out the considerable contribution to this document with a sincere thanks to the other members of this team and their manager.

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This publication was produced under the administrative coordination of Alain Saucier, Director of Direction de la gestion intégrée de l'information, Pierre Laflamme, Assistant Director General of Direction générale adjointe aux ententes de gestion, and Lise Verreault, Assistant Deputy Minister of Direction générale de la coordination, du financement, des immobilisations et du budget.

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Masculine pronouns are used generically in this document.

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PREFACE

Québec's health and social services system is one achievement of which we can be proud. Its history is filled with the laws, changes and innovations that made it a part of the great trends that marked societies in the 21st century. Québec has much to say on the subject. People are, of course, very interested in the principles and values that frame our system, but they are just as, if not more, interested in the organization of our health and social services system as well as in factual information describing its structure and operation.

Although all of this information is available, it is often piecemeal, sitting in immense data bases, or consigned to specialized documents and voluminous reports with a limited distribution list. We therefore need a more accessible instrument to meet the need for information.

It therefore gives me great pleasure to give you the document titled "*Focus on the Québec Health and Social Services System*."

This publication from the Ministère de la Santé et des Services sociaux aims to help the reader gain an overall understanding of Québec's health and social services system. Its originality lies, on the one hand, in its proposal of historical references to the main events that led to its establishment and current development and, on the other hand, in its presentation, in a synthesized manner, of a statistical overview of its main aspects, whether as regards the human and institutional resources that it requires, the use that is made of the services it provides, or the costs that it generates.

We fervently hope that this document will be used in a variety of ways: as a means to initiate new arrivals to the Ministère; as a useful tool for those who are interested in conducting research in this sector; as a way of explaining the evolution of Québec's health services and social services to our visitors and our foreign interlocutors; or as a primary source of information for the personnel working within the system of services itself. Moreover, the publication will truly have achieved its goal if it succeeds in bringing the background of Québec's health services and social services to the attention of the public.

Why does the Government of Québec allocate so many resources—whether financial or other—to the organization of services to better adapt them to the new realities and new needs of those for whom they are intended? Why do all stakeholders involved continue to ponder the best ways of funding and managing these services? Because our desire to give Québec's society a health and social services system equal to its expectations is our constant concern.

I would like to thank all of those who contributed to this publication. The interest you take in the publication will be their reward.

Jacques Cotton
Deputy Minister of Health and Social Services

FOREWORD

For the past twenty years, the Ministère de la Santé et des Services sociaux has produced, on a regular basis, reference documents that describe the various aspects of the Québec health and social services system.

In general, other than a brief history of the health and social services system and a description of its main components, these documents contain a range of statistics illustrating the fundamental aspects of the system. *Focus on the Québec Health and Social Services System* follows the same path as previous publications of the same kind, a few examples of which are included below:

Les affaires sociales au Québec, published in August 1980;
Le système de santé et de services sociaux au Québec, published in 1985;
Le système de santé et de services sociaux du Québec: Un aperçu, published in 1989;
Le système sociosanitaire québécois en quelques chiffres, published in 1992;
Santé et bien-être: La perspective québécoise, published in 1993;
Le coût et l'efficacité des services de santé et des services sociaux, published in 1996;
The Québec Health and Social Services System: A Statistical Profile, published in 2001;

This publication is meant to serve as a practical reference tool. It is not meant to study all aspects of the system in depth, or determine the factors that explain the phenomena that the study highlights, or specify the actions that might reverse the observed trends, but aims to describe them enough to enable readers to gain a general understanding that will allow them to develop an image of the Québec health and social services field that is as accurate as possible.

Nevertheless, those who would like to know more about particular aspects of Québec's health and welfare services can obtain the information at the Ministère de la Santé et des Services sociaux's Documentation Centre, located at the following address:

1075, chemin Sainte-Foy, 5e étage
Québec (Québec) G1S 2M1
Tel.: 418 266-7007
Fax: 418 266-7024

There is also a wide array of relevant information on the Ministère's website **www.msss.gouv.qc.ca,** as well as on those of the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** and the Institut national de santé publique du Québec **www.inspq.qc.ca**.

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The data used to produce the figures were drawn directly from the contents of tables presented in the statistical book.

LIST OF TABLES PRESENTED IN THE STATISTICAL BOOK

Population

Society

Human resources

Institutional resources

Utilization of services

The cost

LIST OF ACRONYMS USED IN THE DOCUMENT

$M	Million dollars
$MM	Billion dollars
AAC	Average annual change
ADRLSSSS	Agence de développement de réseaux locaux de services de santé et de services sociaux [local health and social services network development agency]
ARSSS	Agence régionale de la santé et des services sociaux [regional health and social services agency]
CAP	Canada Assistance Plan
CAU	Centre affilié universitaire [affiliated university centre]
CCS	Centre de communication santé [health communication centre]
CFH	Council of the Federation on Health
CH	Centre hospitalier [hospital centre]
CHA	Canada Health Act
CHC	Canadian Health Covenant
CHSGS	Centre hospitalier de soins généraux et spécialisés [general and specialized care hospital centre]
CHSLD	Centre d'hébergement et de soins de longue durée [residential and long-term care centre]
CHSP	Centre hospitalier de soins psychiatriques [psychiatric hospital centre]
CHST	Canadian Health and Social Transfer
CHT	Canadian Health Transfer
CHU	Centre hospitalier universitaire [university hospital centre]
CIHI	Canadian Institute for Health Information
CJ	Centre jeunesse [youth centre]
CLSC	Centre local de services communautaires [local community service centre]
CPEJ	Centre de protection de l'enfance et de la jeunesse [child and youth protection centre]
CPI	Consumer price index
CR JDA	Centre de réadaptation pour jeunes en difficulté d'adaptation [rehabilitation centre for young persons with adjustment problems]
CR MDA	Centre de réadaptation pour jeunes mères en difficulté d'adaptation [rehabilitation centre for young mothers with adjustment problems]
CR PAT	Centre de réadaptation pour personnes alcooliques et autres toxicomanes [rehabilitation centre for persons who suffer from alcoholism or other problems of addiction]
CR PDI	Centre de réadaptation pour personnes déficientes intellectuelles [rehabilitation centre for mentally impaired persons]
CR PDP	Centre de réadaptation pour personnes déficientes physiques [rehabilitation centre for physically impaired persons]
CR	Centre de réadaptation [rehabilitation centre]
CRS	Conseil régional de la santé [regional health council]
CRSSS	Conseil régional de la santé et des services sociaux [regional health and social services council]
CSD	Compromised safety and development
CSSS	Centre de santé et de services sociaux [health and social services centre]
CSST	Commission de la santé et de la sécurité du travail [occupational health and safety board]
CST	Canadian Social Transfer
DGSS	Direction générale des services sociaux [social services branch]
EHR	Electronic Health Record
EPF	Established programs financing
FRSS	Fonds pour la réforme des soins de santé [health care reform fund]
FTE	Full-time equivalent
FTR	Family-type resource
GDP	Gross domestic product
GMF	Groupe de médecine de famille [family medicine group]
GNP	Gross national product
GSC	General and specialized care
HSLD	Hébergement et soins de longue durée [residential and long-term care]
I/D	Incomplete data
I-CLSC	CLSC integration system
ICT	Information and communication technology
IFR	Intensive functional rehabilitation

INSPQ	Institut national de santé publique du Québec
IR	Intermediate resource
ISQ	Institut de la statistique du Québec
IU	Institut universitaire [university institute]
km²	Square kilometre
MED-ÉCHO	Maintenance et Exploitation des Données pour l'Étude de la Clientèle Hospitalière [maintenance and use of data for the survey of hospital clients]
MSSS	Ministère de la Santé et des Services sociaux
NC	Newborn care
OPHQ	Office des personnes handicapées du Québec
ORAS	Office régional des affaires sociales [regional social affairs office]
ORS	Conseil régional de la santé [regional health council]
PAT	Person suffering from alcoholism or other addiction
PAV	Residential pavilion
PC	Psychiatric care
PDD	Pervasive developmental disorder
PGC	Physical and geriatric care
PID	Person with an intellectual disability
PPD	Person with a physical disability
PROSTAT	Progressive statistics
RAMQ	Régie de l'assurance maladie du Québec
RFT	Regular full-time
RLS	Réseau local de services [local service network]
RRSSS	Régie régionale de la santé et des services sociaux [regional health and social services board]
RSS	Région sociosanitaire [health and social services region]
RUIS	Réseau universitaire intégré de santé [integrated university health network]
SAAQ	Société de l'assurance automobile du Québec
SBF-R	Système budgétaire et financier régionalisé [budgetary and financial system by region]
SDI	Service du développement de l'information
SIFO	Système d'information financière et opérationnelle [financial and operational information system]
SIRTF	Système d'information des ressources intermédiaires et de type familial [intermediate and family-type resource information system]
STPC	Short-term physical care
TAP	Paramedic/ambulance technician
VTP	Voluntary termination of pregnancy
YPA	*Youth Protection Act*

INTRODUCTION

Focus on the Québec Health and Social Services System takes a general look at the main aspects of the health and social services field in Québec.

This descriptive synthesis document has two main objectives. On the one hand, it constitutes an official reference document that can be presented by the Ministère either to foreigners who come to visit or are visited or to new staff members at the Ministère. On the other hand, as it will be circulated both inside and outside the MSSS, this document constitutes a substantial source of information for anyone who, whether closely involved or from a distance, is interested in Québec's health and social services system.

First, it presents the province of Québec as a whole through a few territorial, demographic and social characteristics. Then, it paints a broader picture of the health and social services system, on the one hand, by providing a history of the main events and legislation that marked its evolution to date and, on the other hand, by examining the human and institutional resources it requires, the use that is made of the main health and social services provided to the population, and the financial resources devoted by the government to the system.

In addition to listing the main elements of this evolution, several sections of the document contain statistical charts, in general covering more recent years, along with a descriptive analysis of their informational content. The dates may vary from one theme to another, depending on the closing dates of the various files and systems that were used to produce the documents used as sources of information here. A list of these various sources is provided in the bibliography for those readers who wish to explore any of the themes addressed in more detail.

In order to enable readers to get the most out of the information provided in this document, it contains a statistical book containing a large number of statistical tables presenting a wide range of scalable data related to the various topics covered, including those that were used in preparing the charts that complement the text. Moreover, specifications regarding the type of data considered are also included to add to the proper understanding of the statistics presented.

Lastly, this document, unlike the one published in December 2001 (*The Québec Health and Social Services System: A Statistical Profile*), does not contain a section specifically devoted to population health and welfare results. This very broad universe of information is examined in depth at the Institut de santé publique du Québec (INSPQ), whose website is the following **www.inspq.qc.ca**. There you will find a significant number of targeted analyses and relevant documents, including a file titled *Portrait de santé du Québec et de ses régions, 2006*, to name just one.

Québec

Territorial characteristics

Demographic characteristics

Socioeconomic characteristics

Health and social characteristics

QUÉBEC

Québec is situated in northeastern North America, between the 45th and 60th parallels.

Having been the birthplace of the Nouvelle France from its official discovery by Jacques Cartier in 1534, this possession was then ceded by France to Great Britain with the Treaty of Paris ratified in 1763, as a result of France's defeat in the battle on the Plains of Abraham in 1760.

Following the massive arrival of American loyalists fleeing the United States after independence, the territory was divided into two parts in 1791, that is, Upper Canada, which corresponds to Ontario today, and Lower Canada, or present-day Québec.

In the early 1800s, fierce opposition developed, with demands for the establishment of a true parliamentary system of government. This opposition was led by Louis-Joseph Papineau in Lower Canada and by William Lyon Mackenzie in Upper Canada. London's flat refusal to accede to the demands of the opposition brought about the Rebellion of 1837. This rebellion was harshly suppressed and its leaders were imprisoned, exiled or executed.

In 1840, the British government created a united Canada, endowing it with a governor, an executive council, a legislative council and an elected body.

In 1867, the British North America Act created the Dominion of Canada, which brought together Ontario, Québec, Nova Scotia and New Brunswick. Confederation continued to extend its territory up until 1949, when Newfoundland, the last of the ten Canadian provinces, joined on.

Between 1867 and 1960, political life in Québec was marked by the division between the liberals and the clerical conservatives who succeeded one another to power. In the 1960s, however, Québec underwent major changes on every level, including the secularization of religious powers in the education, health and social services sectors. With the Quiet Revolution, Québec acquired all the tools and attributes of a modern society.

By the end of the 1960s, the independence movement was born and began to grow in Québec, taking official shape with the election of an indépendantiste government in 1976. The following year, the Charter of the French language made French the only official language in Québec.

Today, as in earlier times, Québec closely guards its own claims in all areas under its jurisdiction, including health and social services, while doing everything in its power to offer its population the best possible services, at the lowest cost possible, with the best possible results.

TERRITORIAL CHARACTERISTICS

Québec's territory is immense. Its 10,867 kilometres of borders surround an area of 1,667,441 square kilometres, including 1,312,126 km^2 of land and 355,315 km^2 of water. On a European scale, it could easily hold Belgium, France, Spain, Germany, Switzerland and Italy, while on an American scale, its surface area is equivalent to that of Maine, New Hampshire, Vermont, New York, Massachusetts, Connecticut, Pennsylvania, Florida, Texas and California put together.

Over 50% of Québec's territory is covered by forest, while its urban and agricultural areas represent barely 2%, or 33,530 km^2. The rest of the territory is made up of arctic zones, tundra (a vast, discontinuous, treeless plain that supports the growth of mosses, lichens, and numerous low shrubs), taiga (a coniferous evergreen forest which forms an almost unbroken belt along the southern edge of the arctic tundra), and water. Moreover, Québec boasts a number of lakes and rivers that few countries or states can rival. Its inland waters cover approximately 166,500 square kilometres. The St. Lawrence River, one of the largest rivers in the world, is by far its most important watercourse. Starting from the Great Lakes, it flows through southern Québec from west to east. It extends over 1,140 kilometres and ranks third in the world in terms of navigable distance.

Figure **1** Québec **in North America,** *2008*

Source: Service du développement de l'information, ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, February 2008.

Health and social services regions

Québec is divided into 18 health and social services regions (or régions sociosanitaires (RSS)). These can be grouped together in four major categories: university regions, peripheral regions, intermediary regions, and remote regions.

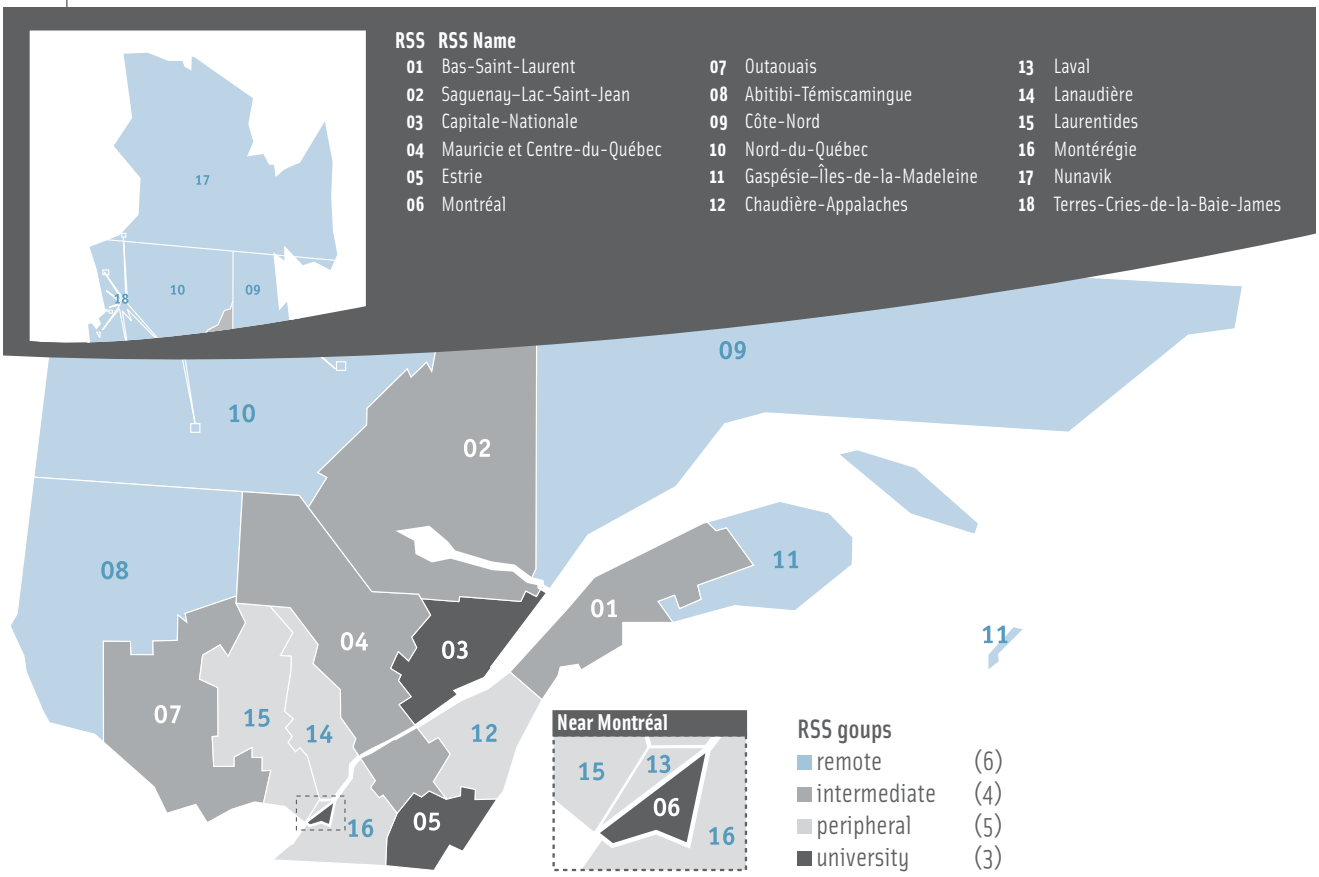
Each health and social services region is subdivided into basic territorial units, i.e., local community service centre (CLSC) territories or districts, currently (2008) making up 166 districts in total in Québec.

Aside from the three regions in the north, the fifteen other health and social services regions include local health and social services networks (or réseaux locaux de services (RLS)). These 15 regions currently (2008) include 95 local service networks comprising 159 CLSC districts.

In order to facilitate access to specialized services, four integrated university health networks (réseaux universitaires intégrés de santé (RUIS)) cover the entire territory of Québec, sharing the 166 CLSC districts. These networks fall under the following institutions: Université de Montréal, McGill University, Université Laval and Université de Sherbrooke. They each have a main territory they cover but they are not constrained by strict territorial exclusivity so as to respect the free will of both patients and professionals.

Historically, Québec was divided into health and social services regions that were specific to the Ministère de la Santé et des Services sociaux (MSSS), but that were largely based on its administrative regions. From 1971 until the end of the 1980s, there were thirteen health and social services regions in Québec. Subsequently, the number rose to 17, and then rose again in December 1991 to the present number of eighteen RSSs. The number of administrative regions, on the other hand, settled at seventeen. These are used as the territorial basis for most other spheres of government activity in Québec. In the decrees of December 1991, the MSSS decided to harmonize the boundaries of the RSSs with those of the administrative regions, but divided the Nord-du-Québec administrative region (10) into three health and social services regions, that is, the Nord-du-Québec (10), the Kativik (17) and the Terres-Cries-de-la-Baie-James (18) RSSs. In 1994, the Kativik RSS (17) was renamed, becoming the Nunavik RSS (17). Then, in 1997, the Mauricie-Bois-Francs administrative region (04) was divided into two administrative regions: Mauricie (04) and Centre-du-Québec (17). However, these two administrative regions continue to form a single health and social services region, the Mauricie and Centre-du-Québec (04) RSSs.

Figure 2 **Québec's Health and Social Services Regions,** *2008*



Source: Service du développement de l'information, ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, February 2008.

DEMOGRAPHIC CHARACTERISTICS

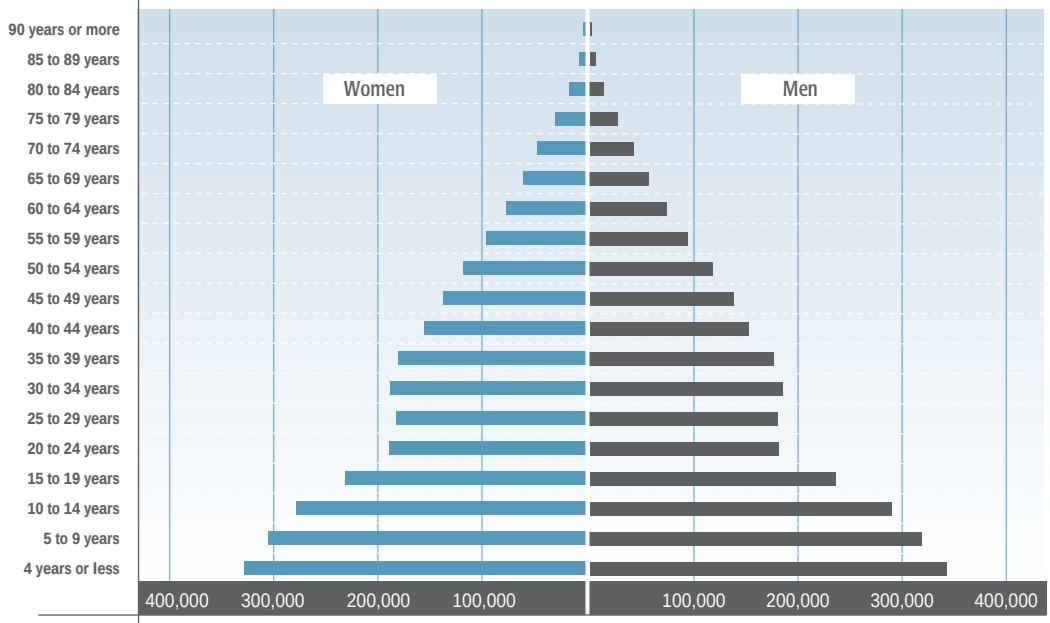
In 2008, Québec's population included some 7,670,000 people, or a little over 23% of the total population of Canada. French is the official language of Québec. In fact, according to the 2006 census of Canada, French is the mother tongue of more than 80% of Québec's population, while less than 8% had English and a little more than 12% had another language as their mother tongue. Furthermore, according to the Secrétariat des affaires autochtones du Québec, in 2005 there were some 82,800 Amerindians and Inuit belonging to 11 nations, or "First Nations", including over 61,800 living on reservations or in northern villages.

More than 80% of Québec residents live in urban areas, mainly in metropolitan Montréal and its surrounding area, which alone account for more than 60% of the population of Québec. The rest of the population is scattered to some extent all across the territory, but is mainly concentrated along the edges of the St. Lawrence River.

As is the case in several other developed societies, the population of Québec is characterized by rapid aging, with all the repercussions that this entails in terms of health and social services needs. However, since the early 1980s, Québec has been in a favourable period in terms of its ability to support persons deemed to be dependent (those under 15 years of age and those aged 65 or older)—a period that should last another few years. However, starting in 2010, the baby boomer generation—people born between 1945 and 1965—will reach retirement age, and this will bring about a rapid increase in the population deemed to be dependent. This rapid growth in "dependency" could extend to the early 2030s, and then slow down.

Figure **3-A**

Population of Québec,
age pyramid,
situation observed on July 1st,
1961



Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, juillet 2007. Data: Statistical book, Table P1.

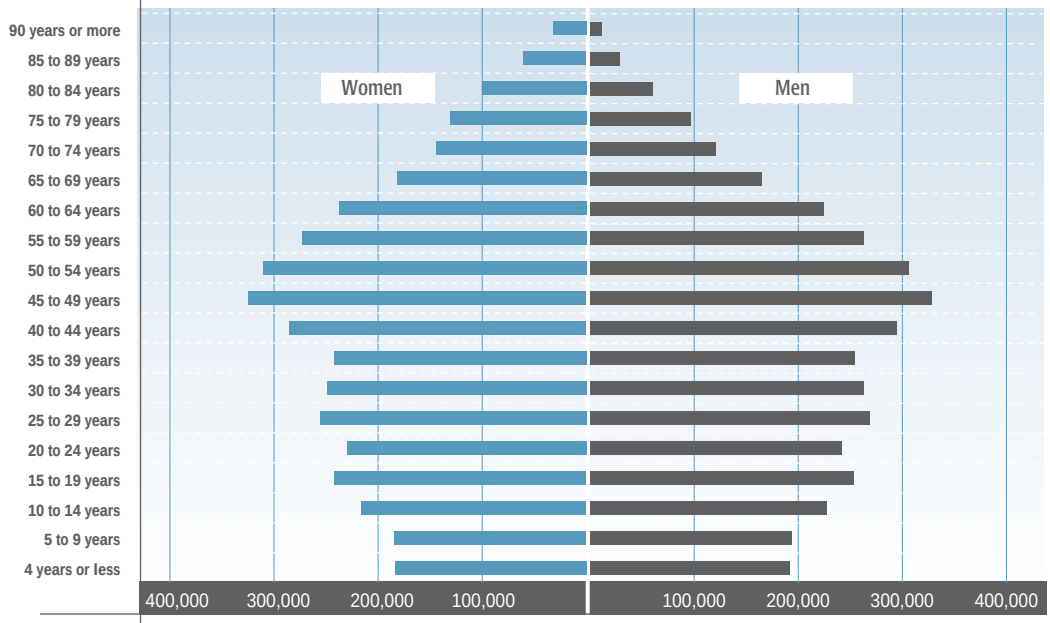
Aging of the population

In Québec, as in many industrialized countries, the age structure of the population is changing at an accelerated pace. An aging population, due partly to a sharply declining birth rate—especially during the 1960s and the 1990s—and to low net migration characterizes the changes in the age structure. In 1961, just as the last baby boomers were born, the age pyramid representing 5.3 million Québeckers could still be said to resemble an actual pyramid in shape. Today, it looks more like a house; the term "age house" should perhaps be used to describe the 7.7 million people currently living in Québec. The situation in some 45 years will look a lot more like a beehive than a pyramid; perhaps the term "age hive" will then be used to describe the 7.8 million people living in Québec.

In the 1961 census, people aged 65 or older represented less than 6% of the total population of Québec. In 1991, they already accounted for 11%, still making Québec one of the youngest societies in the Western world. In 2001, the proportion of those aged 65 or older was 13% ; today (2008), it is closer to 15%. The 20-year period covering the decades of 2010 and 2020 will see the aging of the population in Québec accelerate, with the proportion of elderly people going from less than 16%, in 2011, to close to 27%, in 2031. The rate at which this proportion will increase should resemble that observed in the 1960s, i.e., around 1% every ten years.

Figure **3-B**

Population of Québec,
age pyramid,
situation observed on July 1st,
2008

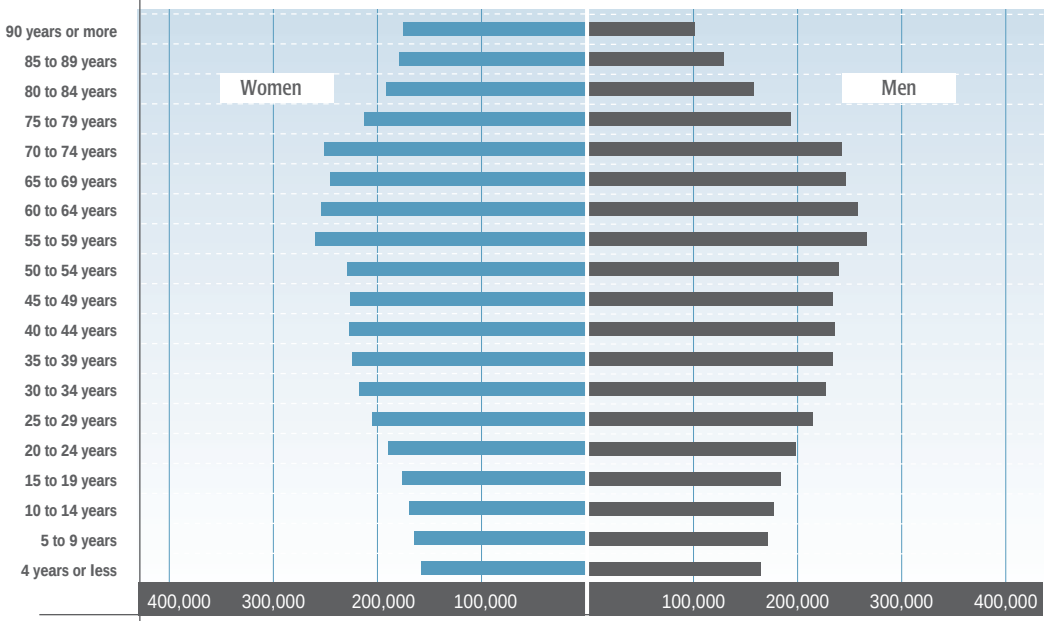


Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table P1.

Figure 3-C

Population of Québec, **age pyramid,** situation observed on July 1st, *2051*

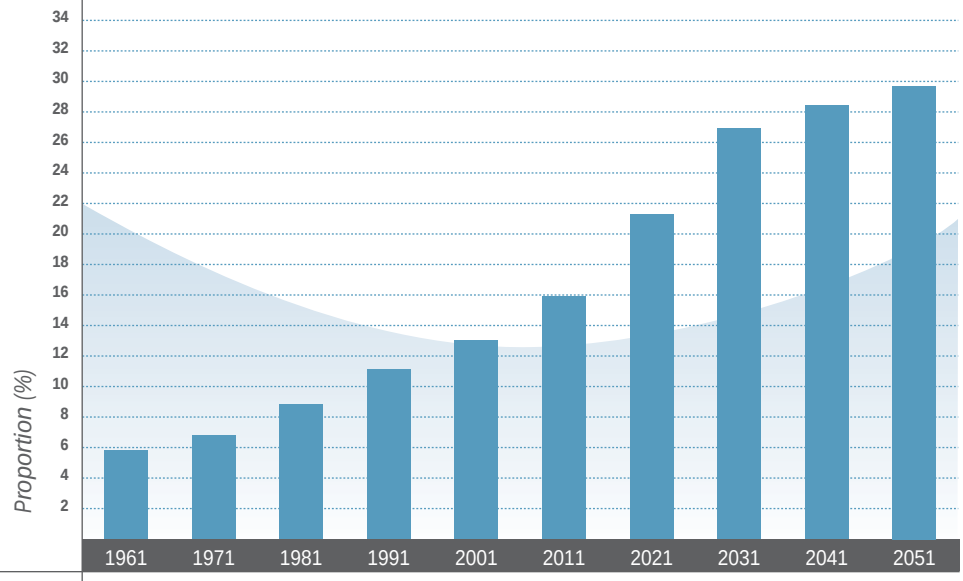


Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, September 2007. Data: Statistical book, Table P1.

Figure 4

Decadal proportion **of people aged 65 or older in the population of Québec,** situation observed on July 1st, *1961 to 2051*



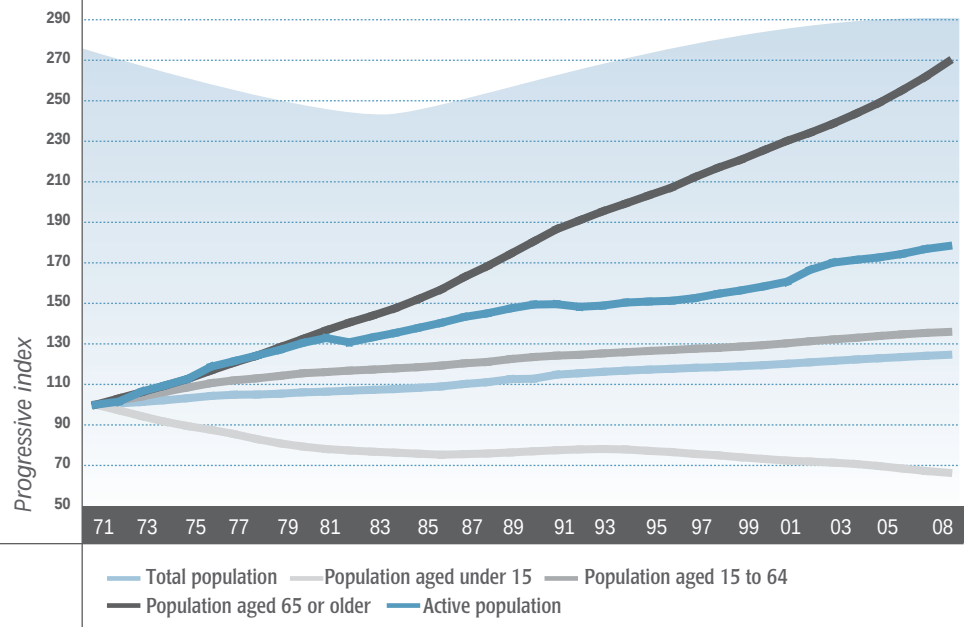
Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2007. Data: Statistical book, Table P2.

During the 1970s, the growth in the economically active population, that is, people aged 15 to 64 who are employable, was similar to that observed in the population aged 65 or older. However, from 1980 onwards, the growth of the first group slowed down, while the growth of the second group accelerated considerably. Since the early 1980s, the active population has been growing at a slightly faster pace than the population aged 15 to 64.

Figure 5

Population development in Québec, **by selected age groups,** situation observed on July 1st, *1971 to 2008*



Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008. Data: Statistical book, Table P3.

Dependency ratio

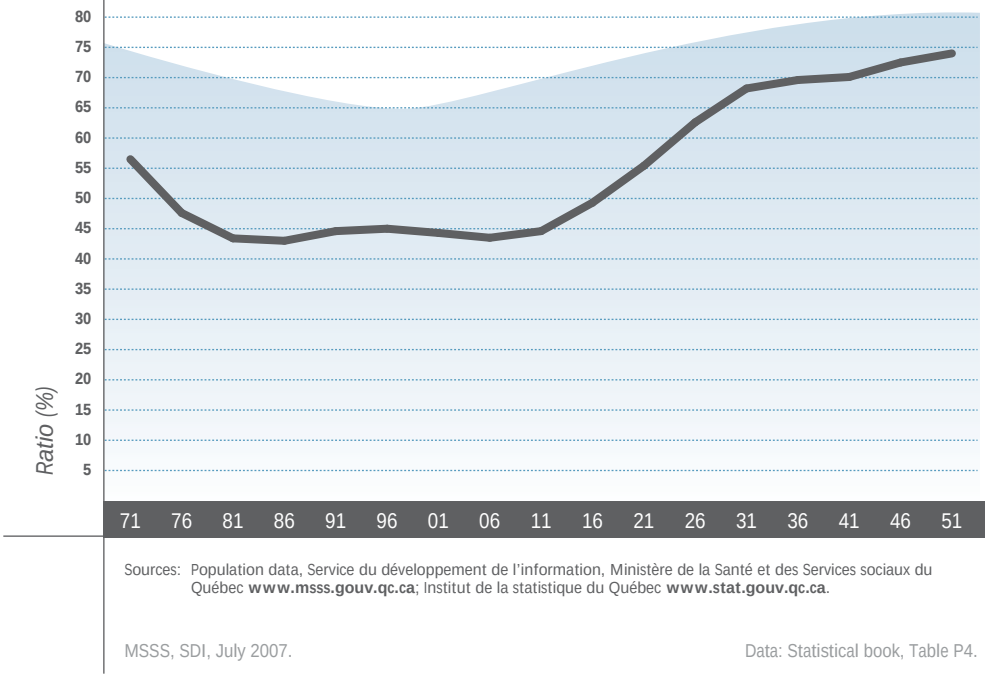
A good way to note the changes that are taking place in the age structure of a population is to follow the development of the dependency index prevailing within it.

The dependency ratio of a population can be defined as the ratio of the total population aged 0 to 14 and 65 or older to the population aged 15 to 64. This index varies little over a short period of time, but, over the long term, clearly demonstrates the fundamental changes that are taking place in the age composition of a given population. Thus, based on the graphic representation of this index, it is possible to visualize the "favourable" periods, that is, periods when the index is relatively low, and the "unfavourable" periods, or periods when the index is very high.

For Québec, the period from 1980 to 2010 appears to be "favourable." In fact, the dependency ratio remains firmly under the 45% mark during this 30-year period, given that the population aged 15 to 64 includes the baby boomer group. On the other hand, starting in 2010, the baby boomers will become part of the group of people aged 65 or older, and this will translate into a dramatic increase in the dependency ratio. This increase period should accelerate until the early 2030s and continue to increase at a slightly less sustained rate after that.

Figure 6

Five-year dependency ratio
for the Québec population,
situation observed on July 1st,
1971 to 2051



Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, July 2007.

Data: Statistical book, Table P4.

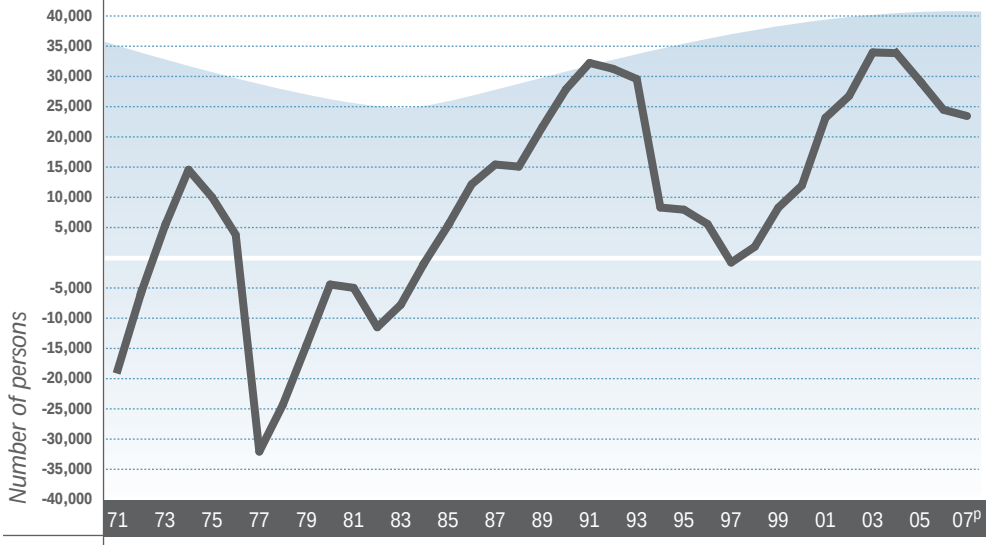
Migratory movements

Every year, Québec sees the arrival of a high number of immigrants from foreign countries, in particular people born in China, Morocco, France, Algeria and Romania. In the new millennium, immigrants from these five countries represented close to 40% of all foreign immigrants to settle in Québec. According to 2005 statistics, the great majority of these immigrants are under 45 years of age, and most of them are between 25 and 40. From 1980 to the turn of the century, in terms of the reasons behind their immigration, immigrants were divided as follows: 47% for economic reasons, 33% to join their families and 20% as refugees. Since 2001, these proportions are 60%, 22% and 18%, respectively.

Since 1971, Québec's net interprovincial migration has been negative, except in 2003. However, if international and interprovincial migrations are considered together for the same period, the net migration has tended toward improvement, even if in the form of alternating negative and positive phases in the 1970s and 1980s. In fact, since the mid-1980s, only 1997 showed a slightly negative overall net migration. The lowest level recorded was in 1977, with a deficit of more than 32,000 people, while the highest peak was achieved in 2003, with a surplus of close to 34,000 people.

Figure **7**

Net migration
for the Québec population,
net national and international migrations,
1971 to 2007



p: provisional data.
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table P5.

SOCIOECONOMIC CHARACTERISTICS

Over the course of the last fifty years, Québec has undergone social change at a pace and to an extent that is unprecedented. Up until the Quiet Revolution in the early 1960s, Québec society was characterized by a traditional way of life and an economy centred around the exploitation of natural resources, the control of which mostly eluded the Francophone majority. The Church played a central role in the collective life of Québec.

Gradually, starting in the 1960s, the state became a major economic lever and a driving force behind a strengthening national identity. Subsequent years were marked by profound changes. Entrepreneurship developed and Québec began to assert itself to a greater extent both economically and politically, as much on the Canadian scene as abroad. During the 1960s and 1970s, Québec's economy saw an annual growth rate of more than 5%.

Other significant phenomena also changed society. In education, for example, Québec achieved immense progress and soon closed the gap that separated it from the other provinces in Canada. Women entered the work force in massive numbers and the family was transformed by the drop in fertility rate and the rapid increase in the number of divorces and common-law relationships.

In the 1980s, economic growth slowed down and the labour market changed. The demands of productivity led to the specialization of work tasks and downsizing in business. So-called "precarious employment" (part-time, casual, contract and freelance work) multiplied and the unemployment rate was over 10%. New forms of poverty appeared as a result of changes in the labour market and family break-up.

Finally, the arrival of the third millennium saw Québec's economic growth again achieve a rate of close to 2% per year, while in early 2008, the unemployment rate fell to its lowest level in more than a quarter century, i.e., a little over 7%. At the same time, there has never been as much concerted action, on the part of all actors in Québec society, aiming to improve the quality of life of every citizen.

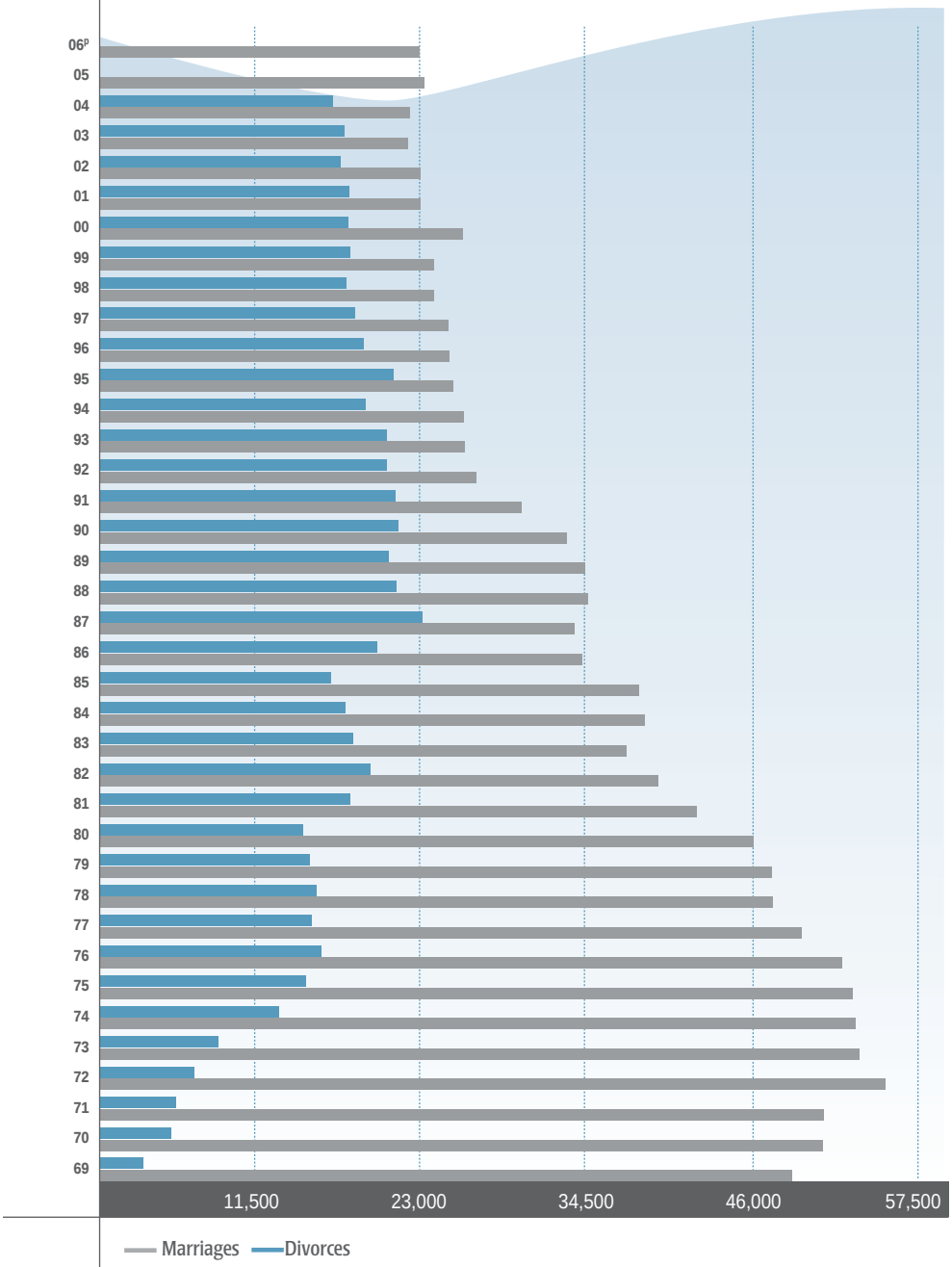
Marriages and divorces

In 1972, close to 54,000 weddings were celebrated in Québec, the highest number since 1900. But, since then, that number has steadily fallen to finally reach some 22,000 weddings in 2006, cutting the marriage rate for the population by two-thirds, falling from 8.7 to 2.9 marriages per 1,000 people.

At the same time, the number of divorces saw the opposite. In the period of 1969 to 1976 alone, the number of divorces increased fivefold, going from fewer than 3,000 to more than 15,000 per year. A peak was reached in 1987, with more than 22,000 divorces, subsequently going down slightly. In 2004, there were some 16,000 divorces. However, given the drop in the number of marriages, the total divorce rate—proportion of marriages ending in divorce based on the conditions for divorce in a given year—has steadily increased, going from 8.8 in 1969 to 52.4 divorces per 100 marriages in 2004.

Figure 8

Number
of marriages and divorces,
Québec,
1969 to 2006



p: provisional data.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

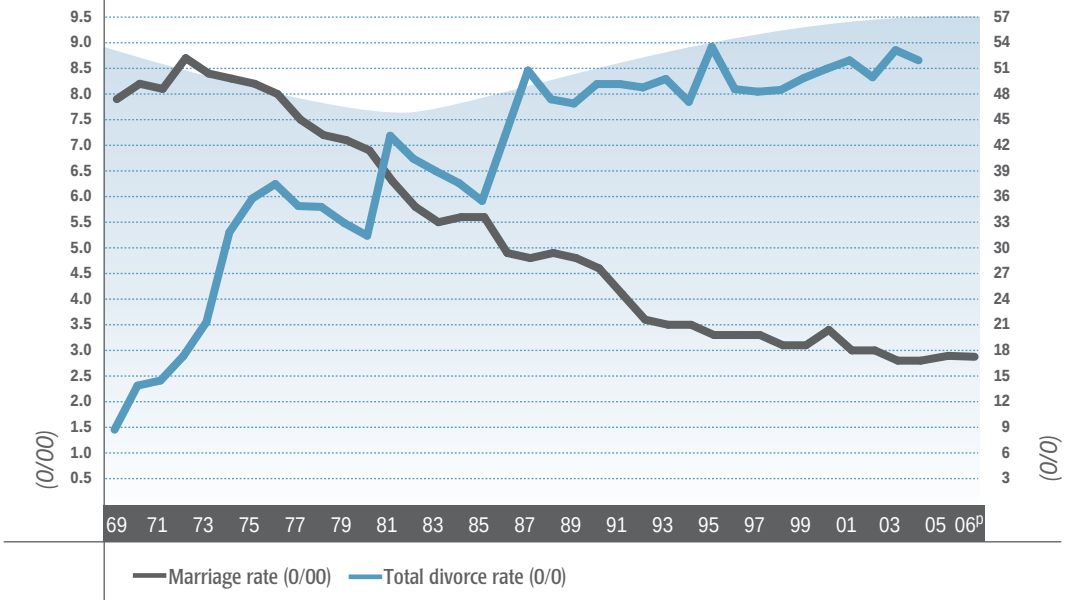
MSSS, SDI, March 2008.

Data: Statistical book, Tables S1 and S2.

Figure 9

Marriage rate and total divorce rate,

Québec,
1969 to 2006



p: provisional data.
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Tables S1 and S2.

Unemployment and employment insurance

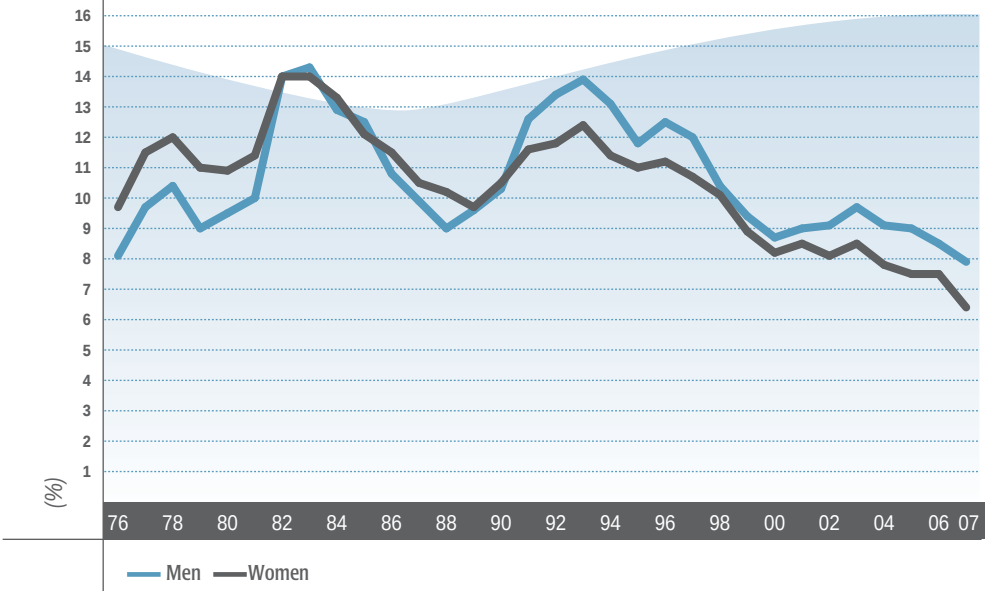
For 30 years, the unemployment rate in Québec has followed a sinusoidal trend, reaching a first peak in 1983, with more than 14%, and a second peak ten years later with more than 13%. However, starting in 1993, Québec's unemployment rate followed a downward trend, dipping under 8% in early 2007 and staying at 7.2% for the rest of the year, a rate that was maintained in early 2008. It should be noted that since the early 1990s, the unemployment rate has remained higher for men than for women.

The last ten years has also seen a decline in employment insurance claims in Québec. In 1997-1998, some 453,200 households (people living alone and families) in Québec received employment insurance benefits (previously known as social security); in 2007-2008, this number dropped by more than 26% to a little over 335,000 households. As for the number of beneficiaries (individuals), the drop was even more significant, falling more than 34% between 1997-1998 and 2007-2008. Currently (2007-2008), there are fewer than 490,000 beneficiaries.

Figure 10

Unemployment rate

for the Québec population, by gender, *1976 to 2007*



Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

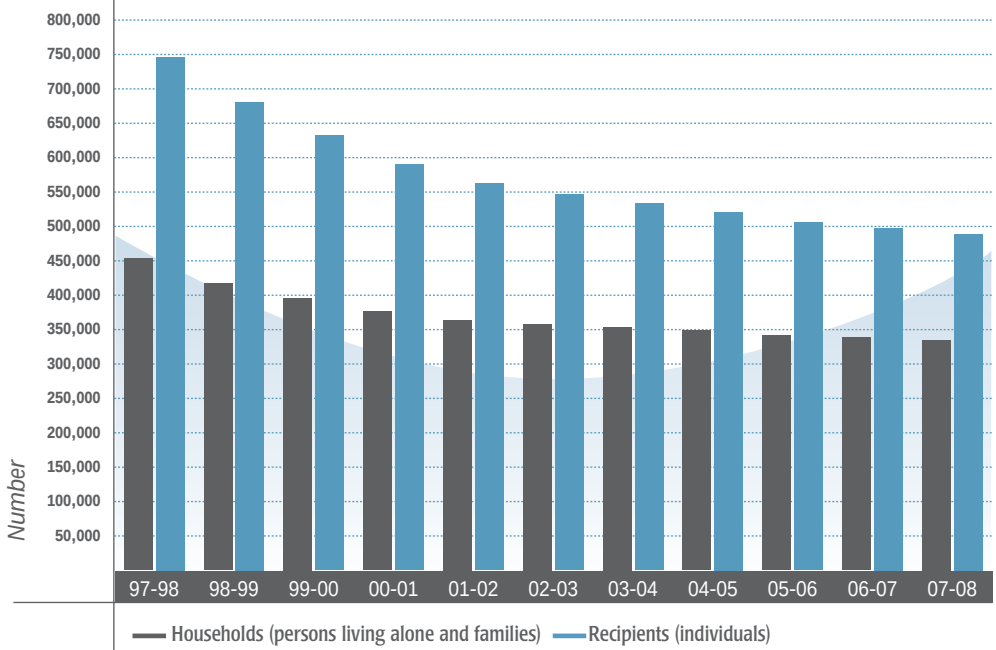
MSSS, SDI, March 2008.

Data: Statistical book, Table S3.

Figure 11

Number of households and beneficiaries receiving employment insurance

in Québec, annual average, *1997-1998 to 2007-2008*



Source: Ministère de l'Emploi et de la Solidarité sociale **www.mess.gouv.qc.ca**.

MSSS, SDI, March 2008.

Data: Statistical book, Table S4.

HEALTH AND SOCIAL CHARACTERISTICS

The mid-1960s marked the beginning of an era characterized by a net decline in birth rates in Québec. By the end of the 1960s, there was a dramatic drop in birth rates. Women's difficulty reconciling the demands of work and family tended to limit the number of children per family. The increased use of induced abortions and the rapid development of effective contraceptives and sterilization, no to mention the Church's failing influence with the Francophone population, all had a hand in the rapid drop in birth rates and the decision to postpone motherhood.

Within the general population, the drop in the crude mortality rate that began in the early 1920s stopped in the early 1960s and has since remained somewhat constant. Infant mortality, on the other hand, is in constant decline in all perinatal and infantile categories.

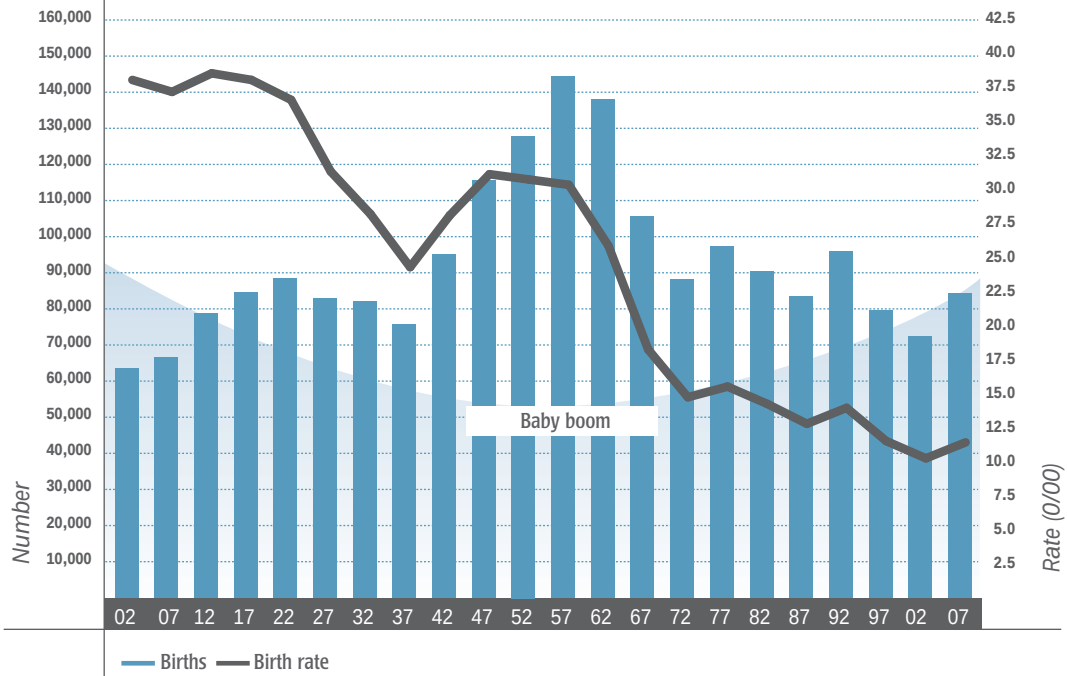
Finally, the life expectancy of Québeckers is constantly improving, so much so that life expectancy at birth now (2006) exceeds 80 years, and that at 65 years of age is getting close to 20 years. As well, in both cases, the historic gap between genders in favour of women continues to lessen.

Fertility and births

From its highest level in 1959, to its lowest in 2000, the annual number of births has fallen dramatically in Quebec, from about 144 500 to 72 000 in just four decades. However, since 2002 there has been a clear upturn, with 84,200 births registered in 2007. When examining the phenomenon in the long term, it is clear that the birth rate has dropped three-quarters since the start of the 20th century, going from 40 to 11 births per 1,000 people. Of course, this has led to a significant drop in the total fertility rate—the average number of children born to a generation of women whose fertility rates have been observed, by age, during any given year. From 3.85 in 1951, this rate fell to 1.66 children per woman of child-bearing age in 2007; it even fell below the 1.40 mark in the mid-1980s. Furthermore, after dropping under 27.5 years of age in the second half of the 1970s, the average age of the mother at the time of birth rose back to the average observed in the early 1950s, i.e., 29.6 years of age. In 1975, the average age of the mother at the birth of the first child was 25; in 2007, it was 28.

Figure **12**

Number of births and five-yearly birth rates, Québec, *1902 to 2007*

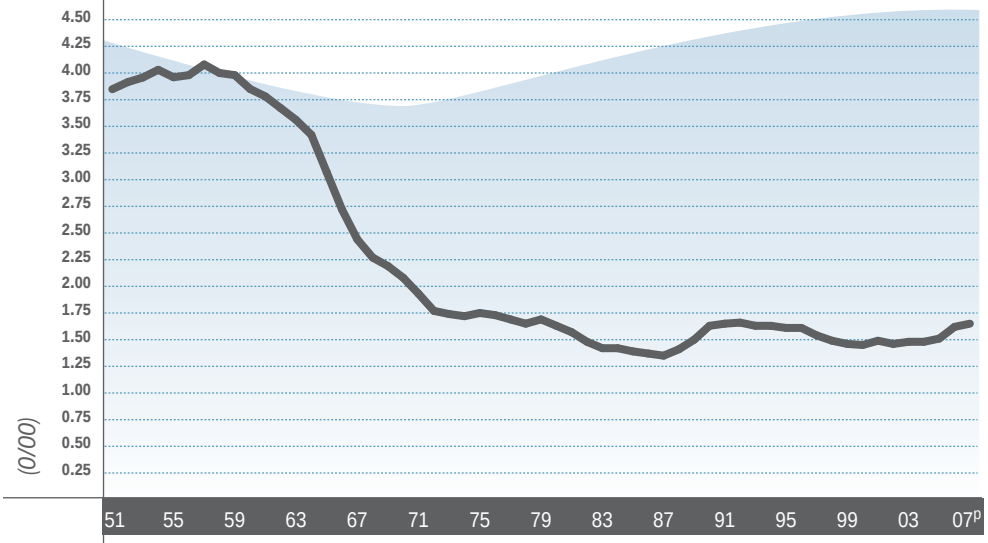


Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008. Data: Statistical book, Tables S5 and S6.

Figure 13

Change in
the total fertility rate,
Québec,
1951 to 2007



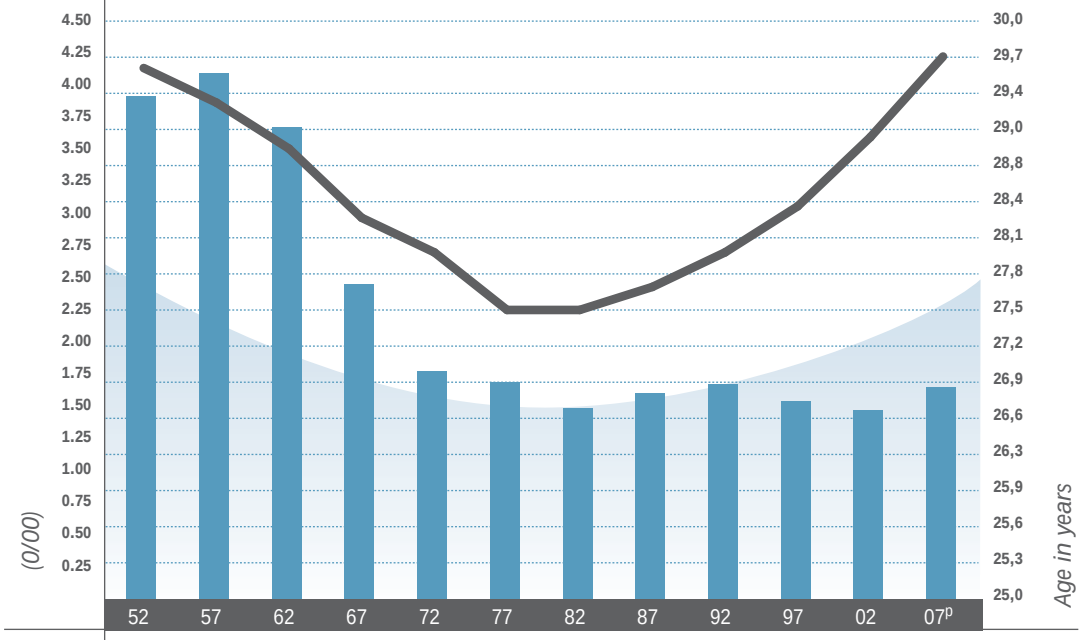
p: provisional data.
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Data: Statistical book, Table S6.

Figure 14

Five-yearly total fertility rate
and average age of the mother at birth,
Québec,
1952 to 2007



p: provisional data.
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Data: Statistical book, Table S6.

As regards the development of fertility for the population of Québec, aside from the use of contraceptives as well as sociological and socio-economic considerations, three measurable factors had—and continue to have—a significant impact: voluntary terminations of pregnancy (VTPs), hysterectomies, and sterilization procedures (tubal ligations and vasectomies).

From 1976 to 2006, the number of voluntary terminations of pregnancy rose from 7,139 to 28,255, i.e., four times more in 30 years. In terms of rates per 1,000 women aged 15 to 44, this number thus rose from 7.3 to 18.3 VTPs per 1,000 women, or 7.3 to 34.4 VTPs per 100 live births.

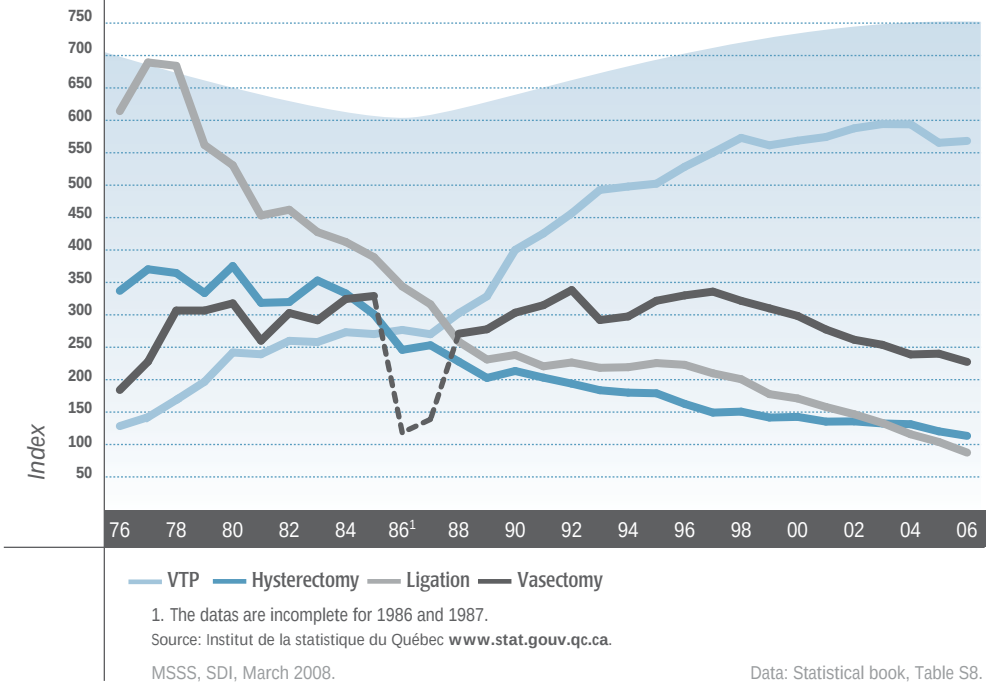
As regards hysterectomies—only those performed on women under 50—, their number has declined since the mid-1980s. There were less than 10,500 in 2006, namely half the number performed in 1973.

However, trends regarding sterilization procedures (tubal ligations and vasectomies) differ. While the number of tubal ligations fell dramatically, going from close to 32,400 in 1978 to slightly more than 4,700 in 2006, a general upward trend has been observed regarding vasectomies up until 1997, with numbers going from less than 8,000 in 1976 to close to 20,200 in 1997 and a peak of close to 20,700 in 1992. However, since 1997, the number of vasectomies has been declining and reached slightly over 12,750 in 2006.

In terms of total rates (sum of rates by age), trends are as follows: the total VTP rate went from slightly over 128 in 1976 to close to 600 in 2003 and 2004, reaching slightly over 568 in 2006; the total hysterectomy rate went from 370 in 1977 to 113 in 2006; the total tubal ligation rate was almost divided by eight in the same period, going from 689 to 88; and the total vasectomy rate remained relatively stable between 1978 and 1997 only to subsequently decline to reach 227 in 2006.

Figure 15

Total voluntary termination of pregnancy, hysterectomy, tubal ligation and vasectomy rates, Québec, *1976 to 2006*



1. The datas are incomplete for 1986 and 1987.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2008.

Data: Statistical book, Table S8.

Mortality and life expectancy

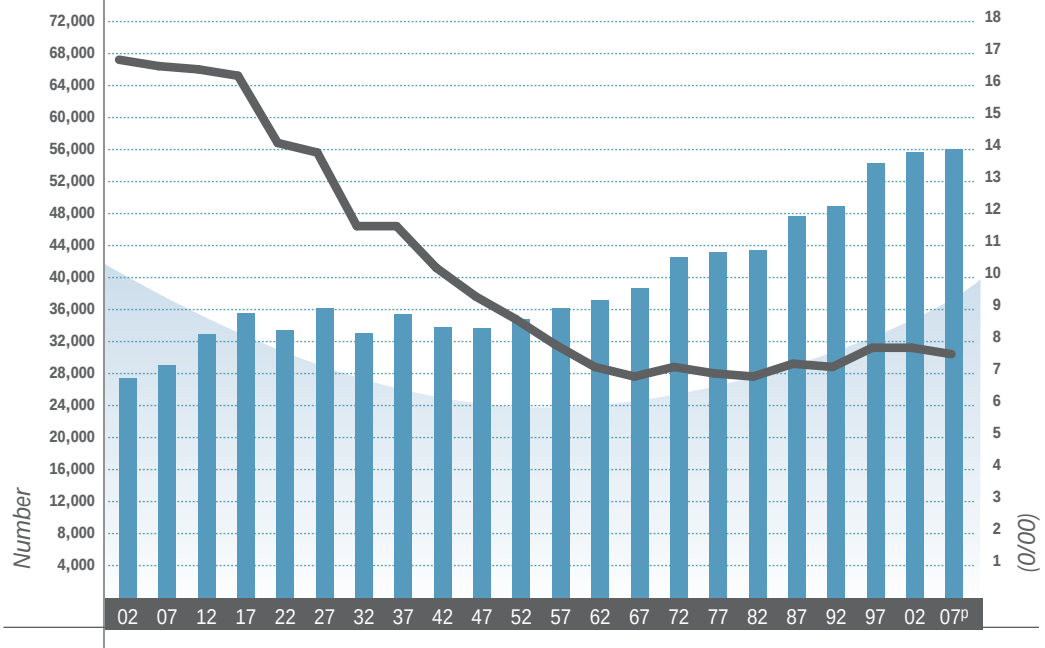
In Québec, during the 100-year period between 1902 and 2002, the annual number of deaths more than doubled, going from some 27,400 to close to 55,800. These are the two extremes observed in Québec since 1900. However, expressed in terms of crude mortality rate per 1,000 people, this number showed a significant decrease between 1900 and 1960, followed by relative stability to today (2007), i.e., between 7 and 7.5 ‰.

In terms of infant mortality, since 1971, the trend is clear: a significant drop in the number of deaths as well as a steady decline in infant mortality rates per 1,000 live births. From some 1,600 infant deaths in 1971, there were only 330 in 2005, i.e., five times less. However, a dramatic upturn was observed in 2006 with 410 infant deaths, followed by a drop (376) in 2007. In terms of rates per 1,000 live births, the number of deaths fell from 17.3 in 1971 to 4.5 in 2007, cut by four, with a single rise to 5.0 in 2006. It should be noted that the infant mortality rate is always higher in boys than in girls, except for 2003 and 2004.

A distribution of the deaths based on recognized perinatal categories shows that they all follow the same trend, i.e., a significant drop in the last thirty years. From 1976 to 2005, the stillbirth rate (babies born dead), as well as the perinatal (babies born dead plus death within 7 days) and neonatal (death within 28 days) mortality rates were cut in half. In the same period, the infant mortality rate (death within one year) was reduced by two-thirds, while the post-neonatal mortality rate (death at 28 days or more) was cut by three quarters.

Figure **16**

Five-yearly number of deaths and crude mortality rate,
Québec,
1902 to 2007



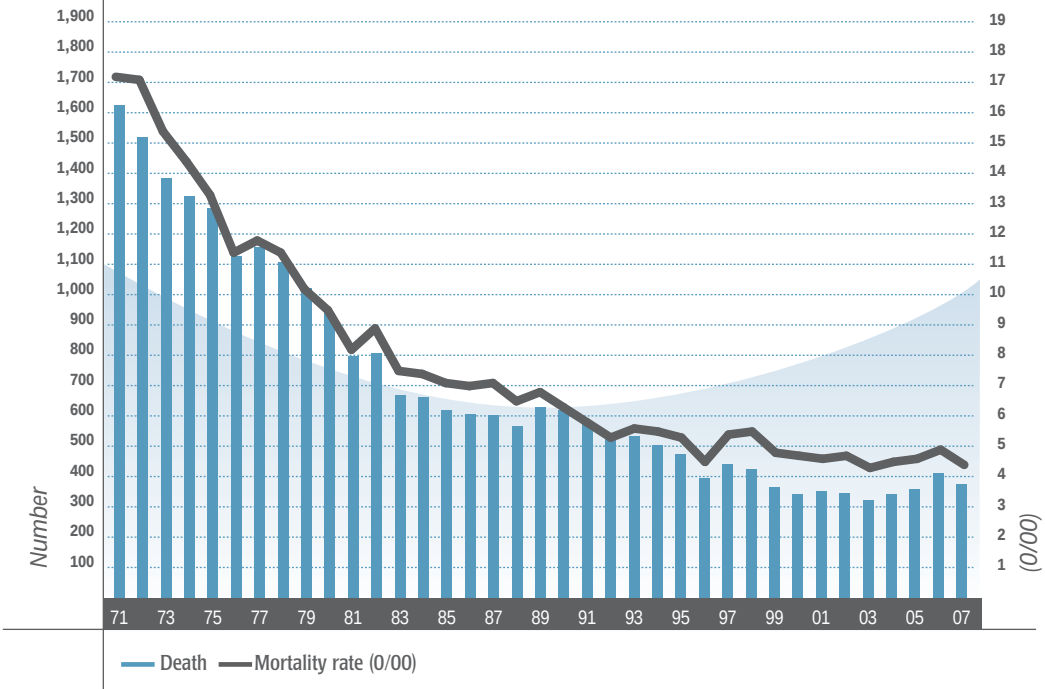
p: provisional data.
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Data: Statistical book, Table S9.

Figure 17

Number of **infant deaths and infant mortality rate** per 1,000 live births, Québec, *1971 to 2007*



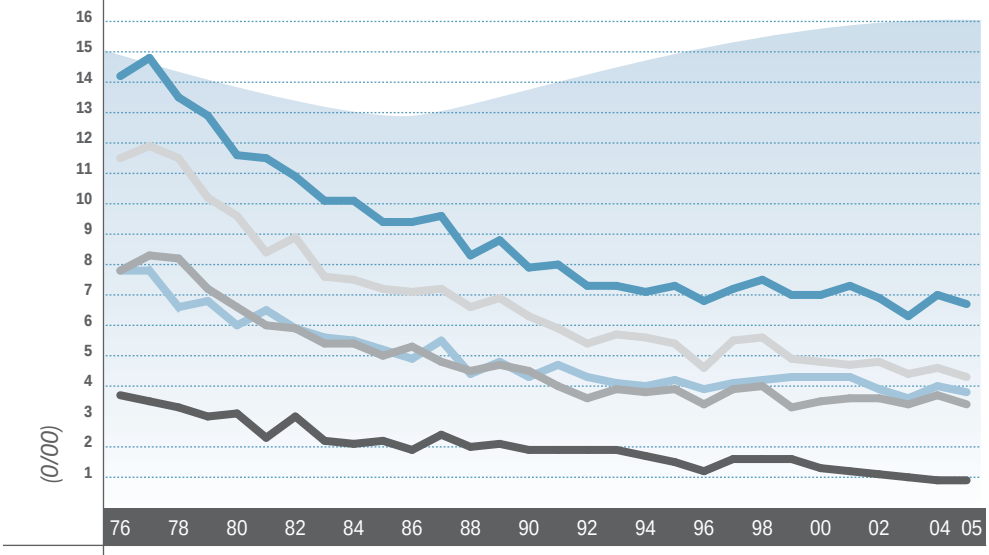
Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Data: Statistical book, Table S10.

Figure 18

Stillbirth rates and perinatal, neonatal and infant mortality rates, Québec, *1976 to 2005*



Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2007.

Data: Statistical book, Table S11.

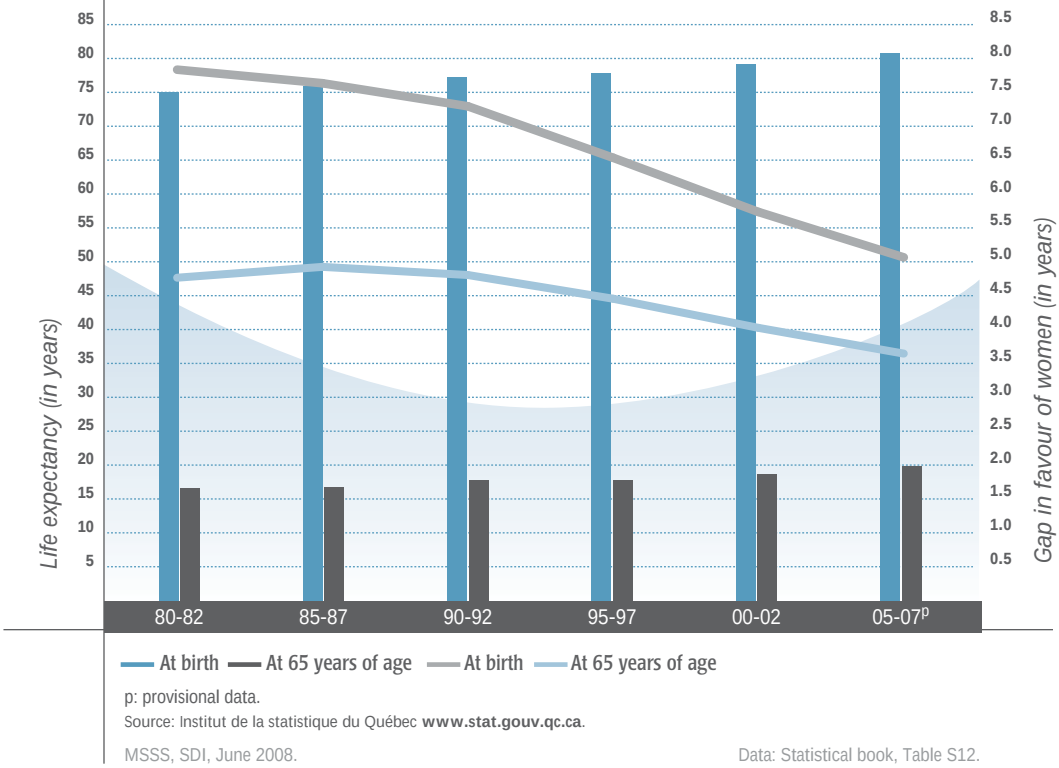
In the last 25 years, the population of Québec has seen its life expectancy at birth increase by more than five years, i.e., close to seven years for men and more than four years for women. In 2007, this expectancy was close to 81 years, i.e., a little over 78 years for men and a little over 83 years for women. It should be noted that the gap between men and women was reduced by 2.8 years, falling from 7.7 years in 1980 to 4.9 years in 2007.

In that same period, the life expectancy at 65 showed an increase of more than three years, reaching 19.9 years in 2007, i.e., close to 18 years for men and more than 21 years for women. The gap between men and women was reduced by more than one year, going from 4.6 years in 1980 to less than 3.5 years in 2007.

Figure **19**

Life expectancy at birth and at age 65

within the population of Québec, change in expectancy gaps in favour of women, based on three-year periods, *1980-1982 to 2005-2007*

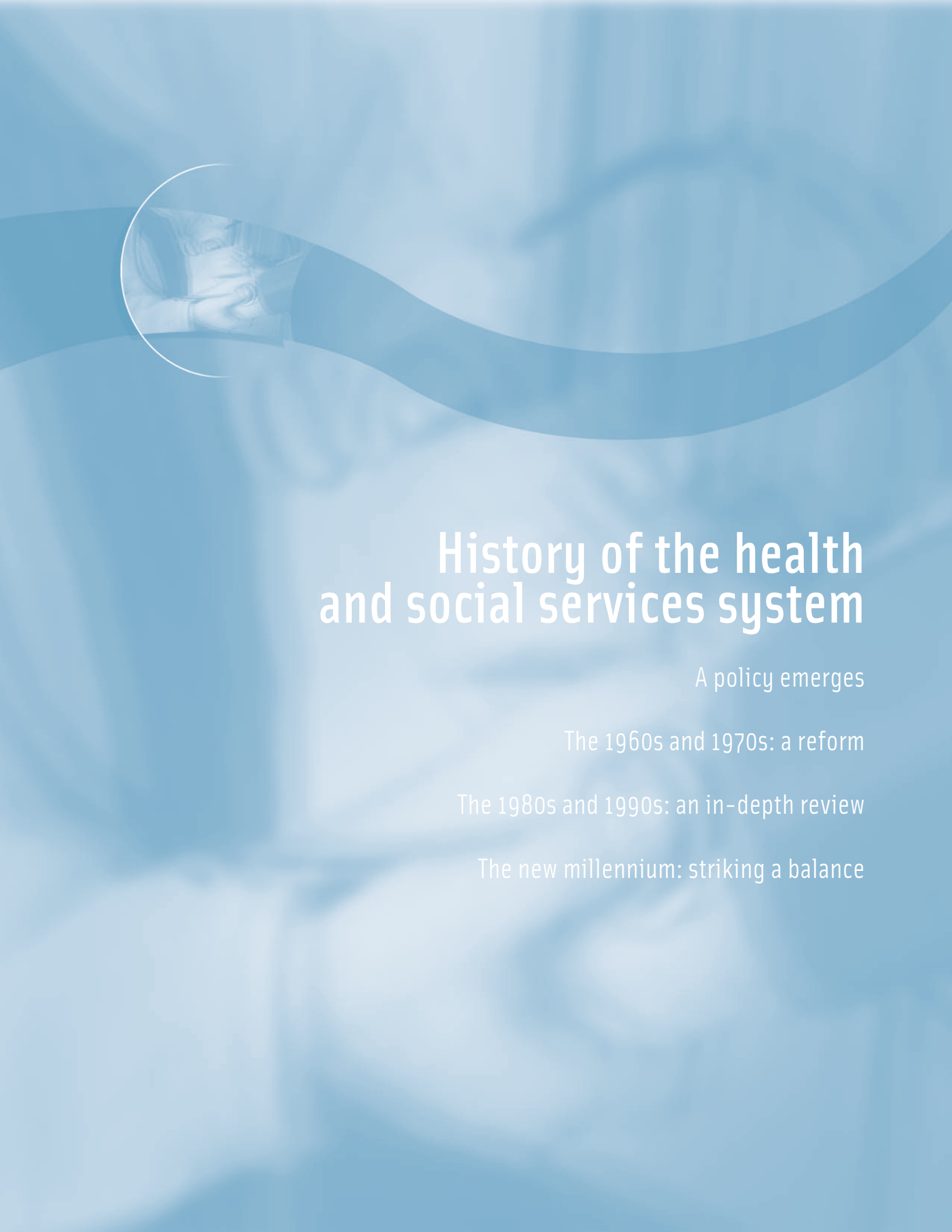


p: provisional data.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Data: Statistical book, Table S12.



History of the health and social services system

A policy emerges

The 1960s and 1970s: a reform

The 1980s and 1990s: an in-depth review

The new millennium: striking a balance

HISTORY OF THE HEALTH AND SOCIAL SERVICES SYSTEM

This overview of the history of health services and social services in Québec no doubt leaves out some of the historical references which would be necessary for a full understanding of the role played by various actors in the development of Québec's health and social services system. Its goal is simply to outline the context that led to the system that is in place today.

Québec's present social policy is the outcome of a long evolution in the health and social services sectors. The first hints of a will to organize matters pertaining to health and social welfare were evident long before 1960. However, starting at this time and through the decades that followed, the system was reassessed several times, bringing about several changes in policy direction and organization from 1970 onwards, adapting the system to the new realities of Québec's society.

A POLICY EMERGES

Under the French regime and during the 19th century, hospital maintenance and funding, as well as care for the poor and destitute, fell to the municipalities, parishes and religious communities, with the help of government grants, charity fundraising campaigns and parish revenues. As well as running the great majority of institutions delivering health care and social assistance, the religious communities looked after training and employing paramedical and social services staff.

The provincial government, however, intervened relatively early in the area of public health, with the creation, in 1834, of the first hospital founded and run by the state, named Hôpital de la Marine de Québec. Subsequently, the *Act respecting Public Health*, passed in 1886, gave birth in 1887 to the Board of Health of the Province of Quebec, which more or less oversaw the municipal bureaux d'hygiène (health offices). These were the first in a series of legislative and financial state interventions in Québec.

The Board of Health was replaced by the Provincial Bureau of Health in 1922, following the adoption of the Quebec Public Charities Act in 1921. This Act made it compulsory for municipalities to hospitalize the destitute. The costs were shared equally by the government, the municipalities and charitable institutions.

The unités sanitaires (health service units), created in 1926, were the first organizations involved in public health and preventive medicine in Québec. From 1930 onwards, these units replaced the municipal Bureaux d'hygiène.

During the Great Depression (1929-1936), vast efforts were made to help the poor. These efforts led to the establishment of a number of organizations. The Department of Health, created in 1936, was entrusted with the responsibility of monitoring the application of legislation regarding hygiene and public health, public charities, the insane, and the inspection of hospitals and other charitable institutions. Other functions were added to these: overseeing the development of public health, cooperating with the Government of Canada to facilitate the application of federal public health laws in the province, carrying out scientific studies on public health and, lastly, compiling yearly statistics on births, marriages, deaths and the causes of death.

The Department of Social Welfare was created in 1940. In 1941, the Department of Health became the Department of Health and Social Welfare. Then, in 1944, the latter was divided into two separate entities, that is, the Department of Health and the Department of Social Welfare. Finally, two years after it was created, the Department of Social Welfare was replaced by the Department of Youth and Social Welfare, which, in turn, became the Department of Family and Social Welfare in 1961.

The 1950s spawned a whole series of new developments in the area of public health and social security. The Government of Canada set up two measures that were to have a significant impact on the health and social services reform of the following decade. These were unemployment assistance in 1956, and hospital insurance in 1957.

THE 1960S AND 1970S: A REFORM

The 1960s were transition years in Québec in the health and social welfare sectors. Human and physical resources as well as programs and services were subject to changes that still suffered from the absence of any global vision, or, consequently, of any global policy. However, certain elements were beginning to take shape.

Legislative Framework

Several acts which were passed during that time marked social development in Québec.

The provincial parliament adopted the *Hospital Insurance Act* in 1960. On January 1, 1961, hospital care became free of charge in Québec, that is, covered by the state. In September of that same year, the Government of Québec paid the first benefits to parents with dependent children following the entry into force of the *Schooling Allowances Act*.

In 1965, the *Act respecting the Quebec Pension Plan* was sanctioned. Thus, a social security program was born. In 1966, the new *Workman's Compensation Act* and the *Medical Assistance Act* were adopted. In April 1967, following the example of the federal government in 1944, the Government of Québec created its own family allowance plan and began paying out a quarterly allowance to all families residing in Québec with a dependent child under 16 years of age.

During the summer of 1969, another important event took place: the Health Insurance Board was established. This new organization was to put the administrative mechanisms in place that would be necessary to set up a health insurance plan. From this time onward, medical services have been covered by the state.

Lastly, in December 1969, the *Social Aid Act* was adopted. This law, which authorized assistance benefits to be granted to citizens lacking means of subsistence, constituted considerable progress towards achieving a global social policy in Québec.

Analytical framework

During the 1960s, two committees particularly influenced the general policy directions of the government authorities involved in the health and social welfare sectors. These were the Study Committee on Public Assistance (the Boucher Committee) and the Commission of Inquiry on Health and Social Welfare (the Castonguay-Nepveu Commission).

In its 1963 report, the Boucher Committee recommended that the public sector take over activities related to social assistance which had until then been entrusted to the Church, families and individuals, as well as to charitable organizations and volunteer groups. This committee emphasized the necessity, for Québec, to adopt a global economic and social policy that would allow for a new administrative integration of policies related to labour, education, health and social welfare. The Department of Family and Social Welfare, alone, could not introduce all the necessary corrective measures.

The Commission of Inquiry on Health and Social Welfare was set up in November 1966. It was chaired by Claude Castonguay until March 1970, and then by Gérard Nepveu from April of the same year. The Commission was given the mandate of carrying out an inquiry into all fields related to health and social welfare.

As a first step, the Commission presented the government with an overall vision for social security and stipulated the fundamental elements of social development, these being health, social services and income security. Next, it defined an approach and a health and social services system that would entirely shape the organization of health services and social services in Québec. The state thus moved away from the idea of public hygiene in favour of that of community health.

Carrying out the reform

From this point on, the Department of Social Affairs became the cornerstone of a global policy for social development. Through the impetus given by measures and activities implemented in previous years, a new social development strategy emerged in the early 1970s.

It was now understood that it would be necessary for such a reform, which was becoming urgent, to be based on a global vision for social services, health services and income security. This global vision hinged on new laws and innovative administrative tools.

The reform was focussed on the new Department of Social Affairs, which was put in charge of it. The act creating the Department of Social Affairs was sanctioned in December 1970. By bringing the health and social welfare sectors back together, the Québec legislator intended to put in place the elements that would be favourable to social development. The new Department of Social Affairs was formed by merging the Department of Health and the Department of Family and Social Welfare.

While overseeing the integration of the two departments and the restructuring of administrative responsibilities, the minister's main task was to develop an income security policy as well as to implement mechanisms for rationalizing and monitoring the operation of health and social welfare institutions.

From this time on, a series of laws and regulations defined the legislative framework of this social mission. The *Health Insurance Act*, in 1970, and then the *Act respecting health* services and social services, in 1971, set the main parameters. The former allowed for accessibility to medical care, oral surgery services and optometric services by ensuring that the state assumed the costs. The latter broadened this concept, as it formed the basis for the policy of universal accessibility to full, continuous, complementary and quality care and services. Geographical accessibility to this care and these services became essential. Moreover, this Act aimed to introduce a range of health services and social services, thus facilitating the development of programs, on both a local and regional level, that would take into account the interrelations between citizens' health problems, social problems and economic difficulties.

Subsequently, the Quebec Professions Board was created, followed by the Commission des affaires sociales. Several acts concerning the protection of citizens' groups were adopted. These were the *Public Health Protection Act*, the *Mental Patients Protection Act*, the *Youth Protection Act* and the *Act to secure the handicapped in the exercise of their rights*. The *Act respecting child day care* and the *Act respecting occupational health and safety* should also be mentioned here.

In 1974, the Ministère's administrative structure brought together seven directorates, including Planning and Programming, with the aim of achieving coherence and consistency among the various institutions providing care, within one global system. The planning and hierarchical organization of institutions, care and decision-making, as well as the coordination of these various levels, implied the existence of a centralized administration.

Consolidation

Towards the end of the 1970s, the idea of a range of health services and social services that were coordinated, not to say organized into a hierarchy, slowly gave way to the perception of a complex health and social services system where several actors, each with their own rationality, linked up with each other. This more realistic view of the dynamics of the health and social services system also corresponded to a period when the terms resource reallocation, cut-backs and downsizing were increasingly heard. In particular, this consolidation translated into several legislative amendments that can be found in the *Act respecting health services and social services*.

Thus, in the early 1980s, the Department of Social Affairs came to an essential consolidation and rationalization phase concerning its interventions in the area of public health and social services, from the standpoint of complementarity among the various institutions. The increase in health costs together with the budget restrictions and staff cutbacks imposed by the last economic crisis (the 1982 oil crisis) forced the Department of Social Affairs to ensure a strict management of public funds.

The Department maintained the political and administrative authority allowing it to oversee the development of its two main policy areas, these being health and social services, and hence to carry out its double mandate. On the one hand, it took care of developing and coordinating the main policies and general programs pertaining to social development in Québec. On the other hand, it looked after the evaluation of health services and social services and ensured adequate service delivery throughout Québec. In fact, especially after 1981, several of these mandates were entrusted to the regional health and social services councils, the responsibilities and powers of which were broadened, in a context of administrative regionalization. (Appendix 1 presents a brief reminder of several key moments with regard to regionalization within the Québec health and social services system.)

THE 1980S AND 1990S: AN IN-DEPTH REVIEW

The 1980s marked a significant change in the mandate of the Department of Social Affairs, which, in 1981, dropped the administration of social aid, for which it had been responsible since 1969. This change led, in 1985, to the Department's new name, the Ministère de la Santé et des Services sociaux (MSSS).

Furthermore, on April 1, 1984, the *Canada Health Act* was sanctioned. Through this act, the federal government ensures that certain requirements regarding the provision of health services provided - comprehensiveness, universality, portability and accessibility - are respected by the provinces and territories. These requirements, or "national principles," helped mould the provincial health insurance plans across Canada.

In the mid-1980s, the Québec health and social services system was showing signs of stress. Waiting lists were getting longer in several sectors, hospital emergency rooms were often overcrowded, there were complaints about the age of some facilities and equipment, users were showing their discontent, and, lastly, the question of the rate at which the costs of certain programs were increasing was becoming a concern.

Thus, in 1985, the government set up the Commission of Inquiry into Health and Social Services (the Rochon Commission). The Commission suggested several measures to be based on three main thrusts, these being the adoption of a government policy on health and welfare, the regionalization of the service system and the adoption of a "population-based approach," in particular for the allocation of resources and the delivery of services. These recommendations led to the reform that took place in the early 1990s towards greater administrative decentralization.

A revised strategy

Québec, therefore, undertook to review its health and welfare strategy, structured around three main complementary measures. This review led first to the creation of a global policy on health and welfare, which was published in 1992 and which suggested putting health and welfare back at the centre of all sectors of collective life. It also led to the adaptation and reorganization of the network of services as well as to a true regionalization, made concrete with the adoption of the new *Act respecting health services and social services* (chapter 42, 1991) and subsequently the *Act to amend the Act respecting health services and social services and other legislative provisions* (chapter 38, 1998). Lastly, it led the government to adopt certain policies likely to slow the rate at which public expenses associated with health and social services were increasing, and make the system perform better.

The Health and Welfare Policy set precise objectives for the system which would henceforth direct all of its activities. In reality, it substituted the obligation to find the means, or, in other words, to offer quality, accessible and continuous services—an obligation that had traditionally guided the system's organization and operation—for the obligation to obtain results with regard to the health and welfare of the population. The policy finally aimed to establish greater equity between individuals and social groups, in terms of health and well-being, and not just with respect to access to services.

Furthermore, this policy put the citizen more at the centre of the system, both as a user and as a decision-maker. The roles and functions of all partners were redefined in relation to this user, that is, the person receiving care, support or assistance. The reform was based on this guiding principle, which translated into the following policy lines:

- Asserting users' rights and implementing effective mechanisms for processing complaints;
- Redefining the missions of the institutions in terms of their clients, leading, in particular, to the grouping together, under the authority of a single board of directors, of institutions providing services to the same population on a given territory;
- Strengthening front-line services, in order to improve access to services for all citizens, all across the territory;
- Regionalization and a greater democratization of all decision-making centres at both the local and regional levels.

This new strategy was based on two main convictions. The first was that health and welfare are the result of a constant interaction between a person and his or her environment. From this angle, the maintenance and improvement of health and welfare should rely on a balanced sharing of responsibilities among individuals, families, the living environment, institutions, firms and government authorities. All interventions should therefore allow a person to exercise his or her decision-making power over the various aspects of his or her life, and permit the family to fully fulfil its role. They should also foster the development of dynamic living environments and solidarity. The network of services should, moreover, play an active role in supporting the partnership necessary to foster health and welfare.

A second conviction guided all interventions taken within the system: health and welfare represent both an investment for society and an important factor in determining how dynamic a society remains and the progress it makes. In short, health and welfare are fundamental values as well as being the greatest wealth society can have. They are, moreover, the first, and by far the most important factor of its development, from all standpoints. All efforts should henceforth strive towards helping individuals and the community gain awareness of their foremost responsibilities when it comes to their own health and well-being.

A network transformed

In the mid-1990s, the Ministère and its partners undertook the immense task of transforming the health and social services network to adapt it to the changing needs of the population, the development of new practices and the community's capacity to cover costs.

This transformation was structured around a common objective, that of improving accessibility to services while consolidating regionalization. All of the actors involved in the health and social services network were rallied to this end, and all available energies were channelled towards this goal.

The success of this plan hinged on the construction of networks of integrated services, based on the presence of access points to basic services at the local level, meaning the CLSC districts, and on the introduction of simple access mechanisms to specialized services at the regional level, as well as to highly specialized services at the Québec-wide level.

Offering direct services to the population became the major preoccupation of the network and the foremost obligation of the organizations within it. The transformation of the health and social services network was based, then, on certain strategic structural elements and several principles of action, including the following:

- Providing a full range of basic services at the local level, so as to bring them as close as possible to the home environment of users;
- Establishing the region as the centre point for the coordination of services, this being the concrete expression of administrative decentralization and the key element of the structural reorganization and the reorganization of the provision of services;
- Instituting national parameters for the equitable allocation of resources, defining conditions of access to services, determining high quality standards and setting national targets and objectives regarding priority issues;
- Choosing results-based management, where all interventions within the network are marked by the quality of services and where actions are determined on the basis of both the results obtained and the costs incurred;
- Implementing mechanisms for reporting on results, an essential tool for ensuring accountability on the part of the actors for responsibilities that are entrusted to them.

All of these actions were accompanied by legislative measures, such as the adoption of the *Act to amend the Act respecting health services and social services and other legislative provisions* (chapter 38, 1998) and the *Act respecting prescription drug insurance and amending various legislative provisions* (chapter 32, 1996), and administrative ones, such as the move to group institutions together and change some of their missions, as well as the creation of the Institut national de la santé publique and the restructuring that took place within the MSSS itself.

In particular, the establishment of a public prescription drug plan allowed all Québeckers who are not covered by a private group drug plan to gain access to the pharmaceutical services they need at a reasonable cost.

THE NEW MILLENNIUM: STRIKING A BALANCE

Despite all of the actions that have been taken, there are still problems that need to be addressed, and the foreseeable future is clouded by the increasing pace at which health costs are rising, due, in large part, to the rapid aging of the population, as well as the sheer scale of the technological revolution. The latter can be defined in terms of its three main components: the rapid development of information and communication technologies (ICT); the technological development and sophistication of medical equipment; and the arrival of new medications due to breakthroughs in pharmaceutical research.

This distressing situation led the government of Québec to create the Commission of Study on Health Services and Social Services, in June 2000, to take another look at the organization and financing of services. The Commission was chaired by Michel Clair, who was given the task of ensuring that the people of Québec be given the opportunity to make suggestions to the commissioners concerning the balance to be struck in the face of rapidly changing needs, and regarding the efficient organization of services and funding possibilities.

In December 2000, the Commission tabled its report, submitting to the government of Québec the parameters of this new balance. In fact, given the deficiencies that it raised, the Commission put forward a vision for the future to the people of Québec concerning the organization, governance, provision and financing of health and social services. This organizational vision, generally well received, was based on performance measurement, contractual agreements and recognition of the importance of the concept of "the money following the client," but always within the capacity of citizens to cover the costs.

Among the Commission's recommendations and proposals, there were suggestions for certain orientations and policies that could create a new dynamic within the health care system. Other, more explicit, suggestions were aimed at setting conditions, in the short term, that would be favourable to the implementation of concrete solutions to the problems that were noted in the report.

In this way, the Commission presented certain solutions of a global or systemic nature and requiring government commitments regarding orientations and policies over the next decade. A good example of this is the priority granted to the organization of basic health and social services close to individuals in all regions of Québec. Other options called for a mutual commitment by all stakeholders by targeting established practices in an attempt to slow down the cost increase. Lastly, a few of the options led to the necessary revision of the key principles contained in the *Canada Health Act*, without, however, undermining their underlying values of solidarity, fairness and compassion.

The Commission based the success of the entire undertaking on a close synergy between the network's actors, stressing the importance that every actor—from the user to those at the departmental level—gain an awareness of their responsibilities, with the aim of reducing, if not eliminating, the inflexibility that is paralyzing the system and preventing it from evolving towards the balance sought.

Results- and accountability-based governance

By adopting, in November 1999, the *Financial Administration Act* (Bill 82), the primary aim of which was the modernization of public administration based on three basic principles (results-based management supported by strategic planning, transparency with the public, and organizational accountability), Québec established a government framework, i.e., set the specific context for its governance actions, in particular in the areas of health and social services.

In this way, on June 21, 2001, the government sanctioned Bill 28, amending the governance of the health and social services network. This new framework for results-based management, from the standpoint of increased accountability at the various levels of responsibility, thus takes the same tools as those imposed on the Ministère in the *Public Administration Act* and applies them to the health and social services network.

The *Act to amend the governance of the health and social services system* is structured around four main areas of interest. First, with respect to regional governance, not only does the law maintain all of the responsibilities already granted to regional authorities, it also adds a number of monitoring and intervention authorities for establishments. It also gives regional authorities the obligation to produce, for the minister, a three-year strategic plan for the organization of services. As regards the governance of institutions, the law modifies the composition of all boards of directors, in particular by increasing the presence of members representing the community, and imposes the grouping together of the boards of directors of local establishments. Third, the law orders the establishment of annual management and accountability agreements, on the one hand between the Ministère and regional authorities, and, on the other hand, between authorities and the institutions. These mutual agreements must be accompanied by accountability indicators published in an annual management report. Lastly, as regards the governance of public health, in addition to adjusting the mandates of the regional director, the law provided for the appointment of a national public health director to ensure the national and interregional coordination of public health program activities.

The Forum de la population [people's forum] was also created when the *Act to amend the governance of the health and social services system* took effect. The purpose of this forum is to ensure the implementation at the regional level of various modes of public consultation regarding satisfaction with the services offered, needs associated with the organization of these services, and various health and social issues, based on the dynamics of each region. (Appendix 2 presents a brief summary of several memorable events regarding public participation in the management of Québec's health and social services system.)

A number of other structuring actions arising in the wake of the *Act to amend the governance of the health and social services system* also added to set of tools at the disposal of the Ministère and the system.

These actions included the adoption, in December 2001, of the *Public Health Act*. The measures prescribed by this act included the Programme national de santé publique 2003-2012 [2003-2012 national public health program], the instrument of choice for all orientation and planning in this regard for the next ten years. Another important measure was included in section 54 of this Act, giving Québec government departments and organizations the obligation to consult the Minister of Health and Social Services in the development of legislation and regulations likely to significantly influence health. Section 54 thus shows the government's desire to measure the potential impacts of bills and regulations on public health and, consequently, explicitly acknowledges the principle of intersectoral action.

Other actions besides the *Public Health Act* included the following: the sanctioning in December 2002 of the *Act respecting emergency hospital services*, which sets out the roles and responsibilities of the Minister, regional authorities, ambulance technicians and, if applicable, the first respondents in this area; the certification of the first family medicine groups (or Groupes de médecine familiale (GMF)), in November 2002, the establishment of which aimed to facilitate access to a family doctor, promote the latter's role and, ultimately, improve the quality of general medical care; and the creation, in February 2003, of the Conseil du médicament, which is responsible in particular for assisting the Minister in establishing the list of medications covered by the general drug insurance plan, in addition to monitoring their use.

In addition to this came the adoption, in June 2002, of Bill 90, the *Act amending the Professional Code and other legislative provisions as regards the health sector*, in which the legislator described, among other things, the responsibilities of the future specialized nurse practitioners. The purpose of introducing this new category of nurse in health care teams was to improve the accessibility, quality and continuity of care and services in addition to providing more attractive career opportunities for nurses. In 2004, fifteen nurses enrolled in graduate studies, and the first cohort of specialized nurse practitioners graduated in late fall 2005.

Toward the integration of services

In December 2003, in order to, on the one hand, bring services closer to the people and, on the other hand, facilitate the advancement of people within the service system, the government sanctioned the *Act respecting local health and social services network development agencies* (Bill 25). This act marked the beginning of a transition period in the organization of Québec's health and social services system toward the greater integration of health and social services.

Then, in 2005, Bill 83 made it possible to take an important step in the organization and administration of health and social services. Among other things, this new legislation clarified the responsibilities of the various levels of governance of the system following the establishment of the 95 local services networks. Furthermore, the local health and social service system development agencies (ADRLSSSS) became regional health and social services agencies (ARSSS) and were from that point onward responsible for coordinating the establishment of services in their respective areas. These regional authorities were in particular required to develop regional orientations and priorities, exercise regional public health functions, facilitate the deployment and management of local service networks and allocate budgets to institutions and subsidies to community organizations. The agencies also had to make sure the population took part in the management of services, the safe delivery of services and making sure user rights were respected.

The service integration project was part of a results-based management process. It set the framework for a number of changes, in particular with regard to the allocation of financial resources, collective bargaining terms in institutions and methods of remuneration for doctors. These changes aimed to correct certain gaps in the health and social services system regarding the accessibility and continuity of the services provided.

In addition to giving the government a better chance of providing citizens with more accessible, better coordinated, more personalized and uninterrupted services, the service integration project aimed for a number of other goals, including narrowing the gap between the decisions taken by those who provide the services and those who use them; consolidating the partnership between the various actors involved in front-, second- and third-line services; and mobilizing clinicians by fostering their participation in the organization and management of services.

Making this project a reality required collective action by the organizations and actors concerned. Two principles guided this action. The first is responsibility for the population, which brought the various stakeholders providing services to the population in a local area to collectively share a responsibility for this population. The second is the hierarchization of services, which guaranteed complementarity and facilitated user movements between front-, second- and third-line services through reference mechanisms between producers. Lastly, the creation of the RLS provided the backdrop for methods and conditions that fostered the complementarity of the services.

By adopting the *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* in December 2003, the government gave itself an important tool to pursue its objectives with regard to the work organization plan. That same year, in order to strengthen the ties binding the institutions to universities with a faculty of medicine, the Ministère created four integrated university health networks (réseaux universitaires intégrés de santé (RUIS)) associated with the Laval, McGill, Montréal and Sherbrooke universities.

Then, in 2004, the Ministère took legislative and regulatory action to address particular issues. For example, in April, the Ministère launched the Politique en soins palliatifs de fin de vie [policy on end-of-life palliative care]. Then, in May, the Regulation respecting the standards and conditions of practice for conducting home deliveries was approved jointly with the Ministère de la Justice. Later, in December, the *Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration* was adopted. This act stipulates concrete measures and the establishment of an action plan to reduce obstacles to the integration of handicapped persons.

In addition, in November of that same year, persons from all areas of Québec society, assembled at the Forum des générations, targeted two challenges having a direct impact on the health and social services system that accordingly should serve as background for all decisions affecting this field, i.e., demographic changes and public finances.

Access to services

2005 was marked by important legislative changes. In addition to pursuing the establishment of measures that had already been adopted, the Ministère also wanted to pursue its efforts aiming to reduce delays and wait times, revitalize the system's organization and improve access to services for citizens.

First, in June 2005, the adoption of Bill 38, *An Act respecting the Health and Welfare Commissioner*, confirmed the creation of the position of commissioner with the mandate to report on the performance of the health and social services system and propose changes likely to increase its effectiveness and efficiency. Bill 112, *An Act to amend the Tobacco Act and other legislative provisions*, was adopted to intensify tobacco control efforts, in particular with youth.

Then, in November 2005, an important step was taken in the organization and administration of health care and social services with the adoption of Bill 83, *An Act to amend the Act respecting health services and social services and other legislative provisions*. Among other things, this new legislation clarified the responsibilities of the system's various levels following the establishment of the RLSs, and allowed for the greater dissemination of information, thus fostering the work done by teams dispensing care as well as the sharing of knowledge. Lastly, in December, *An Act to amend the Act respecting prescription drug insurance and other legislative provisions* was adopted. (See section on pharmaceutical services, p.77.)

Aside from these legislative changes, 2005 also saw several events that prompted the Minister to conduct an extensive public consultation to assess the progress made, on the one hand, and allow the Ministère to lay the foundations for the health and social services system of the future, on the other hand. Of these events, three were of particular importance.

First, in June, the Supreme Court of Canada rendered its verdict in Chaoulli and Zeliotis, proceedings that began in 1997. The Court found that the prohibition against private insurance for services covered by the public plan infringed on the Québec Charter of Human Rights and Freedoms. Then, in July, the Comité de travail sur la pérennité du système de santé et de services sociaux du Québec, chaired by L. Jacques Ménard, submitted a report in which it set out the particular challenge of the long-term funding of the system within a context where growing costs are amplified by the aging of the population. Lastly, in September, under the chairmanship of Jean Perrault, the Équipe de travail pour mobiliser les efforts en prévention, created following the Forum des générations, sounded the alarm on the acute problem of childhood obesity.

With the publication in February 2006 of the document titled Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality, the Minister established the framework for discussions during the public consultation he decided to conduct the following spring. Three major themes set the tone for the debates.

The first theme related to the consolidation and pursuit of actions regarding preventive services, front-line services and medical and hospital services. Provisions were made for a number of measures to this end. The following is not meant to be a comprehensive list but rather to provide examples of these measures: first, as regards preventive services, adopting a food policy, increasing physical activity in youth and their families, and protecting the population in the event of a health threat; second, as regards front-line services, establishing coordination mechanisms between hierarchized services, pursuing the creation of GMFs and network clinics, building on the distribution of tasks, in particular between nurses and doctors, and adopting service delivery methods directed at supporting people within the community; third, as regards medical and hospital services, organizing these services based on the populations to be served at the local, regional and national levels, establishing functional and effective service "corridors" between institutions, enhancing the collaboration and sharing of expertise between integrated university health networks and institutions.

The second theme constituted a response to the Chaoulli-Zeliotis decision. While it allowed for a limited and well-supervised opening to the private sector, the government reiterated its strong commitment to maintaining a solid public system founded on the values and assets that have always characterized it. The response to the Supreme Court's decision thus took the form of a public access mechanism for certain medical procedures, based on a changing perspective, combined with a limited opening to private insurance to cover three types of surgery: hip replacement, knee replacement, and cataract surgery. (Appendix 3 presents several brief historical references regarding the private sector's participation in Québec's health and social services system.)

The last theme was the long-term funding of the health and social services system within the more general context of the future outlook of Québec's finances. A persistent subject if ever there was one, the financing of the health and social services system, within an either-or context of limited financial resources and quasi-endless health and social services needs, is a constant backdrop to most—if not all—debates regarding the health and social services system and its sustainability. Fueled by an argument based for the most part on the accelerated aging of the population and the rapid development of technology, whether in terms of medical equipment, information technologies or new medications, some

describe the evolution of health and social spending as not commensurate with the collective capacity to cover the costs. On the other side, however smaller, there are those who defend the hypothesis that health and social services expenditures are evolving roughly at the same pace as the collective wealth, measured by the gross domestic product (GDP) and that all in all, compared to other jurisdictions, the government controls these expenditures well. And, in all these discussions regarding the financing of the health and social services system, one important player must always be taken into account: the federal government, which, through fiscal and financial transfers, contributes to the financing of the health and social services of Québec, as it does for the other provinces. (Appendix 4 presents a brief overview of the federal government's participation in the funding of Québec's health and social services system over the years.)

Nevertheless, the public consultation launched in the spring of 2006 led to the tabling of Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*, which set the guidelines for Québec's future health and social services system. This act was sanctioned in December 2006.

The *Act to amend the Act respecting health services and social services and other legislative provisions* essentially aimed to improve access to specialized and super specialized medical services. To do so, it made provisions for several measures, including the institution of a central mechanism to manage access to these types of services in the institutions that provide them. In addition, it conferred on the Minister the power to issue directives regarding access to required services in the event of wait times deemed unreasonable. It also provided for the creation of a legal framework for the practice of medical activities in specialized medical centres. The act provided for the monitoring of the quality and safety of the medical services dispensed in a specialized medical centre, in particular by requiring that the centre's operator have a permit, obtain certification and appoint a medical director. It furthermore provided for the possibility for a hospital centre to join a medical clinic to dispense specialized medical services to some of its users. The act also amended the *Health Insurance Act* to give citizens the option of obtaining a private insurance contract to cover the cost of certain covered services that may be required. The act also amended the *Hospital Insurance Act* to maintain the prohibition against insurance contracts comprising a guarantee of payment for the cost of insured hospital services.

New tools

In the wake of, among other things, the *Act to amend the Act respecting health services and social services and other legislative provisions* and the 2005-2010 Strategic Plan, the MSSS continued to adopt new tools in various areas of health and social services activity.

Among the actions taken in 2006-2007 were the Plan d'action sur la prévention et le contrôle des infections nosocomiales 2006-2009, the Plan québécois de lutte contre le tabagisme 2006-2010, as well as the Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012.

In the summer of 2006, the position of Health and Welfare Commissioner was created. The latter was mandated to assess the outcomes of the health and social services system. To advise him in his work, a Consultation Forum was also established with 27 members, including 9 experts and 18 people from each one of Québec's health and social services regions.

In February 2007, the Minister presented his Politique du médicament [drug policy]. The latter guaranteed free prescription drugs for all employment insurance beneficiaries as well as for people aged 65 or older receiving at least 94% of the guaranteed income supplement as of July 1st, 2007, and facilitated access to exceptional medication. Furthermore, starting in April 2007, drug manufacturers were allowed to increase their prices, but only as much as the consumer price index (CPI). Some exceptions could be made, but only with the Minister's consent. In addition, the policy provided for a drop in the price of generic drugs as well as a reduction of the theoretical maximum profit margin that wholesalers can demand, which went from 9% to 7%, then to 6% in February 2008. In fact, the actual margin, i.e., that actually observed, has come back to the same level as before, namely 6%. It is estimated that the effect of the Politique sur la prime des assurés du régime public should not exceed 0.5%.

Provisions were also made in the policy for a number of actions pertaining to the use of prescription drugs. These actions included: the addition of a drug information line within the Info-santé service (telephone service to get medical advice); awareness campaigns on the proper use of prescription drugs; for certain targeted clients, a revision process for drugs taken at home, in collaboration with the family doctor and the pharmacist; and accelerated computerization to allow for direct communications between doctor and pharmacist.

The drug policy maintained the "15-year rule" ensuring the reimbursement of products, during this period of time, to manufacturers of innovative drugs, even if a less expensive generic equivalent exists. In fact, during this period of time, consumers can choose to use a generic drug or not, and the drugs are reimbursed in either case. Lastly, it provided for the possibility of agreements with industry on the sharing of financial risks associated with the use of a medication as well as for the creation of a standing forum involving the government departments concerned and industry.

2006-2007 also saw the fulfillment of the first steps provided for in the business plan for the Electronic Health Record (EHR). This project, with an implementation timeline extending to 2010, consists in equipping Québec with an electronic tool to allow authorized doctors, pharmacists and nurses to access specific clinical information required for the follow-up and management of patients' care, no matter where they receive health care in Québec. Bill 70, introducing the principle of the implied consent of users, will facilitate the implementation of the EHR. The bill was adopted in May 2008.

Lastly, in June 2007, the Cabinet entrusted a task force chaired by Claude Castonguay with the general mandate to make recommendations on the best ways of ensuring adequate funding for Québec's health and social services system.

In fact, this mandate was fourfold:

- Propose to the government additional sources of funding for health services and social services;
- Specify the role that the private sector can play to improve access and reduce wait times, all while preserving a strong public system and upholding the values that characterize the latter;
- Propose a structure for a new "health account" to increase the transparency of the funding of health and social services, better inform the population and illustrate the funding issue in the medium term, particularly as regards federal transfer levels for health and social services;
- Examine any changes suggested to ensure the necessary adjustments are made to the *Canada Health Act*.

In its report tabled in February 2008, the task force defined a central objective: Québec must ensure the sustainability of the public health and social services system by increasing its productivity and adjusting the growing amounts devoted to the latter to the growth of the collective wealth, measured based on the GDP, all while improving access to care and the quality of the services. The report furthermore set out 8 suggestions and 29 recommendations.

Among the recommendations made, some were favourably received, such as the accelerated deployment of front-line health clinics and the creation of an Institut national d'excellence en santé, while others, such as the idea of setting up a stabilization fund reserved for health and social services relying on a premium adjusted to the services used and household income as well as a percentage of the Québec sales tax, were not selected for application by the government.

The great challenge

The issues relating to the area of health and social services in Québec in the coming years will remain clear. We will first have to continue developing effective actions before problems arise. Then, we must continue to adapt the organization of services in such a way as to ensure greater accessibility to and continuity of services, particularly for more vulnerable clienteles. We will also have to persist in actions taken with a view to improving the quality of services and optimizing the use of resources supporting the delivery of services. And, of course, we will have to continue seeking the conditions required to efficiently manage the financial resources allocated to the health and social services system.

Promoting and improving the health and well-being of the people of Québec and safely providing the latter with accessible, continuous and quality health and social services within a reasonable period of time are all challenges facing the Ministère de la Santé et des Services sociaux and the actors concerned.

Aspects of the health and social services system

Current structure

Human resources

Institutional resources

Utilization of services

The cost

ASPECTS OF THE HEALTH AND SOCIAL SERVICES SYSTEM

In Québec, questions regarding health and well-being are looked at as one entity. This is a major thrust of Québec's social policy. Specifically, this policy translated into the implementation of a public system of services in 1970, bringing health and social services under the authority of a single government department, within an integrated network.

Québec's health and social services system rests on a legislative framework that includes some 30 laws governing the various aspects of these types of services. (Appendix 5 presents a list of the laws in effect in the area of health and social services.)

CURRENT STRUCTURE

Québec's health and social services system is based on a three-tiered governance structure.

At the central level, the MSSS is in charge of regulating and coordinating the entire system. More specifically, it determines the orientations and sets objectives in the area of health and welfare, formulates policies, approves priorities and service organization plans in the regions, allocates resources among these regions and assesses the results. The MSSS also oversees the promotion of teaching and research and coordinates the public health program. Lastly, it defines labour adjustment policies and negotiates pay conditions for the professionals and staff of the health and social services network.

At the regional level, fifteen regional health and social services agencies (agences régionales de la santé et des services sociaux (ARSSS)), along with the Nunavik Regional Board of Health and Social Services, the Centre régional de santé et de services sociaux de la Baie-James (Nord-du-Québec), and the Cree Board of Health and Social Services of James Bay (Terres-Cries-de-la-Baie-James), coordinate the implementation of health and social services in their respective regions. They have at their disposal extensive powers and all the necessary levers to organize and adapt resources according to the needs in their areas. The agencies and three regional administrative organizations must report on their management to both the people living in their area and the departmental authority.

At the local level, health services and social services are provided by health and social services institutions, i.e., businesses or administrative entities. The latter oversee facilities, i.e., physical places where care is dispensed. The law divides these institutions under the following five great missions (service centres):

- Local community service centre
- Hospital centre;
- Child and youth protection centre
- Residential and long-term care centre
- Rehabilitation centre.

The mission of local community service centres (CLSC) is to offer, at the primary level of care, basic health and social services. In addition, they must provide, to the population of the territory they cover, health services and social services of a preventive or curative nature and rehabilitation or reintegration services. Lastly, they must carry out public health activities on their territory, in accordance with the provisions made in the *Public Health Act*.

The mission of hospital centres (CH)—whether in the case of general and specialized hospital centres (CHSGSs) or hospital centres for psychiatric care—is to offer diagnostic services and general and specialized medical care.

The mission of a child and youth protection centre is to offer psychosocial services in the regions, including social emergency services, required by the situation of a young person pursuant to the *Youth Protection Act* and the *Youth Criminal Justice Act* as well as services for child placement, family mediation, expertise at Québec's Superior Court on child custody, adoption, and biological history.

The mission of a residential and long-term care centre (CHSLD) is to offer, on a temporary or permanent basis, alternative environment, lodging, assistance, support and supervision services as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services to adults who, by reason of loss of functional or psychosocial autonomy can no longer live in their natural environment, despite the support of their families and friends; The mission of such a centre can also include operating a day centre or day hospital.

Lastly, the mission of a rehabilitation centre (CR) is to offer adjustment, rehabilitation and social integration services to persons who, by reason of physical or mental impairment, behavioural disorders, psychosocial or family difficulties, alcoholism or other problems of addiction, require such services, as well as persons to accompany them, or support services for their families and friends.

In time, a number of service centres within the network of institutions were grouped together with others. In this way, a network of youth centres (CJ) was created, bringing together in each region the child and youth protection centres, the rehabilitation centres for young persons with adjustment problems (CR JDA) and rehabilitation centres for young mothers with adjustment problems (CR MDA).

The establishments, and the facilities that they oversee, have either a public status, i.e., non-profit institutions entirely budgetized by the MSSS, or a private status, i.e., partially for-profit institutions partially budgetized by the MSSS and partially "self-budgetized" (private under-agreement), or totally for-profit entirely "self-budgetized" (private not-under-agreement).

The local level of governance: the CSSS

When the local services networks were implemented, at the heart of each one a super establishment was created, i.e., a local authority called health and social services centre (CSSS), bringing together under the responsibility of a single board of directors one or more local community services centres, residential and long-term care centres and hospital centres.

The CSSS is the foundation of an integrated service offer. Sharing with other partners a responsibility to the population of the local services network territory, it ensures accessibility, management, follow-up and the coordination of services intended for this population. The model rests, on the one hand, on the offer, close to the living environment, of a wide range of front-line services, including public health services, and, on the other hand, on the implementation of orientation and follow-up mechanisms to ensure access to second- and third-line services (specialized and superspecialized services). Thus, the various stakeholders offering health services and social services to this population are in a position to meet the full range of its needs and facilitate its movements within the system, in particular those of vulnerable persons.

Currently (2008), of the 95 health and social services centres, 68 assume the three missions mentioned above, i.e., CLSC, CHSLD and CH. Aside from this group, 14 CSSSs assume only the missions of CLSC and CHSLD, while the last 10 assume the four missions of CLSC, CHSLD, CH and CR. Lastly, one CSSS assumes both the missions of CLSC and CH, another one assumes the three missions of CLSC, CHSLD and CR, while the last one assumes only the mission of CLSC.

Establishments can thus assume several missions. In fact, in 2008, close to half (47%) of all the public and private institutions that make up the network pursue multiple missions. If we consider only under-agreement public and private establishments, the proportion of those that assume more than one mission jumps up to over 56%.

Other organizations

Institutions also oversee some 1,930 intermediate resources (IR) serving clienteles with decreasing autonomy, as well as close to 3,500 family-type resources (FTR), i.e., foster families for young people and foster homes for adults and seniors. In addition to that are also approximately 5,650 family-type resources for children directly associated with the youth centres.

Moreover, outside the network of institutions with a permit issued by the MSSS is a network of approximately 2,300 private residences for seniors certified (or that will need to be certified) by the MSSS to provide residential care.

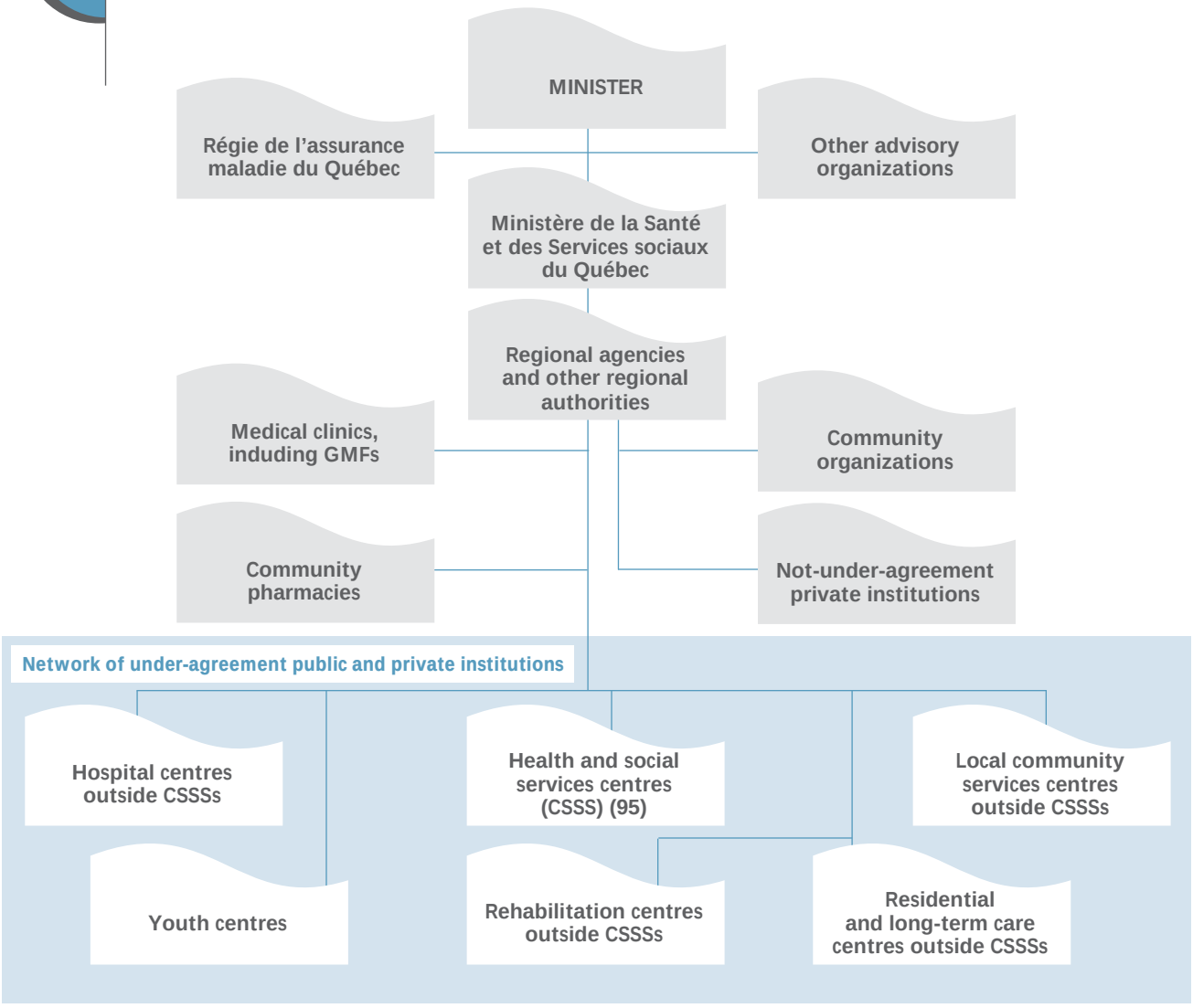
There is also a network of some 3,400 community organizations, close to 3,300 of which are subsidized at the regional level and about 120 at the national level. This network now comprises some forty categories of organizations addressing specific issues and clienteles.

On top of all these resources are also some 2,000 general practitioner and specialist clinics, including 160 certified family medicine groups (GMF) (in April 2008) and 23 network clinics, as well as around 1,630 community pharmacies and some one hundred social economy enterprises providing domestic assistance.

Lastly, fourteen specific organizations report to the Minister of Health and Social Services. Most of them exercise an advisory role with regard to a specific mandate. Others, like the Régie de l'assurance maladie du Québec (RAMQ), have a broader mandate and more extensive resources. (Appendix 6 presents a list of organizations that come under the authority of Québec's Minister of Health and Social Services.)

The role of the RAMQ is to apply and administer the health insurance plan instituted by the *Health Insurance Act*, the prescription drug insurance plan, and any other program that the law or government entrusts to it. It is responsible, for example, in accordance with the law and with any regulations, agreements or accords, for the payment or reimbursement of services and goods provided for under the various programs for which it is responsible, and for monitoring eligibility to the various plans. Concretely, it pays the salary of doctors, whether working at an institution or in an office, as well as of other professionals—dentists, optometrists, pharmacists—who dispense insured services to the clienteles specifically designated by law. The RAMQ is also one of the main health and social services data warehouses in Québec and must manage several information systems at the MSSS in addition to its own.

Figure 20 The Québec health and social services system, *2008*



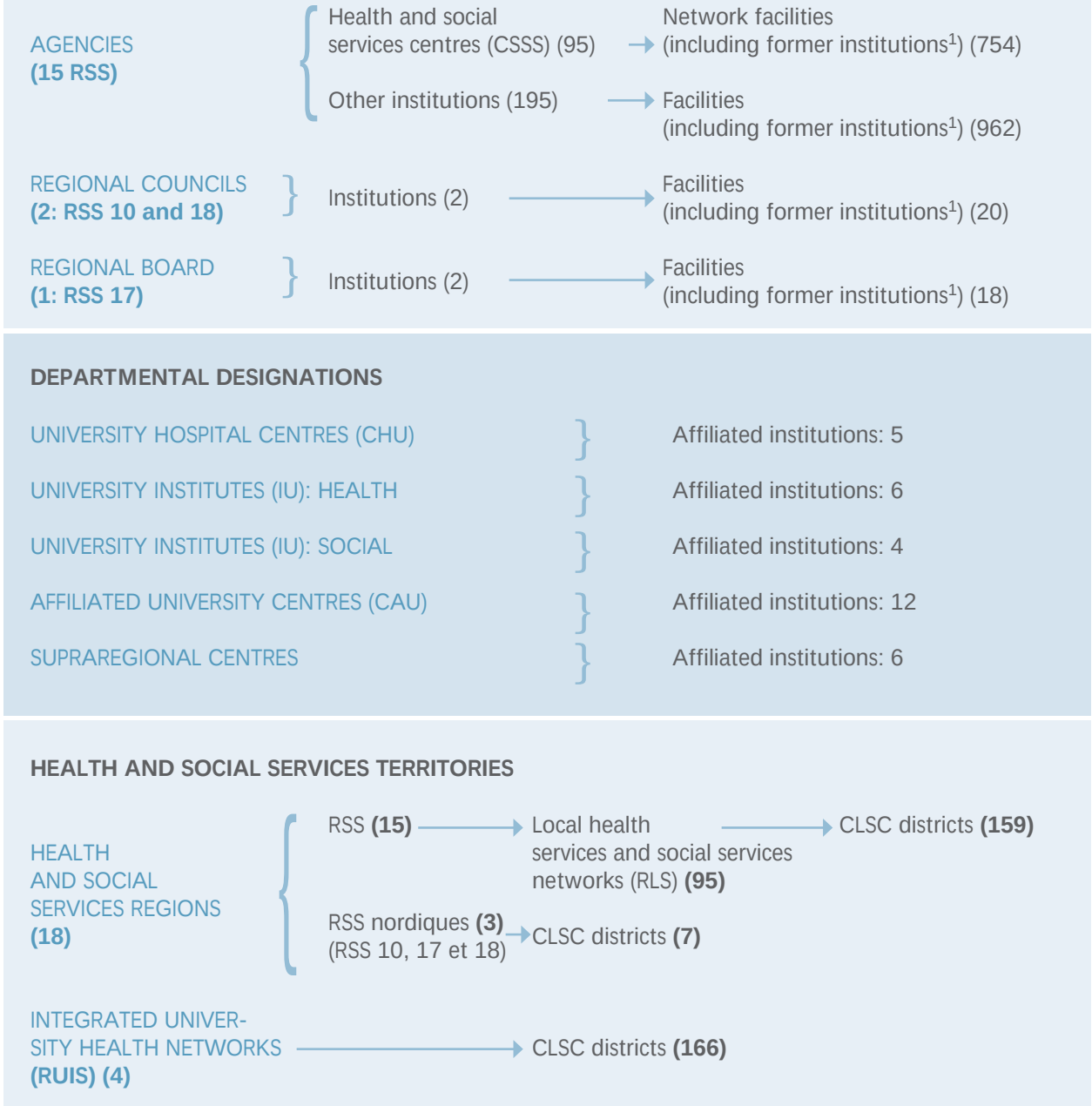
Source: Service du développement de l'information, ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Figure 21

Institutional and territorial structure of the Québec health and social services system,

situation observed on March 31, 2008



1. Facilities were identified as institutions before regrouping the missions.

Source: Système de gestion territoriale M34, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

HUMAN RESOURCES

For the purposes of this document, the expression "human resources" refers principally to health care professionals, including physicians (general practitioners and specialists), the staff of the network of institutions (both managers and unionized employees), especially nurses, and the administrative personnel of the MSSS and the RAMQ.

In 2007, Québec's public system of health and social services employed some 280,000 people, or a little less than 7% of the active population of Québec. Of this number, there are approximately 22,630 professionals who receive fees reimbursed by the RAMQ, including almost 16,100 physicians, and some 255,000 managers and unionized employees in the network of institutions. This latter figure includes close to 107,400 nurses, nursing assistants and attendants, as well as almost 1,800 managers and unionized employees in the MSSS and the RAMQ.

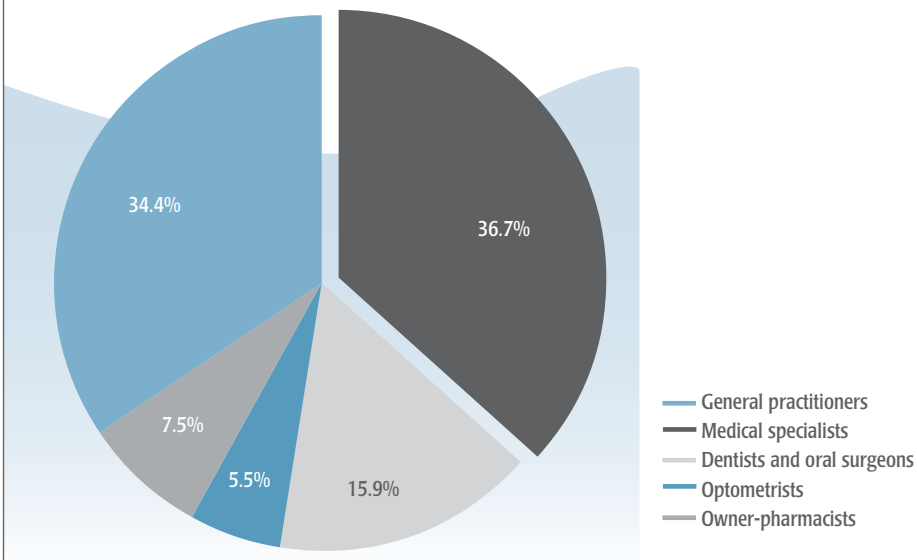
Physicians and other professionals paid by the RAMQ

The number of physicians in Québec is calculated from two sources. When we want to make comparisons, either with other provinces or other countries, of the number of physicians for a given population, we have to use the data provided by the Canadian Institute for Health Information (CIHI) in order to have a common base of comparison. These data are drawn from Scott's Medical Database. This database is not so much a system of statistical data as a file of names and addresses constructed on the basis of questionnaires filled out by Canadian physicians. The number of Québec physicians listed in this database is similar to the number registered with the Régie and subject to an agreement with the government, whether they practise in Québec or not, but without necessarily having submitted a request for payment to the Régie. In addition, the distribution by category of physician and by speciality differs from the distribution given in annual RAMQ statistics, because in Scott's Medical Database the term "specialist" is not always the same as the definition used in the provincial medical insurance plans.

In this publication, the definition used is taken from the Annual Statistics of the RAMQ, which is, the number of "active" physicians. These are the physicians registered with the Régie and subject to an agreement, who practise in Québec and who have submitted at least one request for payment to the Régie during the year. The same is true for the other professionals paid by the RAMQ.

Figure 22

Percentage distribution
of professionals paid by the Régie de l'assurance maladie,
by professional category, Québec,
2007



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

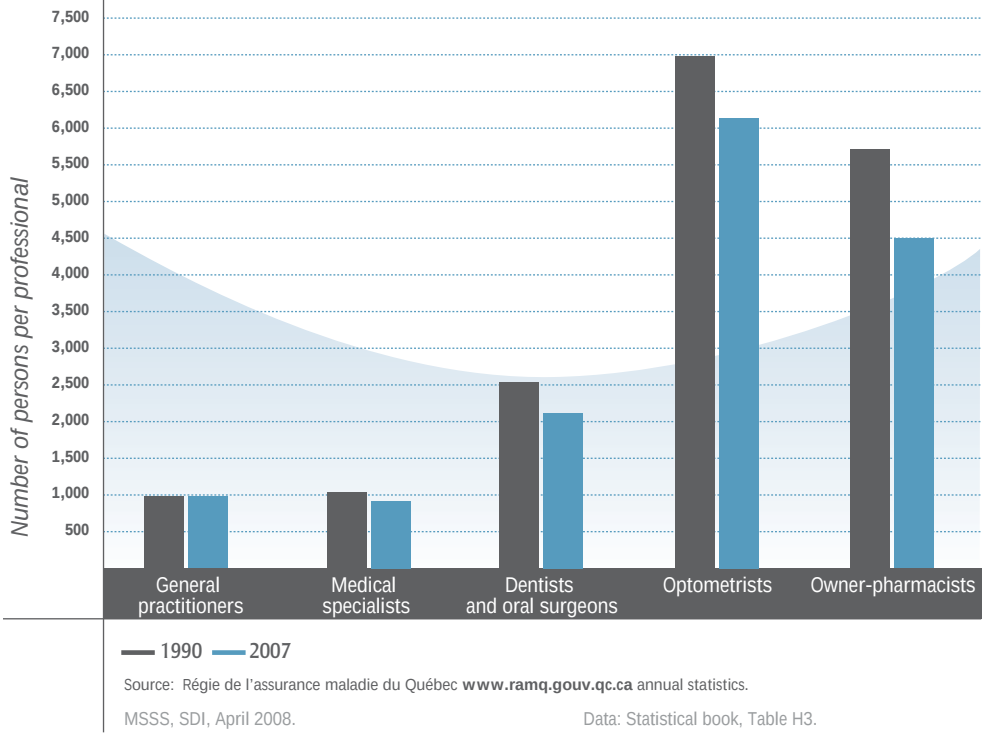
MSSS, SDI, April 2008. Data: Statistical book, Table H3.

In 2007, there were a little less than 22,630 professionals paid by the RAMQ in Québec. More than 71% of the latter are physicians, while slightly less than 16% are dentists. These proportions have changed little since 1990.

Three of these professional categories, i.e., physicians, dentists and optometrists, saw an improvement of the "number of persons/professional" ratio between 1990 and 2007, with their respective numbers rising at a faster pace than that of the general population. As for owner-pharmacists, the trend is similar to other categories between 1990 and 2005, but a drop was noted in 2006 and 2007.

Figure 23

Number of persons
per professional paid
by the Régie de l'assurance maladie
by professional category, Québec,
1990 and 2007



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

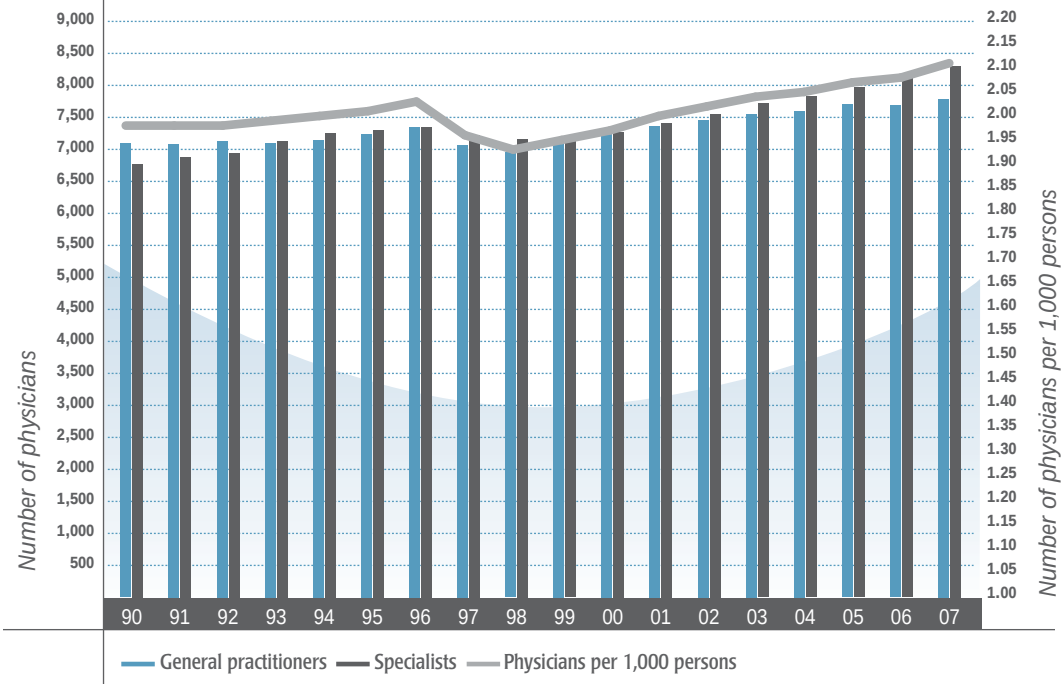
MSSS, SDI, April 2008. Data: Statistical book, Table H3.

In 1990, there were slightly fewer than 14,000 physicians in Québec, i.e., 1.98 physicians per 1,000 people, including some 6,800 specialists; seventeen years later in 2007, the population of Québec can rely on close to 16,100 physicians, including close to 8,300 specialists, a ratio of 2,11 physicians per 1,000 people. After a drop due to early retirements in the late 1990s, the number of physicians once again took on an annual growth rate of about 1.5%.

One of the most important phenomena to occur within the medical profession was, without a doubt, the evolution of the proportion of female physicians. In 1976, barely 8% of physicians were women, i.e., one physician out of ten for general practitioners and barely 6% for specialists. Today (2007), there are close to four women out of ten physicians in Québec, i.e., close to 47% for general practitioners and close to 33% for specialists; and this growth, which has been constant for 30 years, shows no signs of letting up.

Figure **24**

Number of
active physicians
by category of physician and number of active physicians per 1,000 persons, Québec,
1990 to 2007



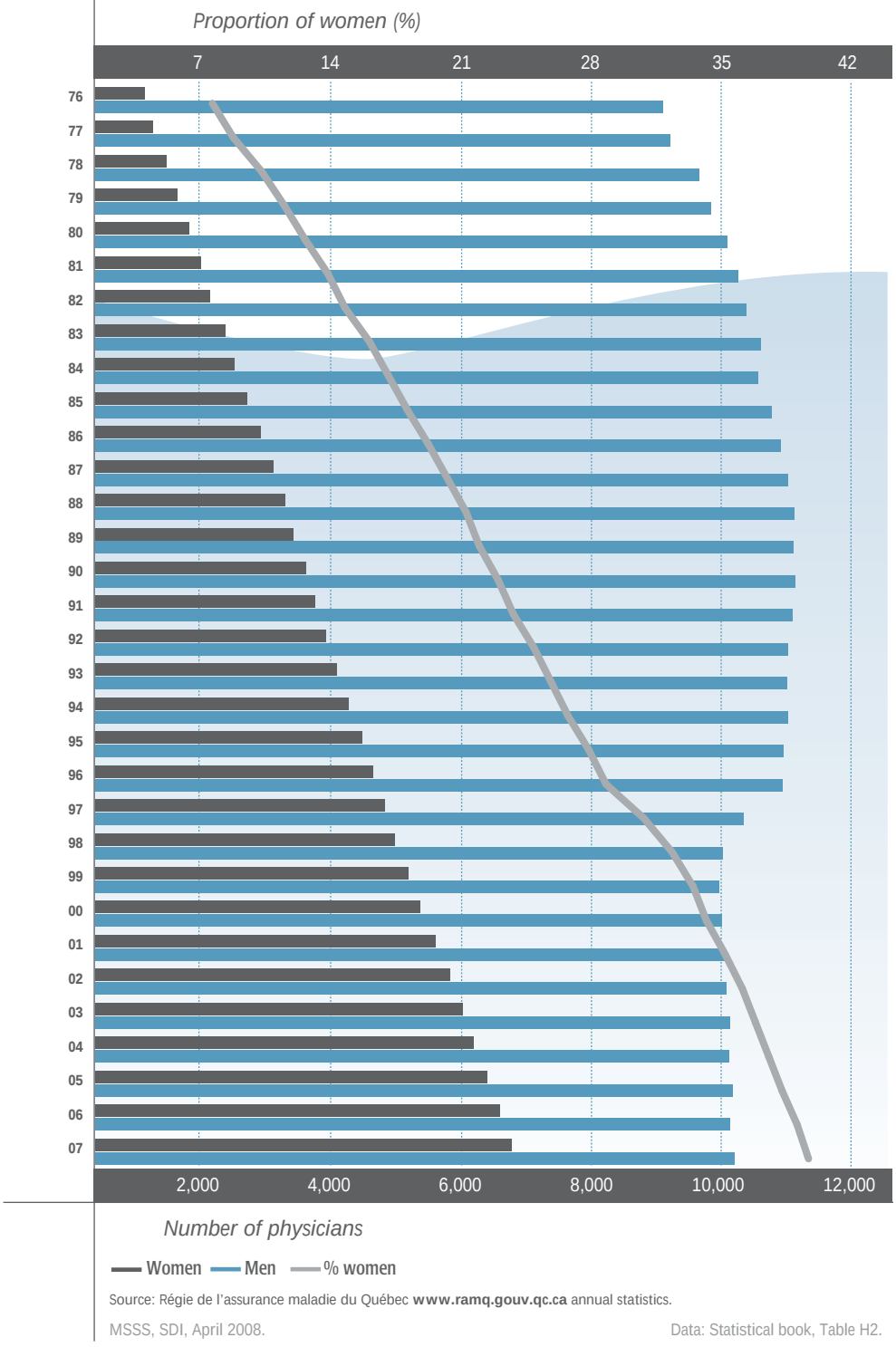
Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Data: Statistical book, Table H1.

Figure 25

Number of
active physicians
by gender and proportion of women among these physicians, Québec,
1976 to 2007



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Data: Statistical book, Table H2.

Network managers and unionized staff

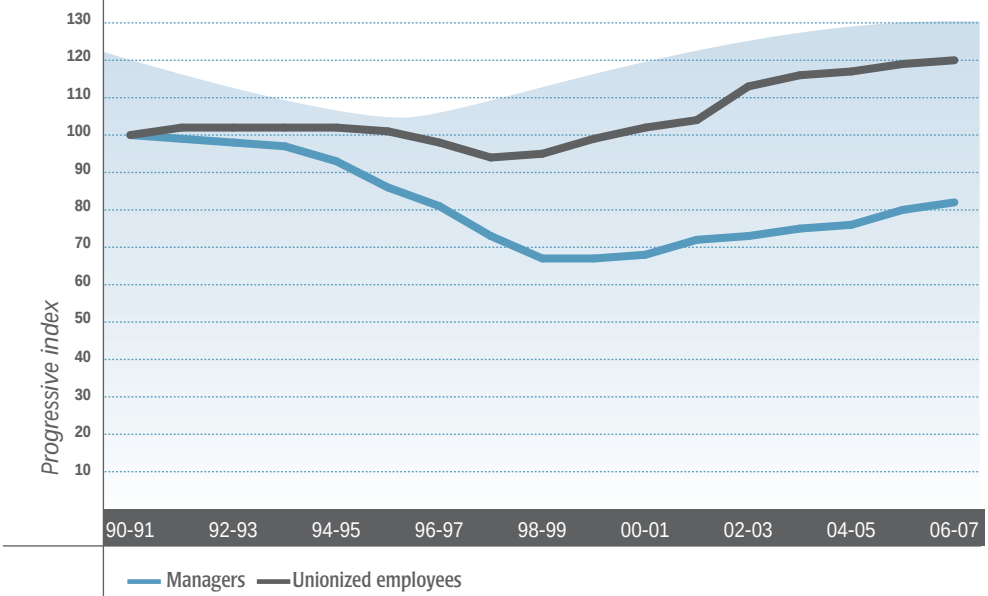
The network staff can be expressed in "number of persons working" irrespective of their job status, or in "full-time equivalents" (FTEs), where one FTE equals 1,826.3 paid hours on an annual basis.

From 1990-1991 to 2006-2007, network staff rose from some 240,500 to over 255,000 persons working, an increase of a little over 6%. While the number of unionized employees increased by 7.9%, that of managers fell by 21%. In terms of FTEs, in 2006-2007, there were some 10,650 managers and close to 188,900 unionized employees.

As of March 31, 1991, 62.3% of the network staff, expressed in terms of FTEs, had regular full-time (RFT) status; by March 31, 2007, this proportion was only 55.3%. Among managers, the RTF proportion went from 89.8% to 90.5%, whereas among unionized employees the trend was reverse, with the proportion going from 60.1% to 53.3%. In 1990-1991, there was a ratio of 12.3 unionized employees for each manager in the network; after reaching a peak of 19.1 in 2003-2004, this ratio fell back to 17.7 in 2006-2007.

Figure **26**

Change in managerial and unionized staff within under-agreement public and private institutions
in the Québec health and social services network,
1990-1991 to 2006-2007



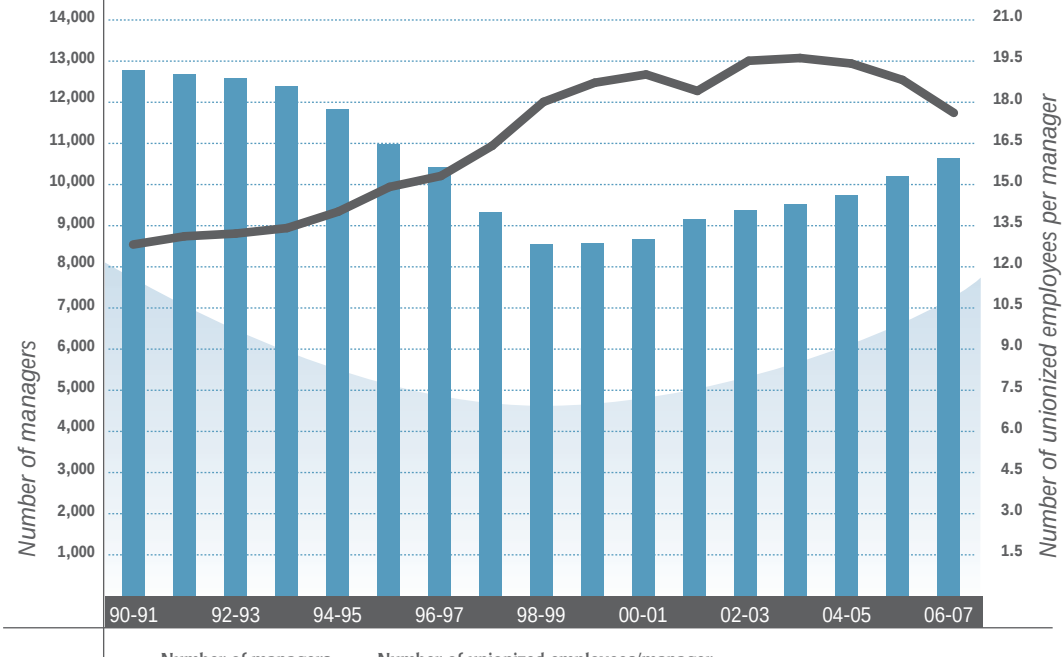
Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table H4.

Figure 27

Number of managers and number of unionized employees per manager

within under-agreement public and private institutions in the Québec health and social services network, *1990-1991 to 2006-2007*



Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

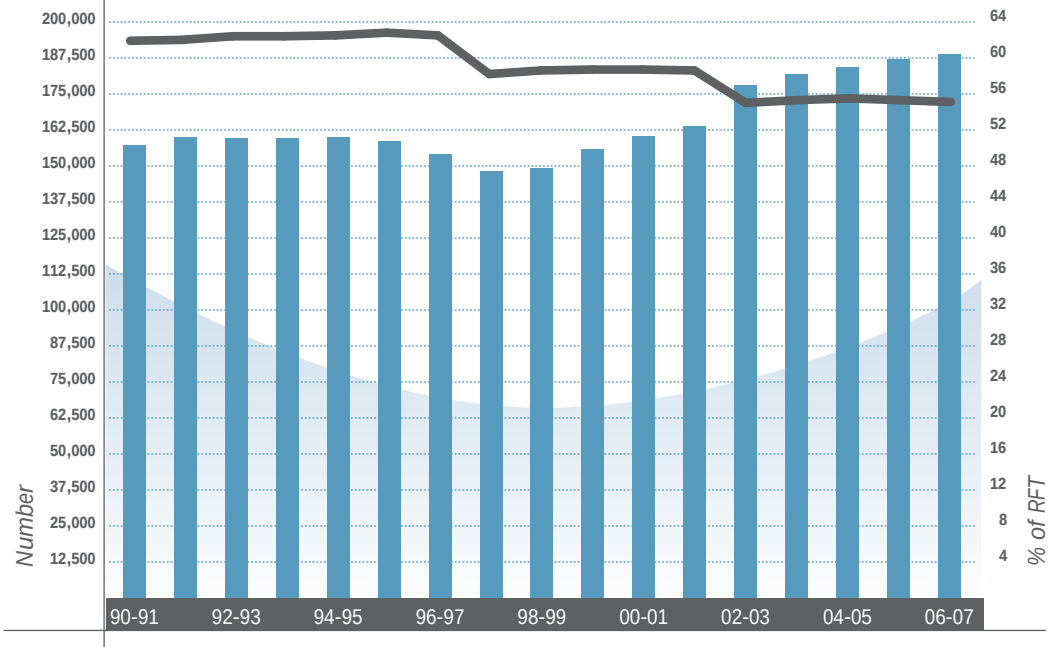
MSSS, SDI, April 2008.

Data: Statistical book, Table H4.

Figure 28

Number of unionized employees and proportion of these employees occupying regular full-time (RFT) jobs within under-agreement public and private institutions in the Québec health and social services

1990-1991 to 2006-2007



Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table H4.

In 1990-1991, the total compensation costs of managers and unionized employees in the network was a little less than $5.2 billion. In 2006-2007, these costs rose by close to 61% to over 8.3 billion dollars.

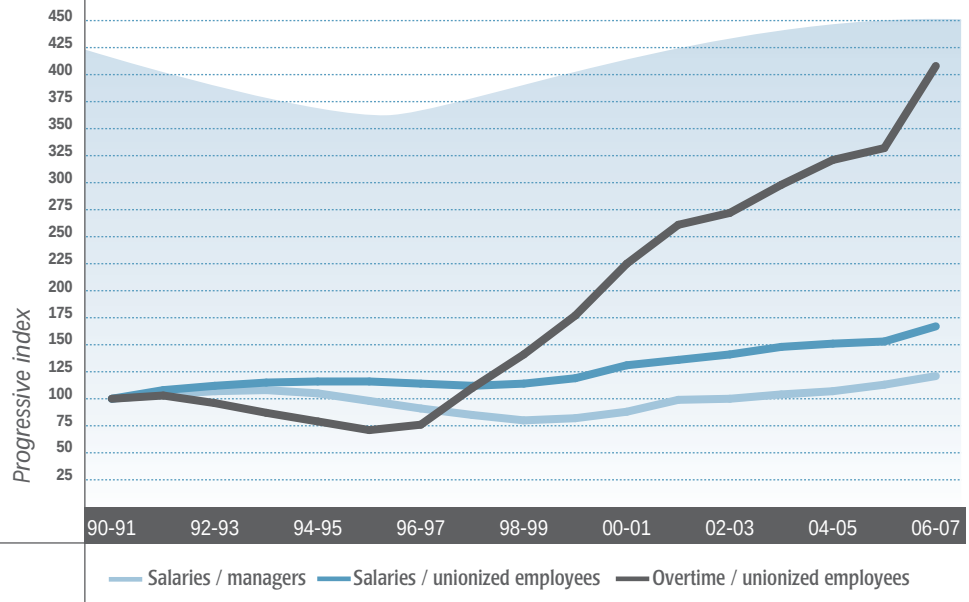
During this sixteen-year period, the average salary of a manager went from $51,400 to $75,900, i.e., a rise of more than 48%, or close to 2.5% annually, on average. For unionized employees, the average salary went from $30,470 in 1990-1991 to $42,873 in 2006-2007, i.e., a 41% increase, or an average annual rise of less than 2.2%.

For unionized staff, overtime pay declined up until 1995-1996, going from $68 million, in 1990-1991, to $48.5 million. Since then, however, we have seen a sharp rise in overtime: overtime pay now (2006-2007) reaches close to $278 million.

Figure **29**

Change in total compensation costs for managerial and unionized staff

within under-agreement public and private institutions in the Québec health and social services network, *1990-1991 to 2006-2007*



Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table H5.

Nursing staff

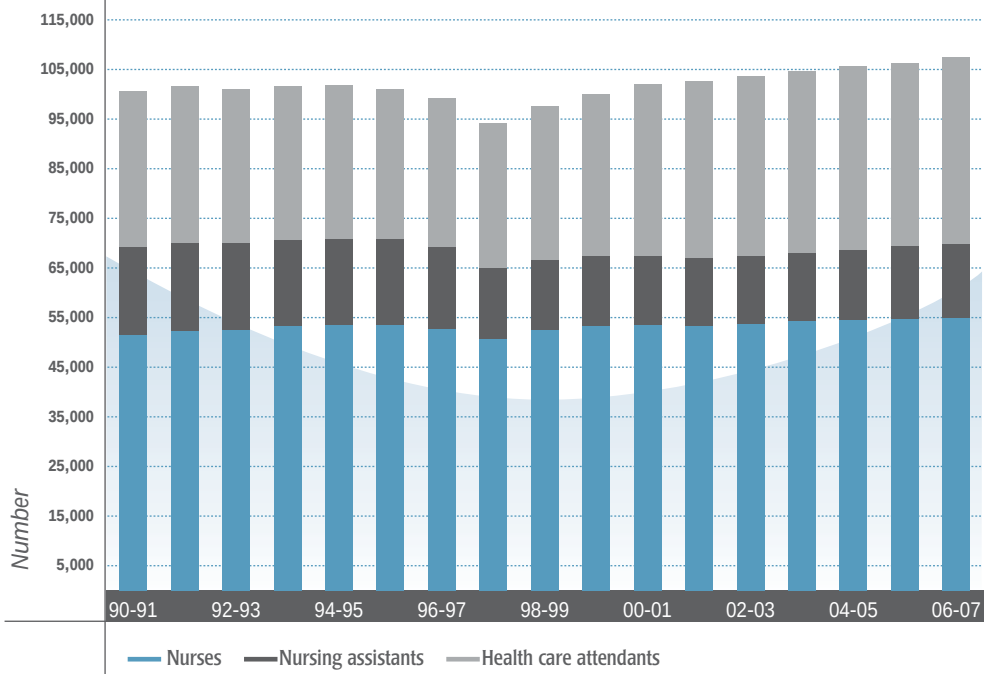
Three groups can be distinguished based on education level: nurses, who have a college or university degree; nursing assistants, who hold a diploma in nursing care at the Secondary V level; and health care attendants, who have received ad hoc training in a recognized educational institution.

In total, these three groups included in 2006-2007 close to 107,240 persons employed for some 82,500 FTEs, i.e., a ratio of 0.77 FTE per person employed. In 1990-1991, there were some 100,600 persons employed for approximately 66,800 FTEs, for a ratio of 0.66 FTE per person employed. At the beginning of the period, the "nurse" group made up almost 51.3% of the total nursing staff, with nursing assistants accounting for 17.6% and health care attendants for 31.1%. In 2006-2007, the proportions were, respectively, 51.2%, 13.8% and 35%. Nursing assistants are the only group that saw a drop in numbers.

The nursing staff bottomed out in 1997-1998 as a result of early retirements. For nurses and health care attendants, that year was the "bottom year" in terms of persons employed. However, nursing assistants saw their lowest numbers in 2002-2003.

Figure **30**

Nursing staff working
within under-agreement public and private institutions
in the Québec health and social services system,
based on category of nursing staff,
1990-1991 to 2006-2007



Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table H6.

Administrative personnel of the MSSS and the RAMQ

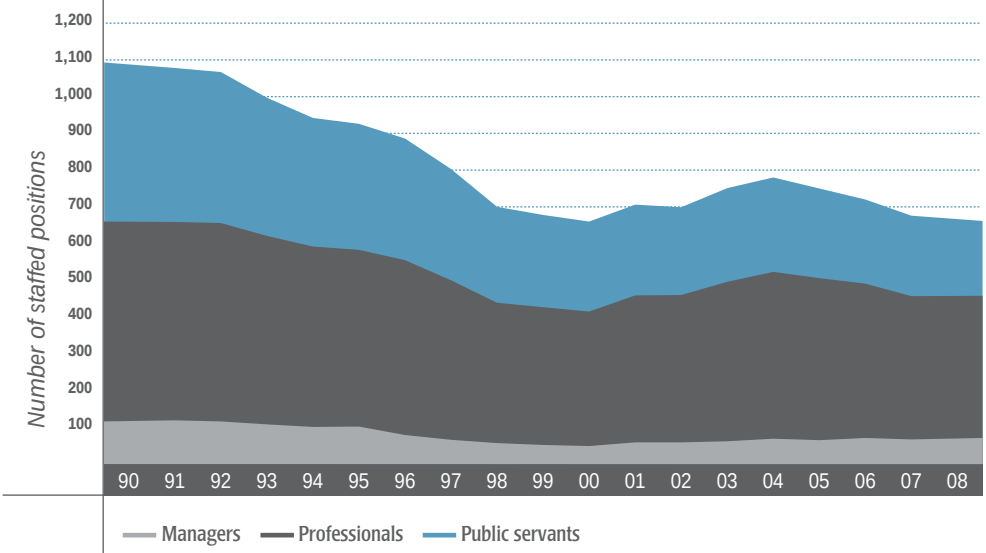
At the beginning of the 1990s, there were almost 1,100 staffed positions (excluding contractual jobs and personnel "on loan") in the MSSS. On March 31, 2000, there were only 660, which works out to a 40% drop. A rise was subsequently noted until 2004, a year in which there were 780 staffed positions in the MSSS, i.e., a rise of more than 18% compared to 2000. Since then the number of staffed positions has been in decline, falling to 662 in 2008.

For public servants, the drop in staffed positions was almost constant between 1990 and 2008. In fact, the period as a whole showed a drop of close to 53%. Professionals saw their numbers start to decline in 1993 and continue to fall until 2000. This was followed by a rise from 2000 to 2004, only to once again start falling after that. Currently (2008), the MSSS has 387 authorized positions staffed by professionals. Up until 1995, managers followed a trend similar to that observed for professionals. Then, from 1995 to 1999, this category saw a sharp drop, essentially due to the fact that many managerial positions were staffed by contractual employees not accounted for in authorized staffed positions. Since then, the number of authorized positions staffed by managers has fluctuated between 65 and 71; in 2008, there were 71.

In 1990, the distribution of total staffed positions among the three groups was 11% for managers, 50% for professionals and 39% for public servants. In 2006-2007, the proportions were, respectively, 11%, 58% and 31%. The positions staffed by professionals are accordingly not only the most numerous, but their relative weight in the MSSS's total staff continues to grow.

Figure **31**

Number of
authorized positions staffed by regular personnel
within the Ministère de la Santé et des Services sociaux du Québec, by job category,
situation observed on March 31, 1990 to 2008



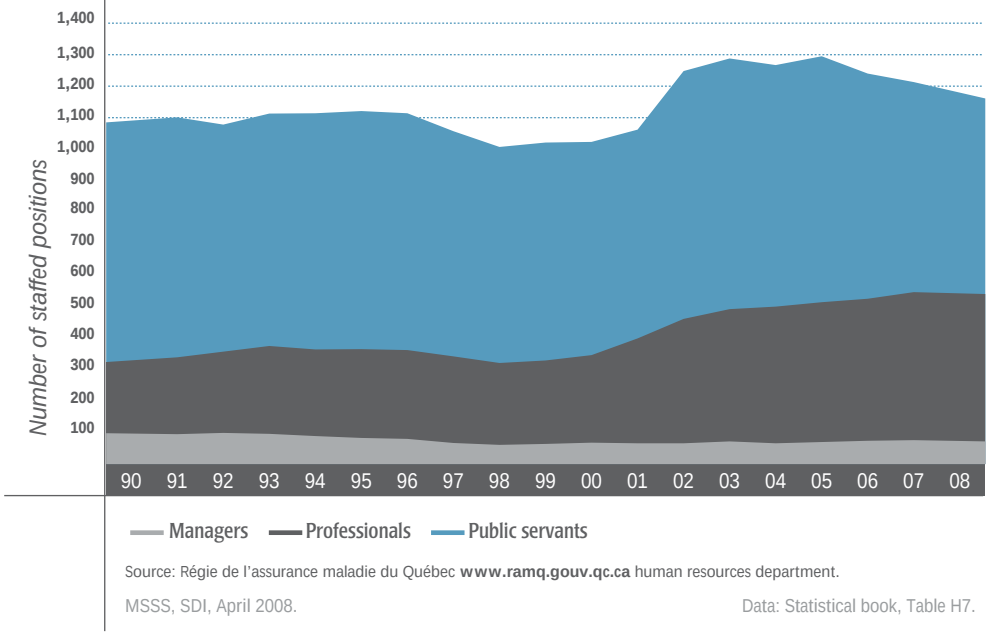
Source: Direction des services au personnel, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.
MSSS, SDI, April 2008. Data: Statistical book, Table H7.

The trends were different at the Régie de l'assurance maladie du Québec. In fact, the number of staffed positions rose from 1,085 in 1990 to 1,295 in 2005, i.e., a rise of approximately 19%. However, since that time, this number has been in decline; it currently sits at 1,161 in 2008. The number of positions staffed by professionals increased by 23% from 1990 to 1993, then stayed relatively constant until 2000. Starting in 2001, it saw a constant rise to reach 468 in 2008; this increase is essentially due to the fact that a number of technicians acquired the status of computer analyst. During that time, the number of positions staffed by public servants fluctuated a number of times to finally drop below 621 in 2008. As regards positions filled by managers, the number began decreasing in 1994 and then stabilized around 65 from 1997 up to 2002. Then came a slight upswing; 72 positions were staffed by public servants in 2008.

In 1990, managers filled 9% of the positions, professionals filled 21%, and public servants filled 70%. In 2008, the proportions were, respectively, 6%, 40% and 54%. Consequently, even though the number of positions filled by professionals is on the rise, public servants continue to fill the most positions.

Figure 32

Number of
authorized positions staffed by regular personnel
within the Régie de l'assurance maladie du Québec,
by job category,
situation observed on March 31, 1990 to 2008



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** human resources department.

MSSS, SDI, April 2008. Data: Statistical book, Table H7.

INSTITUTIONAL RESOURCES

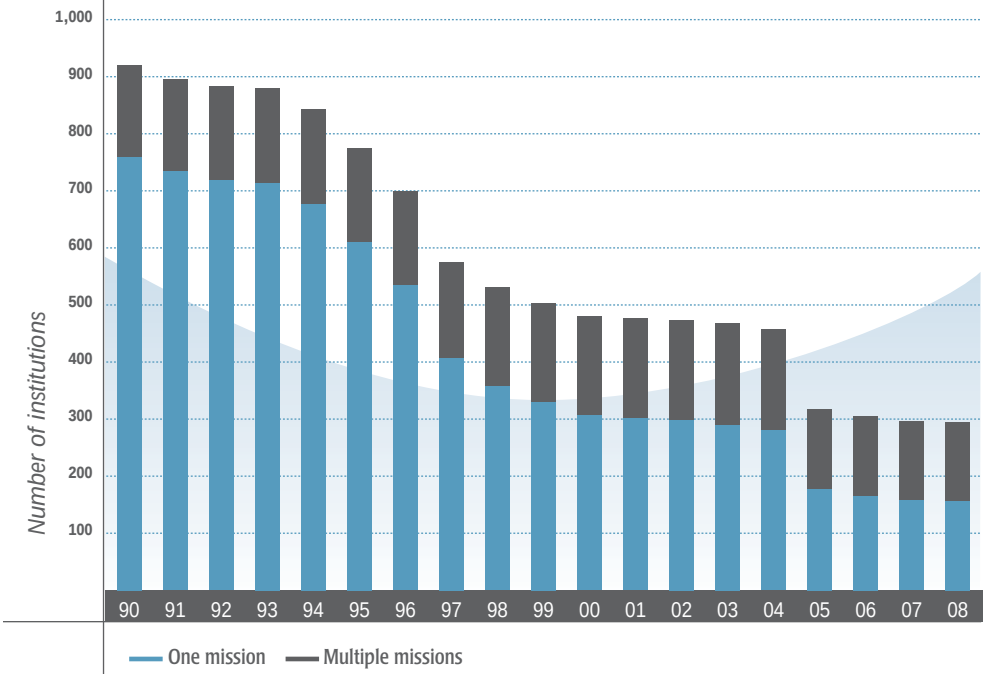
For the purposes of this document, institutional resources mean institutions, facilities, approved beds with operating permit and set-up beds, that is, beds that are staffed and ready for use, as well as certain complementary resources, i.e., intermediate resources, family-type resources, private homes for the aged, and community organizations.

Health and social services institutions

In March 2008, the Québec health and social services network had 294 institutions providing health services and social services to the population; in 1990, there were three times as many. In the early 1990s, less than 18% of institutions assumed more than one mission; today (2008), following the move to group institutions together, close to 47% of them have taken on more than one mission (e.g., health and social services centres). This amalgamation of missions was more prevalent in public institutions. In fact, in 1990, of the 920 institutions with a permit from the MSSS, 684 were public, i.e., a little over 74% of the total number. In 2008, 191 of the 294 institutions listed are public, i.e., slightly less than 65% of all institutions. Between 1990 and 2008, the number of private institutions fell by 56%, compared to a 72% drop for public institutions.

Figure **33**

Number of institutions
in the Québec health and social services network,
depending on whether they take on only one mission or more,
situation observed on March 31, 1990 to 2008



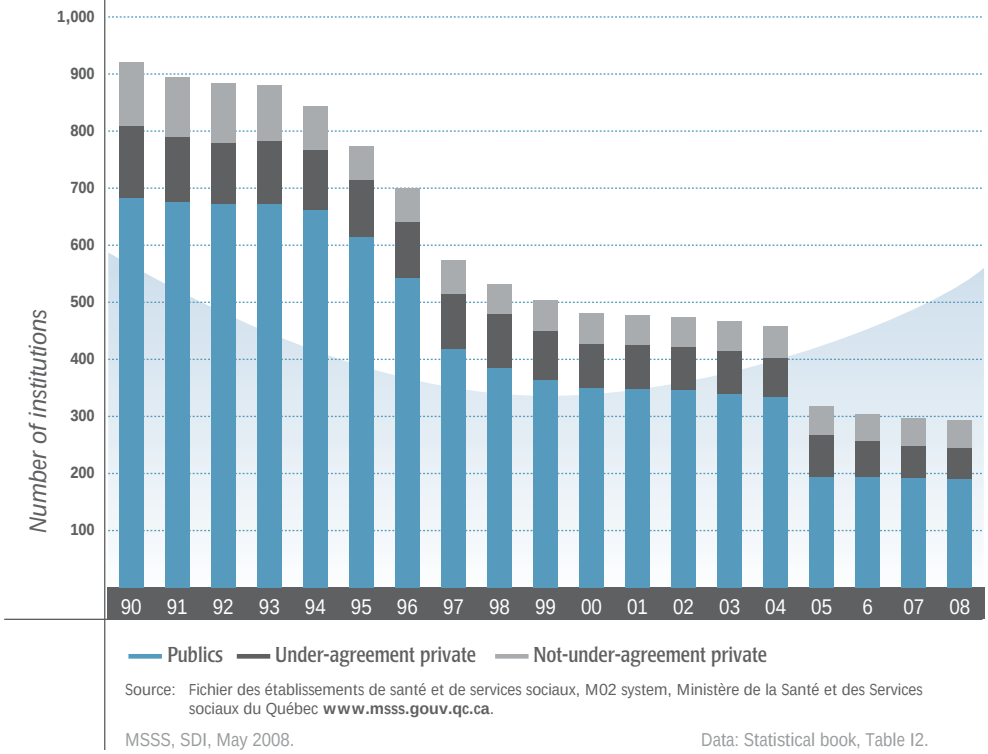
Source: Fichier des établissements de santé et de services sociaux, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Data: Statistical book, Table I1.

Figure 34

Number of institutions
in the Québec health and social services network,
by status and financing Method,
situation observed on March 31, 1990 to 2008



Source: Fichier des établissements de santé et de services sociaux, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008. Data: Statistical book, Table I2.

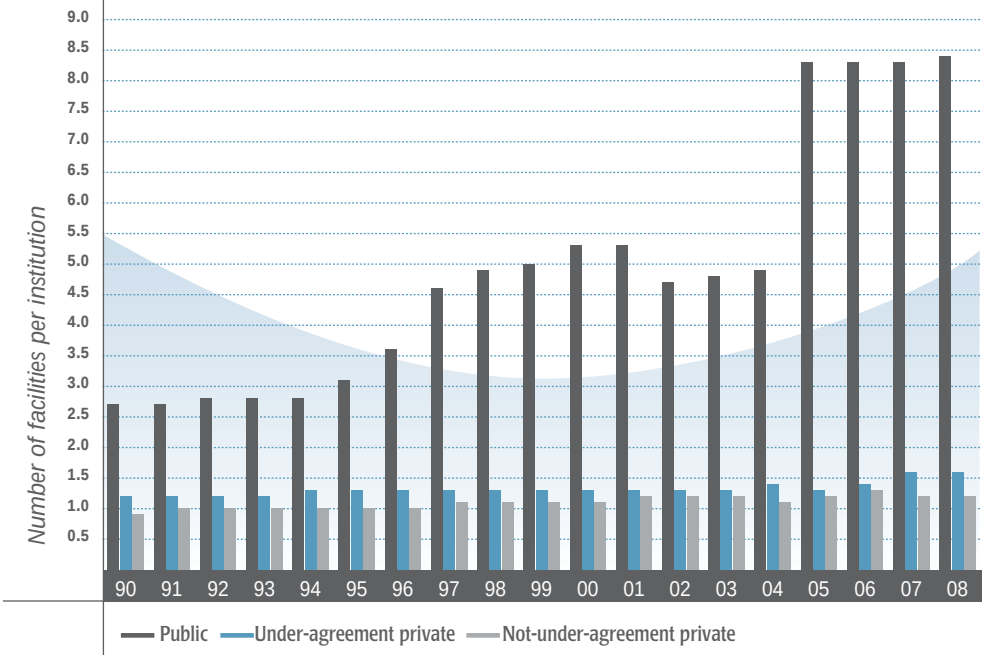
Health and social services facilities

At the present time (2008), the network's 294 institutions oversee some 1,750 facilities, including a little over 1,600 public facilities. While institutions represent companies that manage facilities, the latter are physical sites where health care and social services are provided to the population of Québec. Some institutions have only one facility and thus are physically one and the same. However, several institutions have more than one facility, including some which are located in a different territory from that of the institution to which they belong. It is estimated that close to 40% of facilities are located outside the CLSC territory where the institution to which they are attached is located, and 4% of facilities are outside the health and social services region where the institution on which they rely is located. Although private institutions generally only have one facility, the same cannot be said of public institutions. In fact, because of the move to group together institutions, the average number of facilities per institution went from 2.3 to close to 6 between 1990 and 2008, when considering the network as a whole. The ratio for public institutions alone rose from less than 2.7 to over 8.4.

Although the number of institutions has dropped significantly in the last two decades, the number of facilities has remained relatively stable, apart from the "disappearance" of residential pavilions in April 2001. Indeed, at that time, the 194 pavilions listed became intermediate resources and thus lost their status as facilities.

Figure 35

Number of
facilities in the Québec health and social services network,
by status and financing method,
situation observed on March 31, 1990 to 2008



Source: Fichier des établissements de santé et de services sociaux, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Data: Statistical book, Table I2.

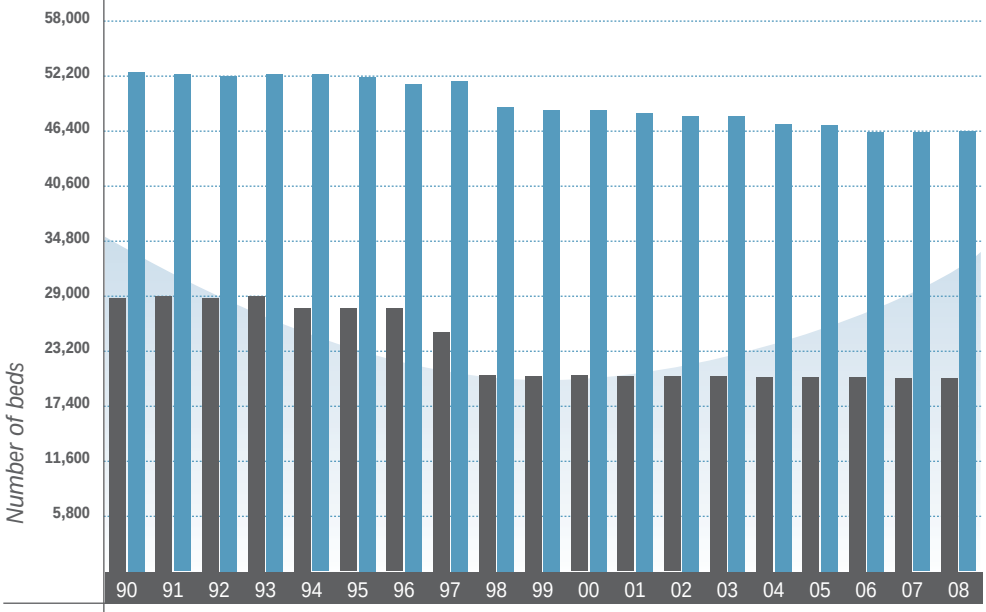
Approved beds with permit

Approved beds with permit are those included in the number indicated on the operating permit issued by the MSSS to each network institution. Between 1990 and 2008, the number of approved beds with permit for general and specialized care decreased by 29%. Approved beds with permit for residential and long-term care saw a drop of less than 12% in that same period of time. As well, for those same years, as a result of de-institutionalization, the number of approved beds with permit in psychiatric hospital centres for short-term psychiatric care was virtually cut by two-thirds, dropping from close to 2,740 to 975.

At the present time (2008), there are some 20,400 approved beds with permit for general and specialized care; this number rises to over 46,350 for residential and long-term care. It should be noted that over 23% of all approved beds for residential and long-term care are private, that is, the great majority (over 90%) of all approved beds included on the permit of private institutions.

Figure 36

Number of
approved beds with permit from institutions of the Québec health and social services network,
by unit of services,
situation observed on March 31, 1990 to 2008



Source: Fichier des établissements de santé et de services sociaux, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Data: Statistical book, Table I4.

Set-up beds

Among the approved beds with permit, set-up beds are those that are staffed and ready for use. The number of set-up beds is established on March 31 of each year. Between March 31, 1991, and March 31, 2007, the number of set-up beds for physical health and geriatric care in under-agreement public and private institutions was cut by a third, falling from over 23,600 to less than 15,700. In March 2007, slightly less than 94% of those that remained were reserved for short-term physical care, i.e., approximately 14,750 set-up beds; this corresponds to a ratio of approximately 2 set-up beds per 1,000 people.

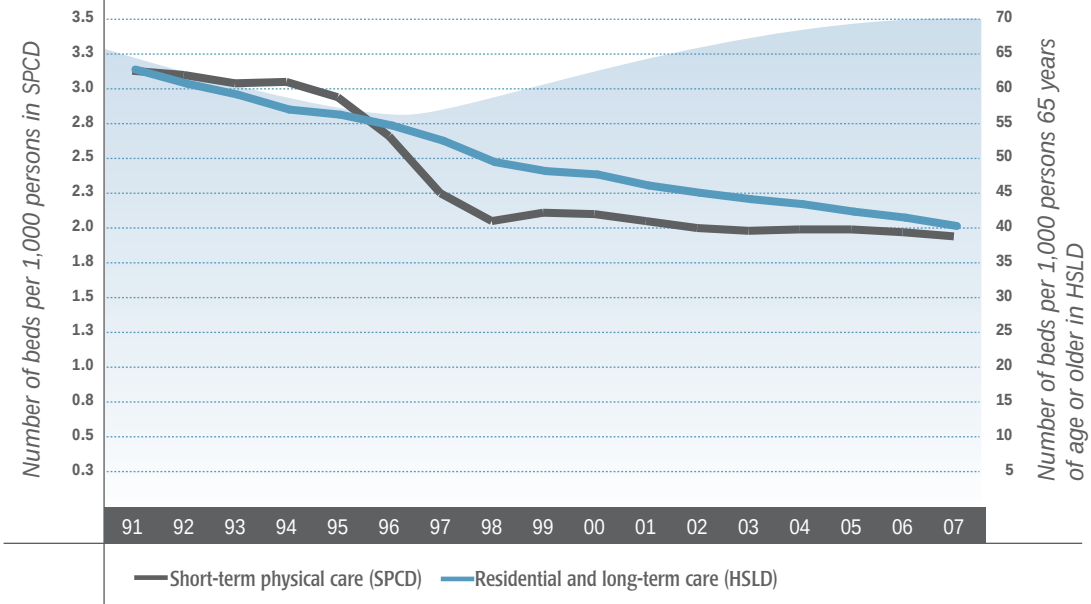
In that same period of time, the number of set-up beds for psychiatric care fell by over 59%, due to the de-institutionalization of clienteles with appropriate levels of autonomy. At the present time (2007), slightly less than 3,200 set-up beds are available for psychiatric care.

The drop in set-up beds for residential and long-term care was limited to slightly less than 11% between 1991 and 2007, i.e., an annual average drop of less than 1% (0.7%). On March 31, 2007, some 41,200 set-up beds were available for residential and long-term care within Québec's network of under-agreement public and private institutions.

Figure 37

Number of set-up beds

per 1,000 people in under-agreement public and private institutions of the Québec health and social services network, by unit of services,
situation observed on March 31, 1991 to 2007



Sources: STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
population data obtained from the Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table I5.

Complementary resources

There are a number of resources that provide health services and social services to the population, complementing health and social services institutions. Some of these are managed by institutions and accordingly form an integral part of the network. These resources include intermediate resources (IR) and family-type resources (FTR). Others operate outside the network of institutions, such as private homes for the aged and community organizations.

For the purposes of this document, the four categories of complementary resource mentioned above have been retained. Of course, a complete portrait should include some 2,000 medical clinics (including 160 family medicine groups and 23 network clinics), dental offices, community pharmacies, as well as many other resources of various types available in the private sector.

An intermediate resource (IR) is defined as follows in section 302 of the *Act respecting health services and social services*:

"Every resource attached to a public institution through which the institution provides a user registered for the institution's services with a living environment suited to the user's needs, together with the support or assistance services required by the user's condition, in order to maintain the user in or integrate the user into the community, is an intermediate resource."

"The immovable or dwelling premises in which the services of an intermediate resource are provided is not deemed to be a facility maintained by the public institution to which the resource is attached, except for the purposes of the *Youth Protection Act* (chapter P-34.1), in which case it is considered to be a place where foster care is provided by an institution operating a rehabilitation centre."

IRs are divided into four types: supervised apartments, rooming houses, foster homes and group homes. As indicated above, it should be noted that the former residential pavilions became IRs on April 1, 2001; they are divided according to the four types of IR. On March 31, 2008, there were approximately 1,930 intermediate resources, comprising over 12,200 places for various clienteles.

As for the family-type resources, they include foster families for children and foster homes for adults and elderly persons. The law defines them as follows:

"One or two persons receiving in their home a maximum of nine children in difficulty entrusted to them by a public institution in order to respond to their needs and afford them living conditions fostering a parent-child relationship in a family-like environment may be recognized as a foster family."

"One or two persons receiving in their home a maximum of nine adults or elderly persons entrusted to them by a public institution in order to respond to their needs and afford them living conditions as close to a natural environment as possible may be recognized as a foster home."

On March 31, 2008, approximately 3,500 family-type resources—excluding the some 5,650 FTRs associated with youth centres—provided over 11,300 places in foster families for children and in foster homes for adults and elderly persons.

A private home for the aged is defined as follows:

"A private home for the aged is a congregate residential facility where rooms or apartments intended for elderly persons are offered for rent along with a varied range of services relating, in particular, to security, housekeeping assistance and assistance with social activities, except a facility operated by an institution and a building or residential facility where the services of an intermediate resource or a family-type resource are offered."

There are five types of private homes for the aged, divided based on their management approach. There are private, for-profit residences (by far the most numerous), low-rent housing, non-profit organizations, cooperatives for seniors, and religious communities. These non-network housing resources do not need an operating permit issued by the MSSS.

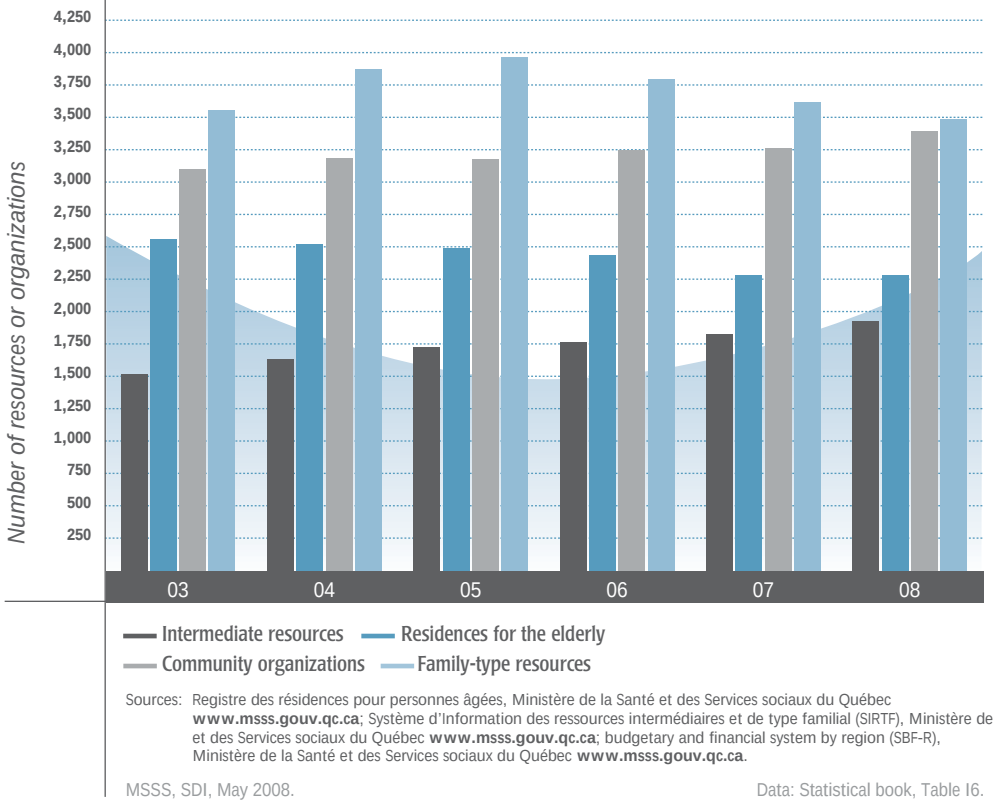
On March 31, 2008, as a complement to the network of public and private residential and long-term care centres (CHSLD), the population could rely on close to 2,300 private homes for the aged, bringing together over 95,700 housing places for independent and semi-independent residents. According to a regulation adopted in February 2007, these residences will need to have, starting in February 2009, a certification signed by the regional agency responsible, failing which the law provides for fines for their owners.

Lastly, community organizations are grouped together in some forty categories depending on the clientele targeted (e.g., women victims of sexual abuse, young people with difficulties) or specific health and social issue (e.g., AIDS, cancer). These organizations are subsidized, either at the regional or national level.

On March 31, 2008, there were some 3,400 community organizations, including 122 subsidized at the national level.

Figure 38

Number of **resources complementing the Québec health and social services network,** by resource category, *situation observed on March 31, 2003 to 2008*



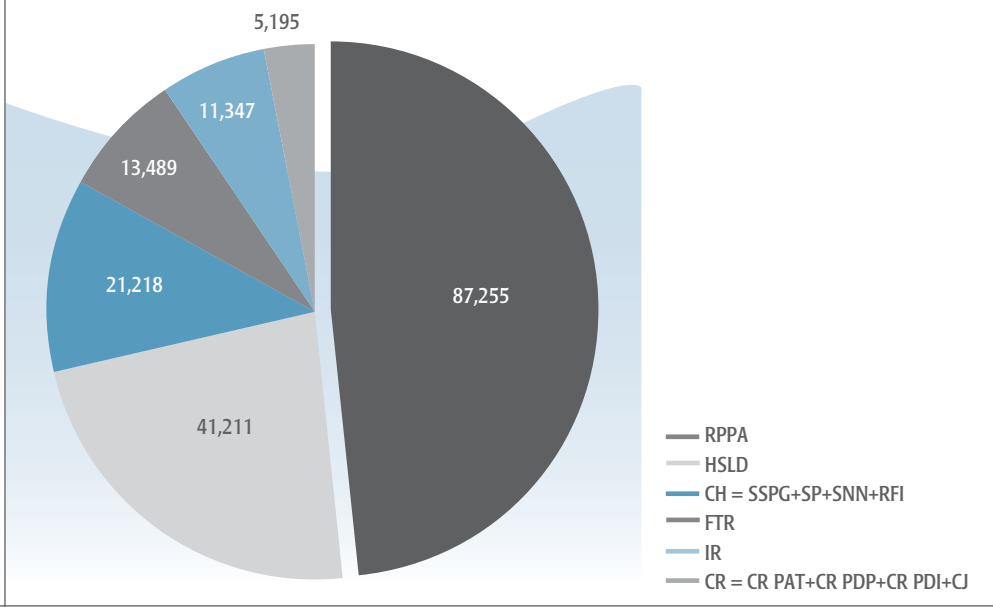
Sources: Registre des résidences pour personnes âgées, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Système d'Information des ressources intermédiaires et de type familial (SIRTF), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; budgetary and financial system by region (SBF-R), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Data: Statistical book, Table I6.

Figure 39

Distribution of
set-up beds and internal places available in health and social services,
by resource category, Québec,
2006-2007



Sources: Registre des résidences pour personnes âgées, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Système d'information des ressources intermédiaires et de type familial (SIRTF), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Tables I5 and I6.

UTILIZATION OF SERVICES

This section of the document provides an overall picture of the utilization of the health and social services provided to the population of Québec. Because it would be impossible to cover all of the available services in an exhaustive way, the observation is limited to those that seem to be the most important with regard to the frequency with which they are used, their cost, or even their nature, for example those that are the "entry points" to the health care and social services system.

Three general categories of health and social services can be identified based on their place of delivery. First, services that are received in the home or "home services." Second, services that are provided, on the one hand, to users who must travel to obtain them and, on the other hand, that do not require the users to be admitted. Here we are referring to users registered for services that are called "ambulatory services." Lastly, the third category of services includes those that are provided to users admitted to an institution for more than one day, such as short- and long-term hospital care, medical services provided to users admitted to institutions, rehabilitation services for users who are admitted, and accommodation services for users with decreasing autonomy. All these services are provided to persons in hospitals, residential centres or rehabilitation services.

Services can also be categorized based on a three-tier structure representing the three levels of service: front-, second- and third-line services.

Front-line services respond to a variety of common health and social problems. They correspond, on the one hand, to the general services intended for the population as a whole (e.g., Info-Santé, medical services, etc.) and, on the other hand, to specific services intended for clienteles with particular needs (e.g., home care, etc.). These services are available close to the living environment of the users and rely on light infrastructures and technologies.

Second-line services address complex but widespread health and social problems. Most of the time, access to these services requires a referral from a professional. Delivery of these types of services requires the grouping together of specialized expertise so as to achieve critical masses of resources capable of both meeting quality standards and respecting established financial limits. Second-line services rely on a particular infrastructure and advanced but readily available technology.

The last line of services addresses people with highly complex health and social problems of low prevalence. These services are offered at the national level, concentrated in a limited number of locations and, in almost all cases, accessible only by referral from a professional. They require the expertise of highly specialized stakeholders with rare skills in advanced areas of intervention. Third-line services rely on sophisticated and rare equipment, technologies and expertise with very limited availability.

For the purposes of this document, the categorization of services based on place of delivery, as defined above, is used. It should be noted that these services, and sometimes even service packages included in these services, are not always mutually exclusive. Each has to be considered separately, because adding them together could easily create a significant distortion as some services would be counted twice, thus rendering them irrelevant.

Home support

The ambulatory care shift of the mid-1990s clearly demonstrated the determination of the MSSS to bring services closer to people's home environment and to emphasize less invasive and less heavy medicine. The addition of new home support services to those already in place, and the injection of additional public funds underscored this commitment.

The term "home support" has acquired a broad meaning, in the sense that it designates all of the basic and specialized services provided to users in their home setting by the public health and social services network.

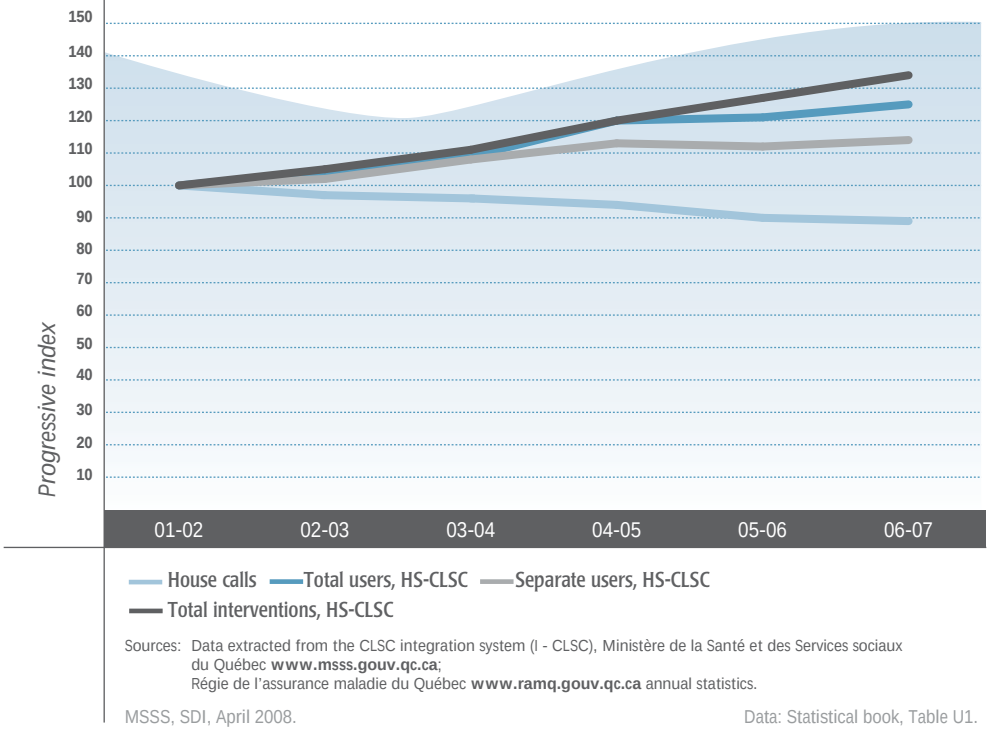
In 2006-2007, Québec physicians carried out close to 521,000 house calls, representing an 11% drop since 2001-2002. In fact, this type of visit has been in constant decline since the early 1990s.

However, in the same period of time, the use of home services provided by CLSCs followed an upward trend. Indeed, while the number of users of these types of services rose from some 401,000 to over 500,000, i.e. a 25% increase (14% for separate users), the number of interventions increased by 34% to reach over 7.2 million in 2006-2007. In light of the latest statistics available (2006-2007), each distinct user thus benefits, on average, of 24 home interventions from a CLSC annually.

Figure 40

Change in the use of home support services,

i.e., doctor's visits and services provided by CLSCs, Québec,
2001-2002 to 2006-2007



Sources: Data extracted from the CLSC integration system (I - CLSC), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008. Data: Statistical book, Table U1.

Ambulatory services

One of the main components of the health and social services provided to Québeckers is, without question, what are called "ambulatory" services. As is the case for many types of services, it is very difficult to establish a precise and complete list of the elements that define ambulatory services in operational terms. Because the current definitions are rather theoretical, it is difficult to quantify them on the basis of existing data. Thus, several different statistical portraits can coexist, although none of them is recognized or accepted by everyone as being the one that officially describes the real situation of this set of services.

For the purposes of this document, a realistic operational definition of ambulatory services is used, albeit it is not claimed that this definition is better than the others or makes them obsolete. Accordingly, four large groups are recognized in these services: hospital services granted to registered users as opposed to users admitted to a hospital, medical services dispensed in institutions or medical clinics to "visiting" users who make their own way to the services they require, all of the services provided by CLSCs and, lastly, day services provided to users who remain in their natural living environment.

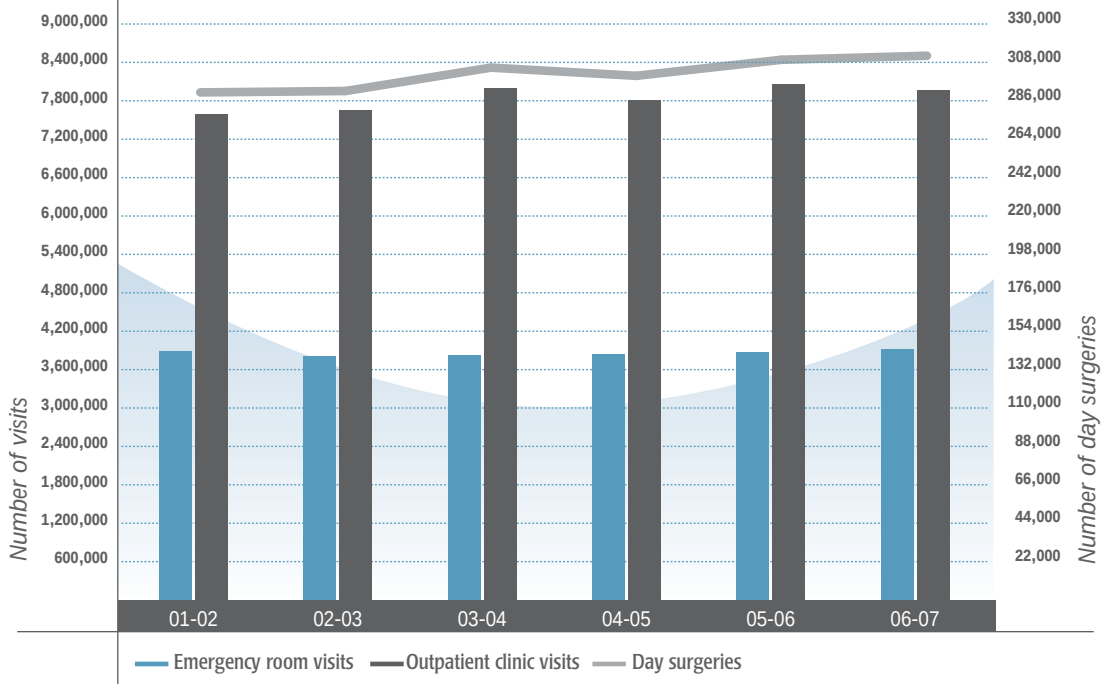
In 2006-2007, Québeckers made over 3.9 million visits to the emergency room, almost the same number as at the beginning of the decade. That same year, there were approximately 8 million visits to hospital outpatient clinics, representing a 4.8% increase compared to 2001-2002. In terms of the medical services paid by the RAMQ, the number of outpatient visits to medical specialists rose 11% since 2001-2002 to reach close to 4 million in 2006-2007. In the meantime, the sum of visits to general practitioners working in offices, outpatient clinics and emergency rooms dropped 5.8% to 28.7 million in 2006-2007.

In the first half of the millennium, while the number of day hospital visits showed a slight decline (-3.5%), that of day centre visits rose 6.3%; however, 2006-2007 saw a drop of nearly 15% in the number of day hospital visits compared to the previous year, as well as a drop of slightly over 1% in the number of day centre visits. Since 2001-2002, the number of care-days in day medicine jumped up 57% to over 950,000 in 2006-2007. The number of day surgeries reached a historic peak of almost 307,000 in the same year. This represents a 7.3% increase since 2001-2002.

Between 2001-2002 and 2006-2007, there was a significant increase in reliance on CLSCs, while the total number of interventions increased by almost 26% to reach close to 13.8 million. The total number of users jumped up close to 37%; there are now (2006-2007) over 3.1 million, or some 2.2 million if we only consider distinct users.

Figure **41**

Use of
certain ambulatory services,
Québec,
2001-2002 to 2006-2007

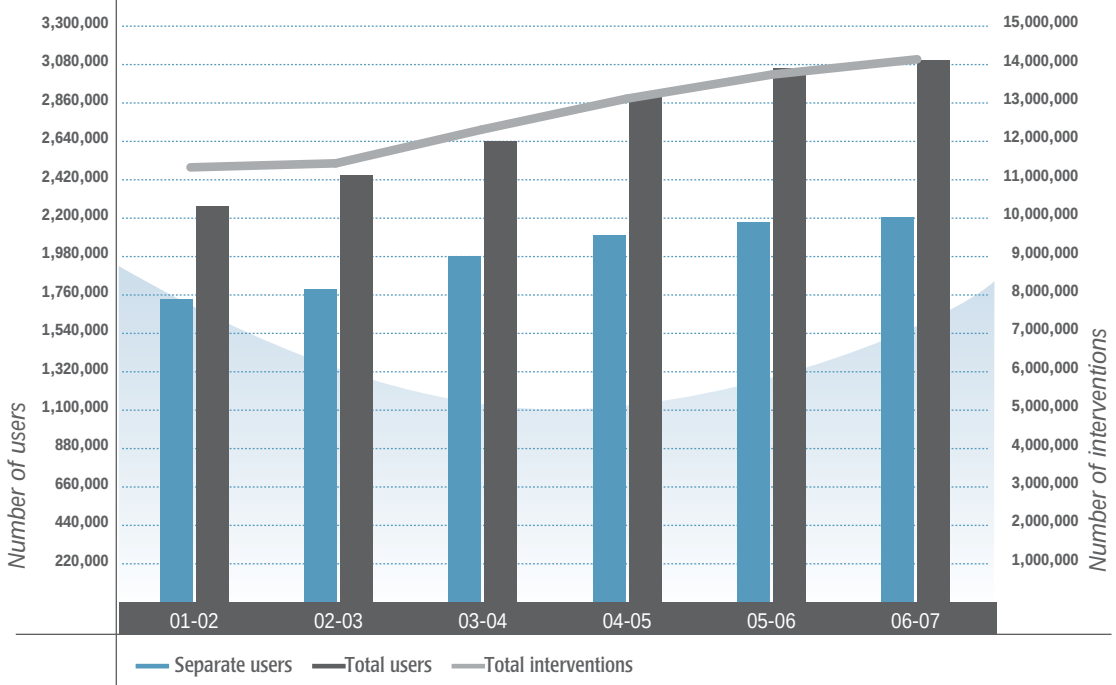


Sources: Annual financial reports of network institutions, M30 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
Med Écho system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table U2.

Figure 42 Use of **services in CLSCs,** Québec, *2001-2002 to 2006-2007*



Source: CLSC integration system (I - CLSC), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table U2.

Services covered by the health insurance plan

The Régie de l'assurance maladie du Québec administers a number of programs in accordance with the laws and regulations in effect and the agreements concluded between various professional federations and the MSSS.

Medical services, dental services, optometric services, pharmaceutical services and technical aids (e.g., prostheses, hearing or visual devices) are all services linked to these programs that are provided by professionals remunerated by the RAMQ.

Certain services are insured for all residents of Québec (e.g., medical services) while others are intended solely for specific clienteles (e.g., dental services).

MEDICAL SERVICES

The "Medical Services" program was established on November 1, 1970, at the same time as the health insurance plan. All persons who are residents of Québec, duly registered with the Régie and eligible for the health insurance plan, are issued a valid health insurance card entitling them to receive insured medical services.

Services of a preventive, diagnostic and curative nature and rehabilitation services are covered. They are provided by general practitioners and specialists as well as by physicians practising within the framework of laws applied by the Commission de la santé et sécurité du travail (CSST). These professionals work mainly in private facilities or in institutions. They may be remunerated on a fee-for-service or unit basis or their remuneration may take the form of salary or flat-rate fees, fixed sums (sessional payment) or, since September 1, 1999, blended remuneration (fee-for-service and fixed sums).

Since 1990, the number of medical services dispensed annually to the population of Québec has fluctuated between 80 and 88 million. In 2007, Québec doctors provided 87.7 million medical services, an 8.8% increased compared to 2001, i.e., the year that saw the lowest number of services provided in eighteen years. In 2007, 67% of medical services were performed on a fee-for-service basis; in 1990, this proportion was of 74%.

In 2007, when the observations are limited to services paid on a fee-for-service basis in medicine and surgery, there were over 6 million participants in this program, representing a slight rise since 1990. However, the participation rate, in decline in the 1990s (going from 81.8% to 79.3% in 2000), has remained rather stable since that time, as has the number of services per participant, which is now (2007) slightly below the 10-service mark.

DENTAL SERVICES

Dental services are provided under four programs implemented during the 1970s in compliance with the provisions of the *Québec Health Insurance Act*.

The Oral Surgery Program, introduced on November 1, 1970, is the oldest of these programs. It is intended for all Québec residents. The services insured include examinations, consultations, X-rays, anesthesia, emergency opening of the pulp chamber and surgical procedures (except teeth and root extractions) and must be performed by an oral surgeon or a specialist in oral and maxillofacial surgery.

The Dental Services Program for Children was introduced in 1974. At the time, it included a range of preventive and curative services intended for all children under 8 years of age. By 1980, the age of eligibility had gradually extended to 15 and under. However, as of 1982, certain services were no longer insured by the RAMQ. Then, in 1992, the Québec government announced that henceforth the program would be intended only for children under 10 years of age. Finally, in January 1997, a new measure established the frequency of dental examinations at one rather than two per year. In 1999, the following services were still insured for children under 10 years of age: examinations, consultations, X-rays, anesthesia, fillings, prefabricated crowns, pins, endodontics and surgery.

Two other programs, the Dental Services Program and the Acrylic Dental Prostheses Program, introduced in 1976 and 1979 respectively, are intended for employment assistance recipients (EARs). In November 1996, a number of government measures decreased the coverage of insured services for employment assistance recipients aged 10 or over (all children aged under 10 are already covered).

In 1990, the number of dental services dispensed under Québec's health insurance plan reached close to 4.6 million, i.e., slightly more than 4.2 services per beneficiary, with a participation rate of 60%. In 2007, close to 2.1 million services were dispensed, i.e., close to 3.6 services per beneficiary, with a participation rate of 50%.

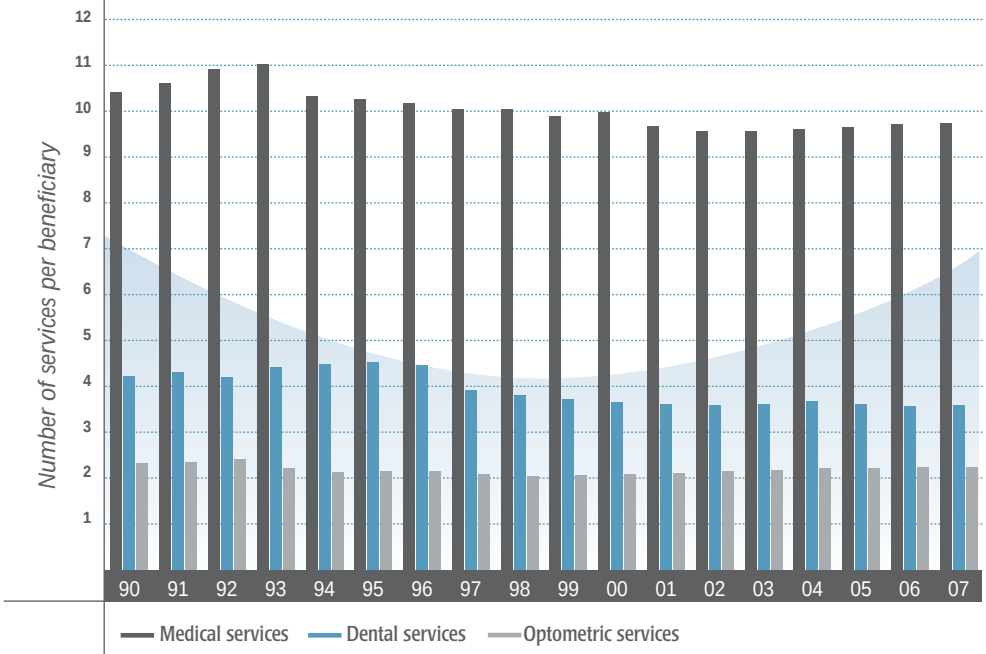
OPTOMETRIC SERVICES

The Optometric Services Program was also introduced on November 1, 1970. Prior to May 15, 1992 all Québec residents were eligible. There have since been two significant reductions in coverage, one in May 1992 when persons aged 18 to 40 were excluded from the program, and the other in May 1993, when persons aged 41 to 64 were excluded. Now, only persons under 18 years of age or 65 years of age or older are eligible.

In 1990, a little over 3.6 million optometric services were dispensed to the population of Québec, i.e., 2.3 services per beneficiary, for a participation rate of 23%. In 2007, a little over 2.1 million optometric services were dispensed to less than one million beneficiaries, i.e., 2.2 services per beneficiary, with an estimated participation rate of 33%.

Figure 43

Average number of **services dispensed by beneficiary,** by program, Régie de l'assurance maladie du Québec, *1990 to 2007*



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008. Data: Statistical book, Tables U3, U4 and U5.

PHARMACEUTICAL SERVICES

On August 1, 1972, the RAMQ was entrusted with the administration of the medications and pharmaceutical services program. From the time the program was created in 1970, it had been the responsibility of the social welfare agencies. Until 1997, the program was intended for employment assistance recipients and persons aged 65 or older.

On January 1, 1997, the prescription drug insurance plan came into force in accordance with the *Act respecting prescription drug insurance*, adopted on June 20, 1996. Certain provisions of the act, however, were implemented as early as August 1, 1996.

The purpose of this mixed public/private plan is to ensure that Québec residents have access to the medications required by their health status. The plan provides basic protection regarding the cost of pharmaceutical services and medications and requires that the individuals and families who are beneficiaries make a financial contribution that takes their economic situation into account. The contribution to be paid, taking the form of a deductible amount and a coinsurance payment, is subject to a maximum that varies according to the clientele insured.

In concrete terms, the RAMQ insures persons who do not have access to a group insurance contract, i.e., members, employment assistance recipients and certain other holders of a valid claim booklet, as well as persons aged 65 or older. The children aged 0 to 17 of insured people as well as dependents aged 18 to 25 who are spouseless, who attend an educational institution on a full-time basis and who are not covered by a group insurance plan are also insured. A person eligible for a private group insurance plan must subscribe and obtain coverage for his or her spouse and children.

The plan covers prescribed drugs purchased in Québec and listed on the official Liste de médicaments (drug list) published by the RAMQ, as well as related pharmaceutical services. The medications must be prescribed by a physician, a medical resident, a dentist, or even—with some restrictions—by a midwife or pharmacist.

In 1990, the program covered some 7 million drug prescriptions for close to 419,000 participants among employment assistance recipients; in 2007, for the same clientele, there were close to 21 million prescriptions for slightly less than 373,400 participants. During the same period, the number of prescriptions for people aged 65 or older also tripled to reach 77.5 million in 2007. Although the participation rate increased slightly for employment assistance recipients, rising from 67% in 1997 to 76% in 2007, it remained somewhat stable (between 81% and 83%) for people aged 65 or older.

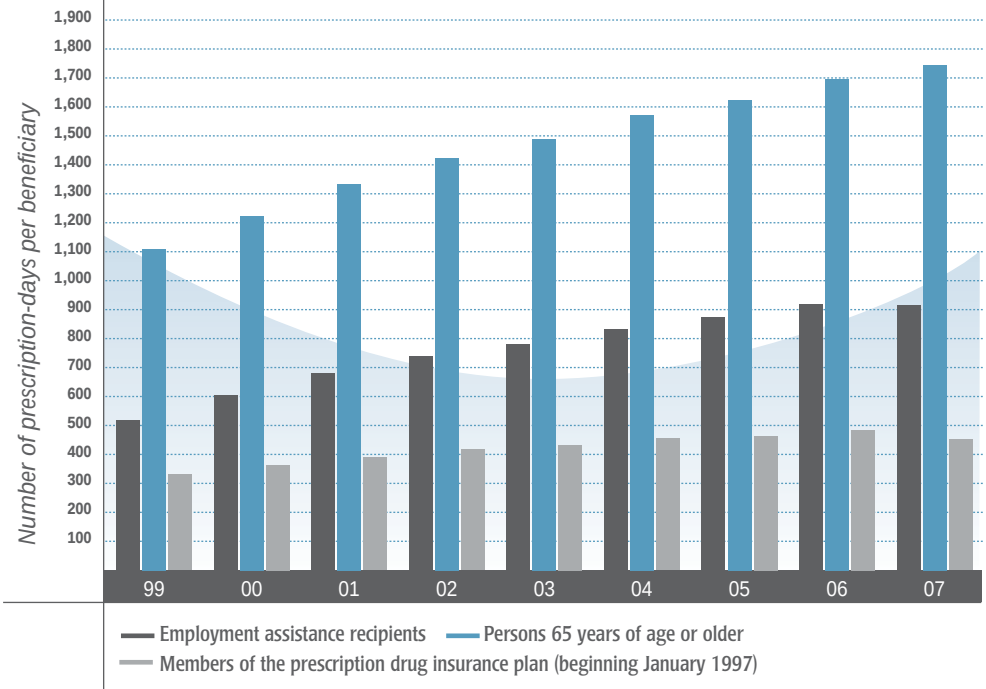
In 1997, aside from these two client groups, approximately 1.4 million people subscribed to the prescription drug insurance plan. Of this number, close to 825,000 were given slightly over 9.5 million prescriptions. In 2007, among the 1.7 million plan members, including 400,000 children, a little over 1.1 million participants were given close to 21 million prescriptions. Since 1997, the participation rate of plan members remained rather stable around 60%.

It is important to note that this seemingly dramatic increase in number of prescriptions for the three client groups cannot be regarded as an indicator of the increase in prescription drug consumption in Québec. Rather, it is mostly a reflection of a change in the way medications are prescribed. In fact, this number reflects, on the one hand, the increase in short-term prescriptions and, on the other hand, changes in the composition of user clienteles; for example, for employment insurance recipients, a highly fluctuating proportion of people with severe employment restrictions.

Indeed, transforming the number of prescriptions by combining it with a prescription duration is an indicator (prescription-day) that is more likely to provide information on the evolution of prescription drug consumption. In 1999, there were, on average, 519 prescription-days per beneficiary for employment assistance recipients; 1,110 for people aged 65 or older; and 331 for members of the prescription drug insurance plan. In 2007, these numbers were, respectively, 914, 1,745 and 451 prescription-days per beneficiary. These represent increases of 76%, 57% and 36%, respectively, over eight years.

Figure 44

Number of **prescription-days of medications per beneficiary,** by client category benefitting from the pharmaceutical services program administered by the Régie de l'assurance maladie du Québec,
1999 to 2007



Sources: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics and unpublished data; Direction de la statistique et du soutien aux expérimentations, Ministère de l'Emploi et de la Solidarité sociale du Québec **www.mess.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table U6.

TECHNICAL AIDS

There are six technical aid programs for persons with physical disabilities:

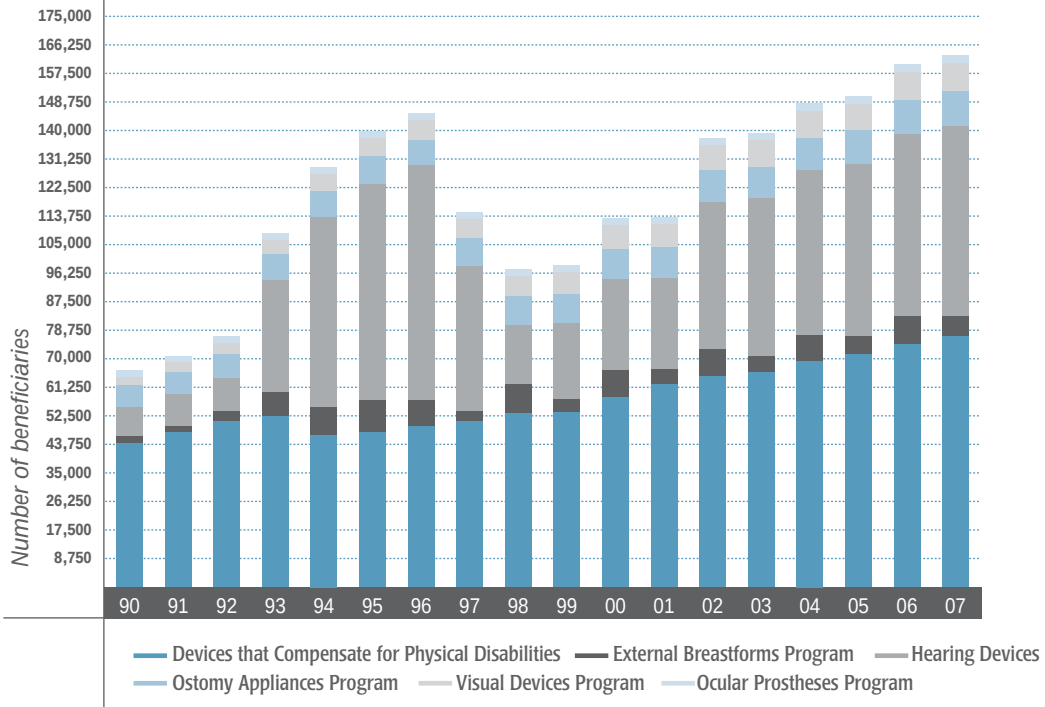
1. Devices that Compensate for Physical Disabilities Program (prosthesis, orthopedic equipment, locomotor assist, posture assist, and other equipment), effective since July 1st, 1975;
2. External Breastforms Program, effective since January 1st, 1978;
3. Hearing Devices Program, effective since August 22, 1979;
4. Ostomy Appliances Program, effective since April 1st, 1981;
5. Visual Devices Program, effective since November 30, 1977;
6. Ocular Prostheses Program, effective since April 1st, 1981.

In the period from 1990 to 2007, the number of beneficiaries of goods and services noticeably increased in each of the six technical aid programs, i.e., close to 21% for the Ocular Prostheses Program, which saw the lowest increase, as well as a slightly less than a seven-fold increase for the Hearing Devices Program, which saw the greatest rise.

During that same period, the number of changes that occurred with respect to coverage gave rise to significant variations in the number of goods and services dispensed. Accordingly, for the Hearing Devices, Visual Devices and Devices that Compensate for Physical Disabilities programs, the average number of goods and services per beneficiary saw multiple fluctuations, resulting in a significant overall drop. However, for the three other programs, the same indicator remained relatively constant in the course of the same period of time.

Figure **45**

Number of
beneficiaries of goods and services,
by technical aid program provided by the Québec health insurance plan,
1990 to 2007



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Data: Statistical book, Table U7.

Youth protection services

Within the framework of the *Youth Protection Act* (YPA), youth centres (centres jeunesse, or the amalgamation of child and youth protection centres (CPEJ), rehabilitation centres for young persons with adjustment problems (CR JDA) and rehabilitation centres for young mothers with adjustment problems (CR MDAs)), located in each of Québec's health and social services regions, receive requests for services, that is, reports that they must process.

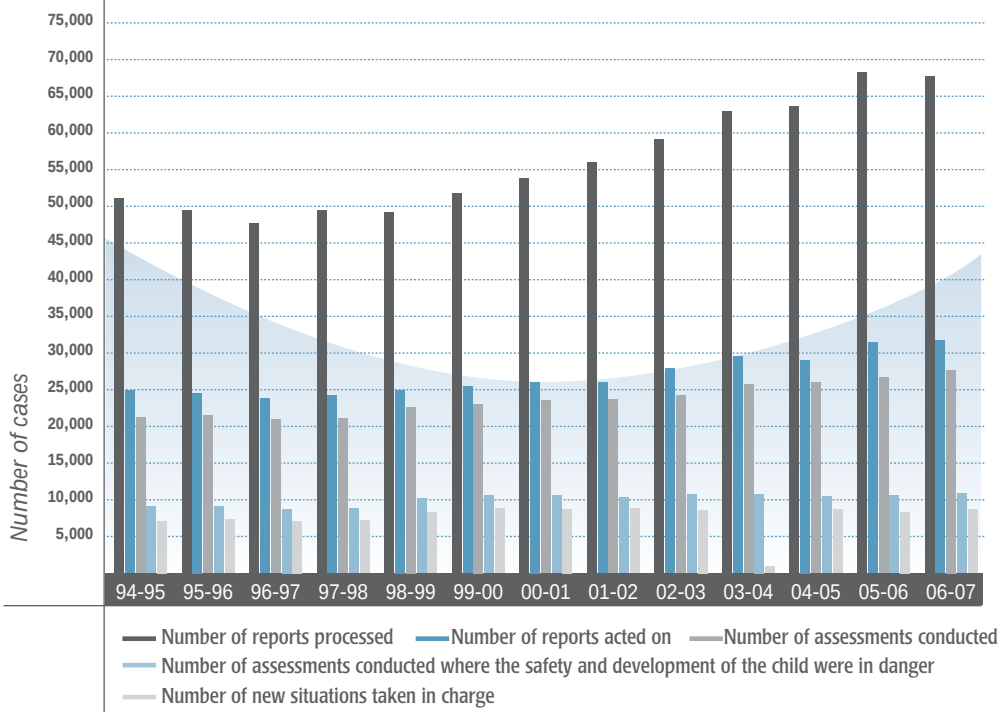
The process of applying the Act includes successive decision-making stages that serve as filters. Once a report regarding the situation of a child has been processed, it must be decided whether or not to act on it and to assess the situation. If yes, it must be determined whether or not the safety or development of the child is in danger. If this is in fact the case, a decision must finally be made to apply the appropriate protection measures, including placement.

In 2006-2007, 67,730 reports were processed by youth centres in Québec in accordance with the *Youth Protection Act*. Of this number, 31,740 were acted on, including approximately 27,700 that became subject to an assessment. Of these assessments, there were some 10,850 cases where the safety or development of the child was in danger. These cases gave rise to over 8,650 new situations taken in charge, of which approximately 4,700 were directed to the courts.

Figure 46

Five benchmark indicators

relating to the application of the *Youth Protection Act*, Québec, *1994-1995 to 2006-2007*



Source: Benchmark indicators relating to the application of the Youth Protection Act, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

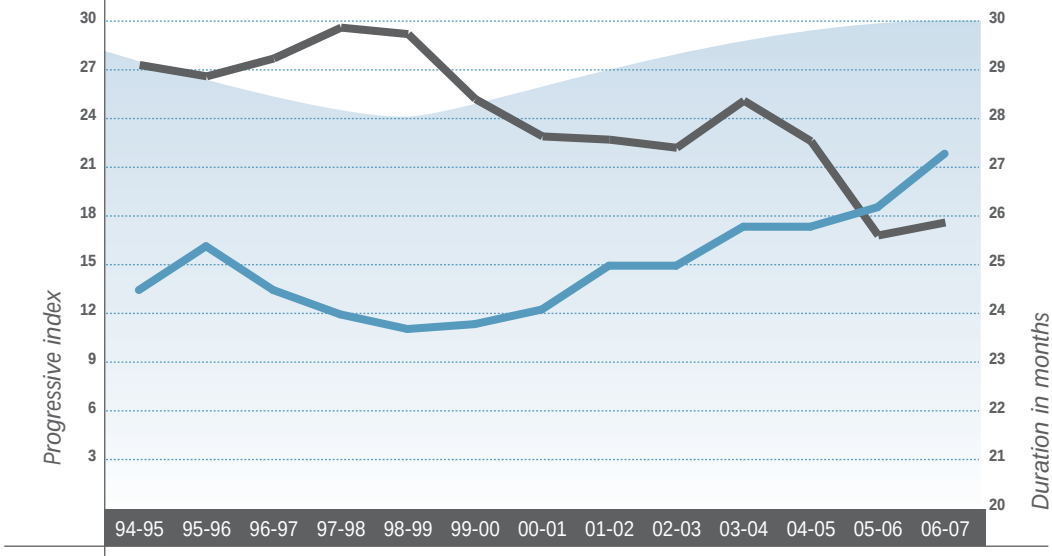
MSSS, SDI, May 2008.

Data: Statistical book, Table U8.

Between 1994-1995 and 2006-2007, the average waiting period for an assessment went from 27.3 days to 17.6 days, that is, an improvement of almost 36%. In that same period of time, the average time to process reports and complete the intervention followed an upward trend, particularly at the beginning of the millennium; the process currently (2006-2007) takes 27 months.

Figure 47

Average waiting period
for the assessment of reports and average time to process reports and complete the intervention,
in relation to the application of the *Youth Protection Act*, Québec, *1994-1995 to 2006-2007*



Source: Benchmark indicators relating to the application of the *Youth Protection Act*, Direction de la jeunesse et de la toxicomanie, MSSS **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table U8.

Short-term care

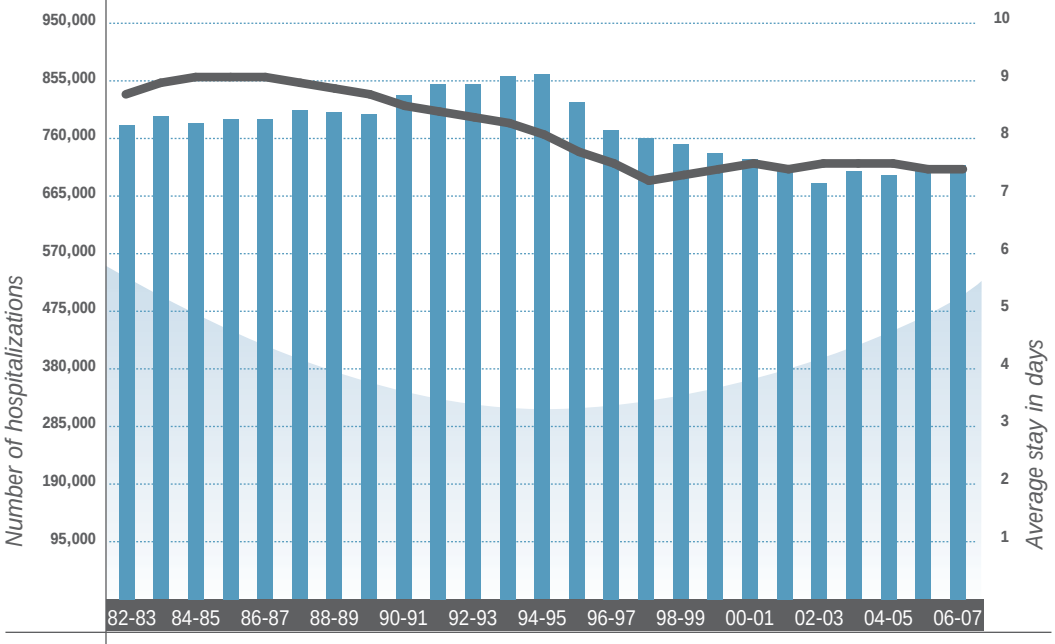
The observations presented in this section only relate to what is known as "active" short-term care. This includes physical care, psychiatric care and care of new-borns, provided in general and specialized care facilities (hospitals), and excluding those facilities that principally provide long-term rehabilitation, convalescent or psychiatric care. In addition, long-term care provided in the facilities analyzed, whether in beds assigned to short- or long-term care, was also excluded. The most recent data available at the time this document was produced cover the 2006-2007 fiscal year.

The observed trend in hospitalization for short-term active care is largely the result of three phenomena. First, the development of medical technologies, by gradually reducing the use of what are called "invasive" methods, led to a decrease in the length of hospital stays. Second, the arrival of new, better adapted and more effective medications, which contributed to reducing the complexity of cases and thus preventing some care episodes. And third, the increased use of day surgery, which directly contributed to reducing the number of hospitalizations. However, it is interesting to note that the use of day surgery created a slight upward trend in the overall average stay between 1997-1998 and 2003-2004. Indeed, during this period, the increased use of day surgery resulted in a decline in the number of hospitalizations requiring short stays in institutions, thereby giving more weight to long stays in the calculation of average stay, even though the latter's length is shorter than what it used to be. Since 2003-2004, the average stay has resumed its downward trend

Figure **48**

Number of hospitalizations and average length

of stay for short-term general and specialized care, Québec, *1982-1983 to 2006-2007*



Source: MED-ÉCHO system statistics, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table U9.

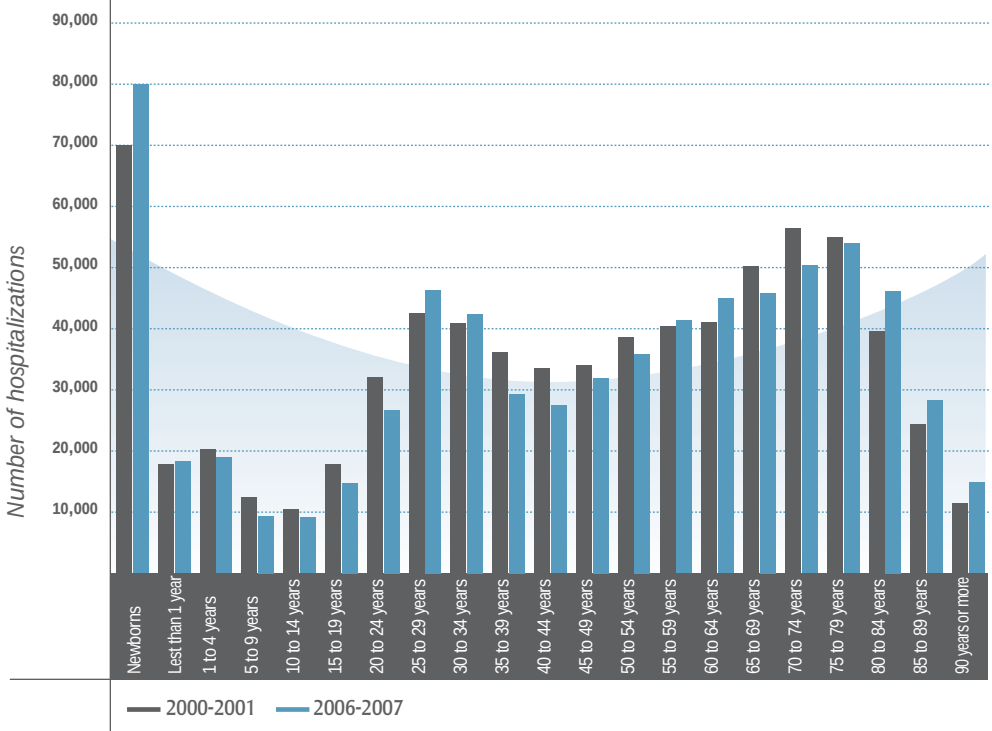
In 1982-1983 in Québec, some 782,000 hospitalizations for short-term care generated 6.7 million hospitalization days, i.e., an average stay of 8.5 days for each hospitalization. A quarter century later, despite a 15.6% increase in population and the latter's accelerated aging, there were less than 716,200 hospitalizations generating 5.1 million hospitalization days, for an average stay of less than 7.2 days. The highest number of hospitalizations (over 865,500) was recorded in 1994-1995. As regards the length of stay, a ceiling of close to 7 million hospitalization days was reached in 1987-1988. The longest average stay was observed in 1985-1986, with more than 8.8 days. 2002-2003 showed the lowest values for the period covered as regards the number of hospitalizations (barely 685,600) and hospitalization days (slightly less than 5 million); as for average stay, the shortest observed was in 1997-1998 (7 days).

Between 2000-2001 and 2006-2007, the number of hospitalizations increased for newborns and children under one year of age, as well as for beneficiaries aged 25 to 34, 55 to 64 and 80 years or older; it declined for the other age groups. In terms of average stay, only those aged 15 to 24 and 90 years or older showed an increase in the same period.

Figure 49

Number of hospitalizations for general and specialized short-term care,

by user age group, Québec,
2000-2001 and 2006-2007



Source: MED-ÉCHO system statistics, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

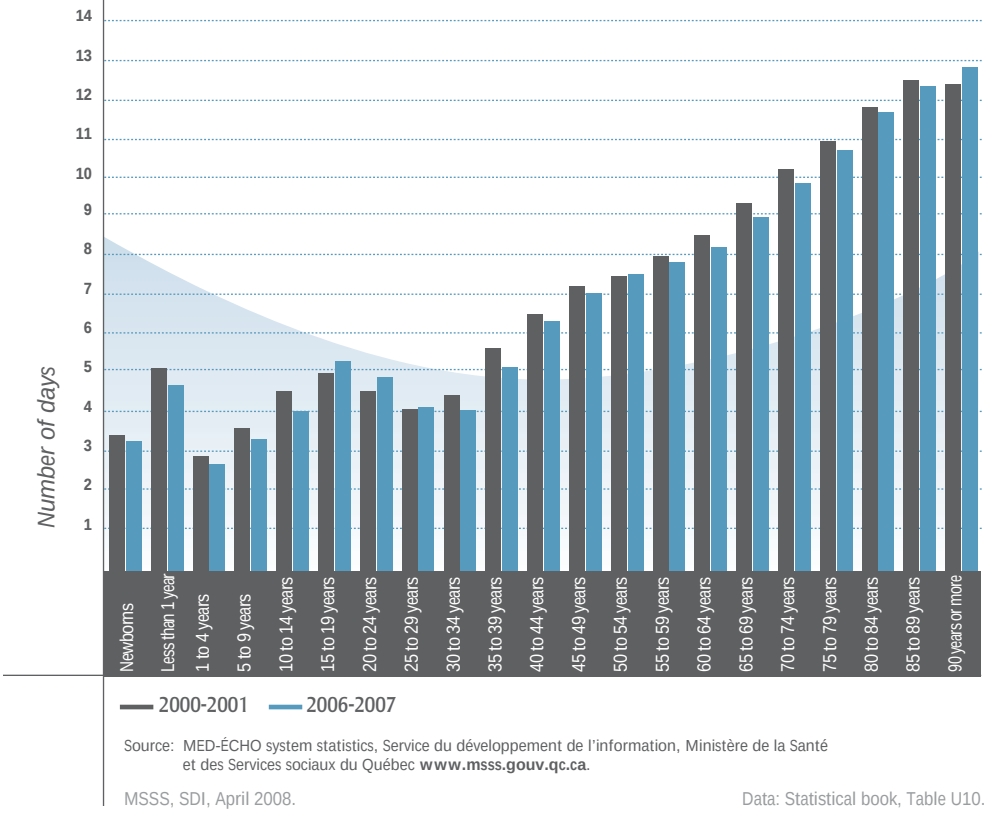
MSSS, SDI, April 2008.

Data: Statistical book, Table U10.

Figure 50

Average stay for general and specialized short-term care,

by user age group, Québec,
2000-2001 and 2006-2007



Source: MED-ÉCHO system statistics, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

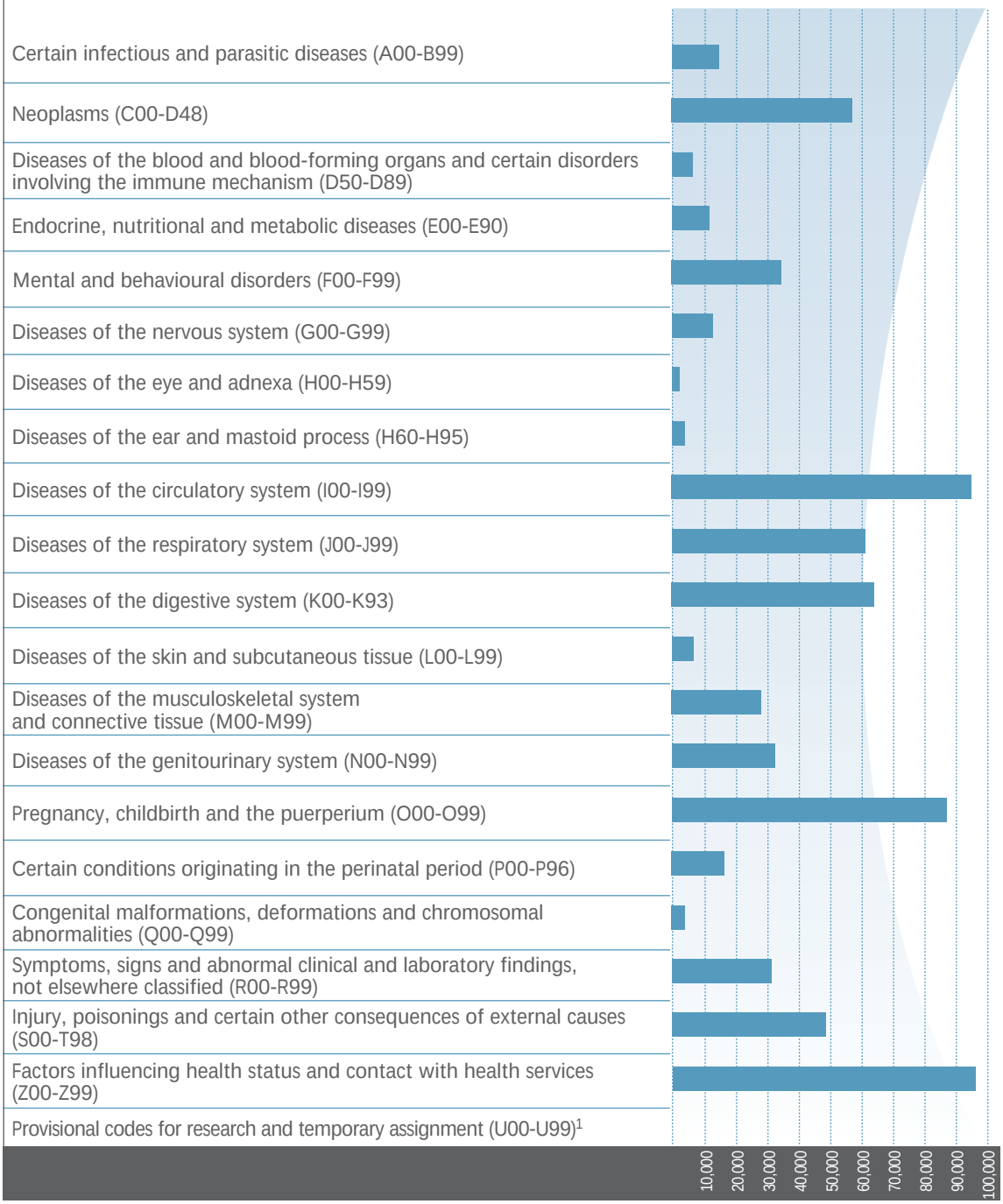
Data: Statistical book, Table U10.

Even if their number was declining in the first half of the 2000s, hospitalizations for respiratory diseases are still the most numerous in Québec. However, psychiatric disorders, on average, prompt the longest hospital stays, followed by tumours.

Figure 51

Number of hospitalizations for general and specialized short-term care,

by diagnostic grouping in 23 chapters, Québec, *2006-2007*



1. Does not appear because of small numbers.

Source: MED-ÉCHO system statistics, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

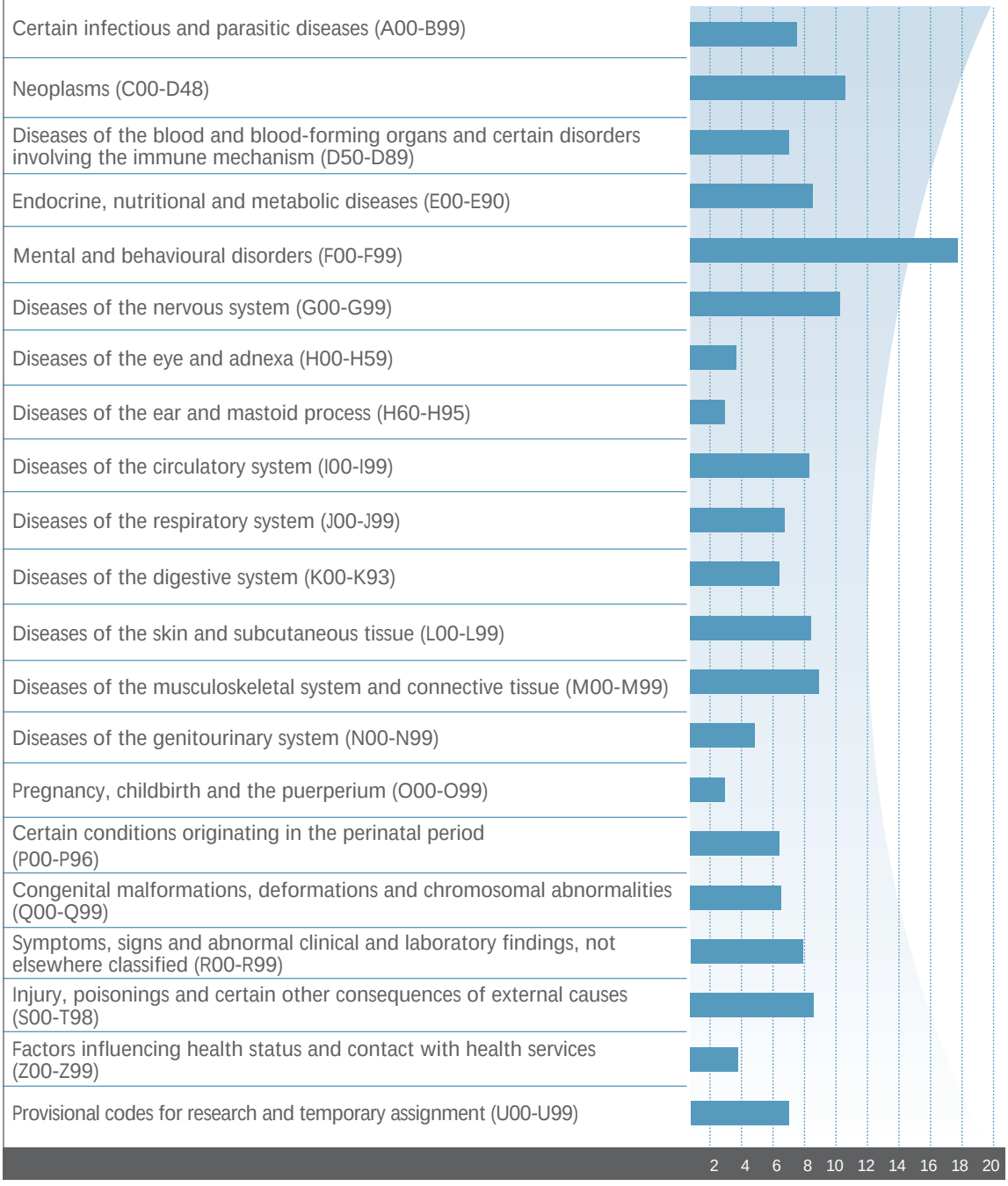
MSSS, SDI, January 2008.

Data: Statistical book, Table U11.

Figure 52

Average stay for general and specialized short-term care,

by diagnostic grouping in 23 chapters, Québec, *2006-2007*



Source: MED-ÉCHO system statistics, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table U11.

Residential and long-term care services

Considering the aging of the Québec population, there is an increasingly high demand for residential and long-term care services for seniors with loss of autonomy.

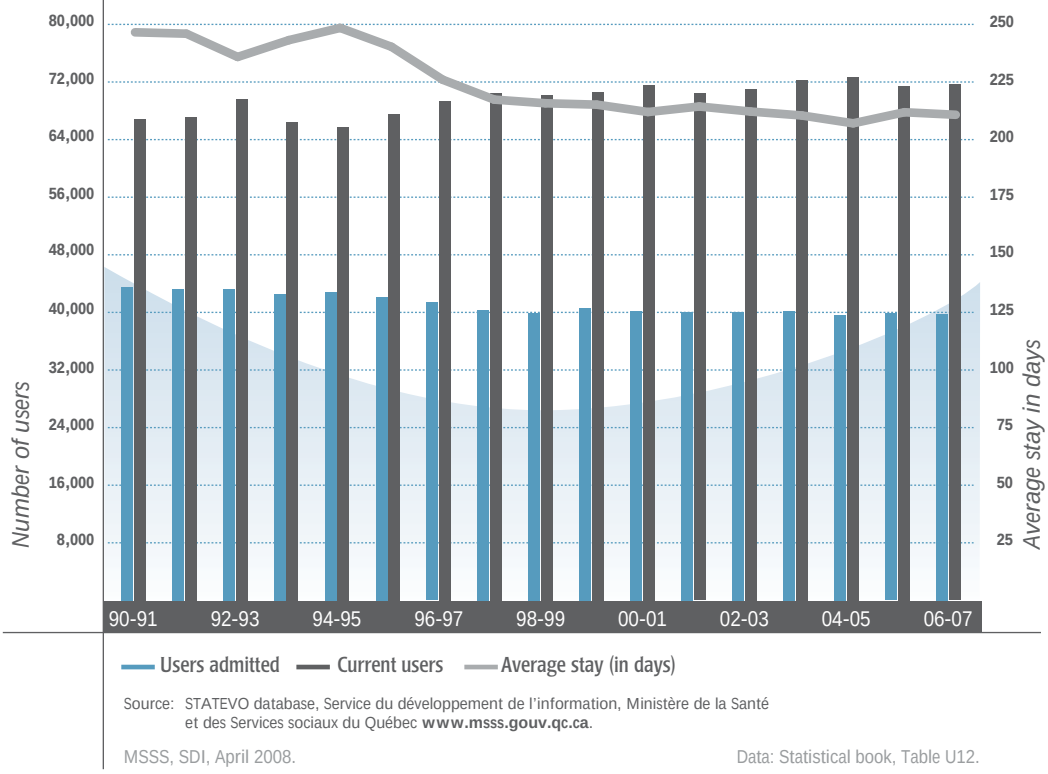
The context of the 1990s—budget constraints, downsizing, the need to provide services closer to people's living environment—somewhat changed the supply of this type of services. Home support services and the development of lodging services in the private sector now meet an increasingly large part of the needs of persons who still have a sufficient level of autonomy.

Thus, since the mid-1990s, the number of residential and long-term beds intended for persons requiring less than two and a half hours of care per day in health and social services institutions has decreased somewhat. On the other hand, a certain number of beds for users requiring more than two and a half hours of care per day have been created, although the latter do not compensate entirely for the initial cut. Although the total number of beds has decreased, the number of persons accommodated has continued to increase. However, up until the late 1990s, the number of residential attendance days, within the network of residential and long-term care centres, followed a downward trend, reflected by a significant drop in annual average stay. Since then, the situation has remained relatively stable in this regard.

Between 1991 and 2007, the individual number of users admitted on March 31 of each year has decreased by slightly less than 9%, going from close to 43,600 to less than 39,740 users. However, if we take the users present at any given time of the fiscal year, we see an increase in volume of users. Indeed, in 1990-1991, less than 66,900 people were accommodated in the network of under-agreement public and private CHSLDs in Québec; sixteen years later, this number reached over 71,650, representing more than a 7% increase. These people accounted for some 16.1 million accommodation days in 1990-1991. In 2006-2007, there were slightly over 14.7 million, a number that has remained relatively stable since the late 1990s. During these seventeen years, the average stay of people accommodated went from 241 to 205 days annually.

Figure 53

Use of **residential and long-term care services,** within Québec's network of under-agreement public and private health and social services institutions, *1990-1991 to 2006-2007*



Source: STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table U12.

Rehabilitation services

Rehabilitation services are intended for three clienteles in particular: persons suffering from alcoholism and other problems of addiction, persons with a physical impairment, and persons with a mental impairment or a pervasive developmental disorder. In all three cases there has been a dramatic increase in people registered for outpatient rehabilitation services over the past fifteen years. However, while the number of people in the first two groups admitted to rehabilitation institutions has remained relatively stable, the number of admissions for people suffering from a mental impairment or a pervasive developmental disorder (PDD) has dropped significantly.

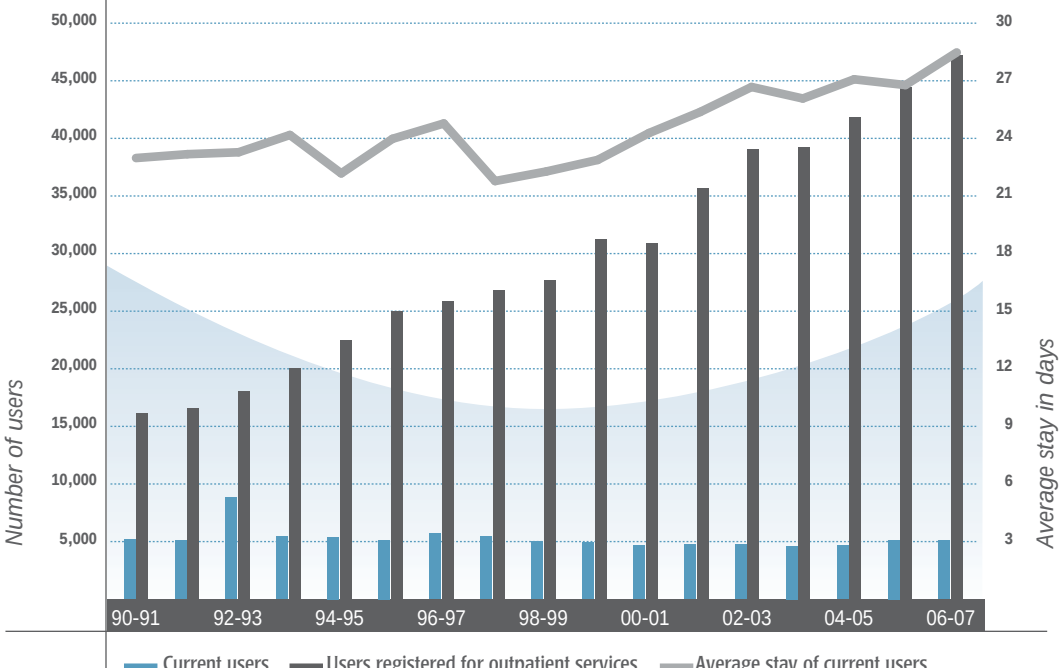
It should be noted that in the figures, the "current" users are those who were admitted at some time during the year. This is the volume of users. The term "users admitted" refers to those present on March 31, like a picture at any given time.

PERSONS SUFFERING FROM ALCOHOLISM AND OTHER PROBLEMS OF ADDICTION

In 2006-2007, at some time during the year, some 5,100 people were admitted to a rehabilitation institution to receive treatment for alcoholism and other problems of addiction, a number comparable to that recorded in 1990-1991. However, during that same period of time, the number of registrations for outpatient rehabilitation services went from less than 16,200 to over 47,250, a 193% increase.

Figure **54**

Use of services
provided to persons suffering from alcoholism and other problems of addiction,
within the Québec network of under-agreement public and private health and social services institutions,
1990-1991 to 2006-2007



Sources: Annual statistical reports from rehabilitation centres for persons suffering from alcoholism and other problems of addiction (AS-481 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

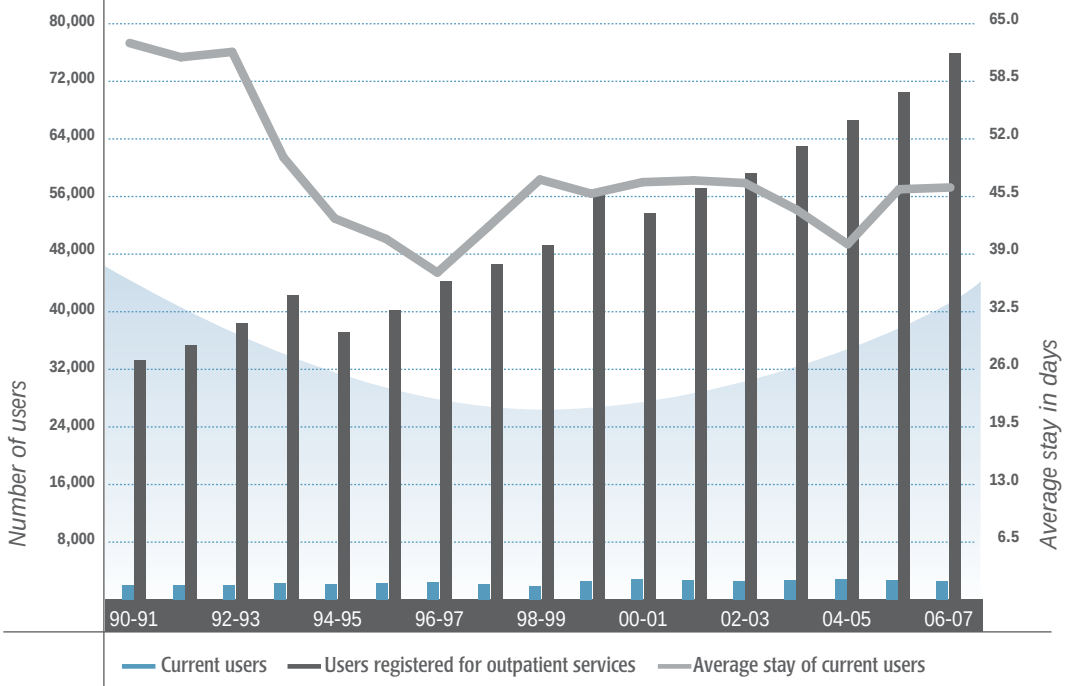
Data: Statistical book, Table U13.

PERSONS SUFFERING FROM A PHYSICAL DEFICIENCY

Between 1990-1991 and 2006-2007, the number of people admitted to a rehabilitation centre for problems of physical deficiency at some time during the year went from less than 2,000 to close to 2,600, a 33% increase. During that time, the number of registrations for outpatient services more than doubled, rising from approximately 33,300 to over 75,900.

Figure 55

Use of services
provided to persons suffering from physical deficiencies,
within the Québec network of under-agreement public and private health and social services institutions,
1990-1991 to 2006-2007



Sources: Annual statistical reports from rehabilitation centres for persons with a physical impairment (AS-484 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

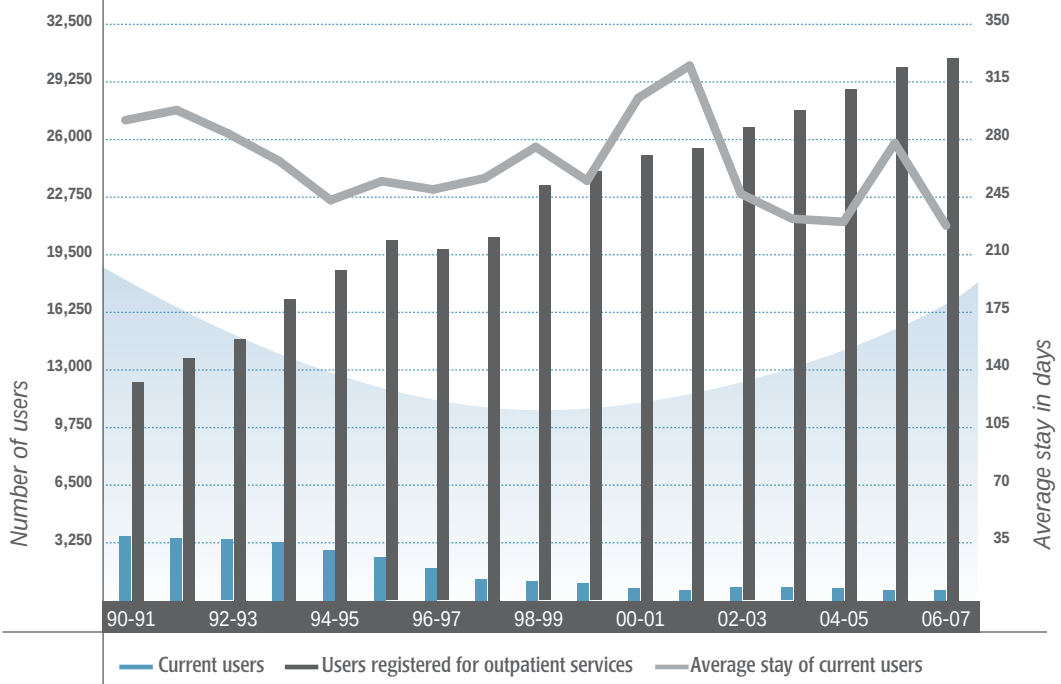
Data: Statistical book, Table U14.

PERSONS WITH A MENTAL DEFICIENCY OR PERVASIVE DEVELOPMENTAL DISORDER

Since 1990-1991, the number of people admitted to a rehabilitation centre for mental deficiencies or pervasive developmental disorders, at some time during the year, went from some 3,700 to less than 600, in 2006-2007, i.e., six times fewer. During that same period of time, the number of registrations for outpatient rehabilitation services increased by 148%, going from some 12,300 to over 30,600. These statistics clearly show the efforts made to de-institutionalize persons suffering from this type of deficiency.

Figure **56**

Use of services
provided to persons suffering from mental deficiencies,
within the Québec network of under-agreement public and private health and social services institutions,
1990-1991 to 2006-2007



Sources: Annual statistical reports from rehabilitation centres for persons with a mental impairment (AS-485 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table U15.

Pre-hospital emergency services

GENERAL OVERVIEW

The fundamental objective of the pre-hospital emergency system is to provide, at all times, an appropriate, efficient and quality response to the people who call on these services so as to minimize the mortality and morbidity of these people in distress. In Québec, the pre-hospital emergency system is comprised of a chain of interventions whose effectiveness essentially hinges on the optimal coordination between the response to users' needs and the availability of pre-hospital emergency resources. Each link in the chain of interventions is part of a chain of events involving several people.

1. The chain of interventions starts with a call to the 9-1-1 centre, made by the "first actors," i.e., the first people to arrive at the scene of an incident and see that an individual requires care.
2. The 9-1-1 centre receives all calls requiring one or more emergency interventions (firefighters, police, ambulance services) and transfers those requiring pre-hospital services to the health communication centre (centre de communication santé (CCS)).
3. The CCS receives and handles calls, assigns pre-hospital resources based on priorities and monitors and manages these resources.
4. The "first responders," often police officers, firefighters or citizens with the necessary training, begin dispensing care to prevent the person's condition from deteriorating while waiting for the ambulance. They are particularly important in compressing response times.
5. Paramedic/ambulance technicians stabilize the condition of the victim and transport him or her quickly to an institution capable of providing the necessary care. Ambulances are also used to transfer patients from one institution to another, depending on the needs associated with their health status..
6. The last link in the chain is the emergency room of the institutions, which takes charge of the user's care.

The health and social services agencies are responsible for the organization of pre-hospital emergency services in their area, in collaboration with the health communication centres, ambulance companies, as well as the health institutions. In the regions of Montréal and Laval, Urgences-santé carries out the duties devolved to an agency while providing the services of a health communication centre. This company is responsible for the ambulance service in these regions.

AMBULANCE SERVICES

Ambulance services are carried out by teams composed of two paramedic/ambulance technicians with training recognized by the MSSS and the Ministère de l'Éducation, namely, an attestation of collegial studies of 840 hours. A study program leading to a diploma of collegial studies to become an ambulance technician has also been available since 2006. All technicians must carry a card attesting to their basic training and are subject to standards for the maintenance of their skills. Québec currently (2006-2007) has over 3,630 paramedic/ambulance technicians (TAP), which corresponds to a ratio of 1 TAP per 2,100 people. These technicians performed over 4,817,000 hours of service in 2006-2007, i.e., 65,700 more than the year before.

In 2006-2007, Québec had 624 ambulances, i.e., 8.21 vehicles per 100,000 people. These ambulances made some 585,700 trips, i.e., a ratio of 77 trips per 1,000 people. The previous year, 560,140 trips were made, i.e., slightly over 74 trips per 1,000 people.

THE COST

In the field of health and social services, the notion of "cost" applies to a range of terms covering different realities and concepts. For example, the term "total health expenditures" or "national health expenditures" is defined as all expenditures, both public (including federal, provincial and municipal) and private associated with health, but excluding spending on social services. This pan-Canadian definition makes it possible to compare Québec to the rest of Canada and internationally.

However, we know that the Québec system integrates health services and social services within a network of institutions under the authority of a single department, a situation that is unique both in the Canadian and international contexts. Thus, when we want to study changes over time in health and social services expenditures in Québec, we use a different concept. We consider "government expenditures for the Health and Social Services Mission" through various informational vehicles, such as Québec's Public Accounts and the financial reports of network institutions. In this way, the financial resources allocated to health services and social services can be compared to those allocated to the other major missions of the Québec government. This was used as the basis for the costs associated with Québec's health services and social services presented in this document.

Sources of funding

Public expenditures for health and social services are almost entirely funded from the Government of Québec Consolidated Revenue Fund, which finances more than 90% of the total spending. In addition, other sources of funding include revenues taken in as autonomous financing of the health and social services sector, such as the contributions paid by accommodated adults, supplementary payments for private and semi-private rooms, income from third-party payers (e.g., the CSST and the Société de l'assurance automobile du Québec (SAAQ)) and costs billed to non-residents.

The share of the funding that comes from the Québec Consolidated Revenue Fund essentially includes five sources of revenue: income tax from companies and individuals; consumption taxes; employer and individual contributions to the Health Services Fund; federal transfers; and contributions to the Drug Insurance Fund.

There are two types of federal transfers: financial transfers, i.e., cash linked to certain programs and transferred directly to the provinces; and fiscal transfers, i.e., tax points transferred to the provinces' tax bases.

Until March 31, 1996, federal transfers for health and social services came under the Canada Assistance Plan (CAP), instituted in 1966, and particularly under the Established Programs Financing (EPF), which took effect in 1977. Since 1996, these transfers have been made under the Canada Social Transfer (CST) program, later transformed—following the recommendation of the Auditor General of Canada—into the Canada Health and Social Transfer (CHST), so as to improve its transparency.

The Health and Social Services mission

The budgeting structure set out in the Government of Québec's Public Accounts is made up of three main levels: the missions, the portfolios, and the programs.

The first level is made up of six major governmental missions: Health and Social Services, Support for Individuals and Families, Education and Culture, Economy and Environment, Governance and Justice, and Debt Servicing. The second level of the structure, the portfolios, corresponds to the various government departments. In the case of the Health and Social Services mission, the portfolio and the mission are one and the same, since there is only one department, the MSSS, involved.

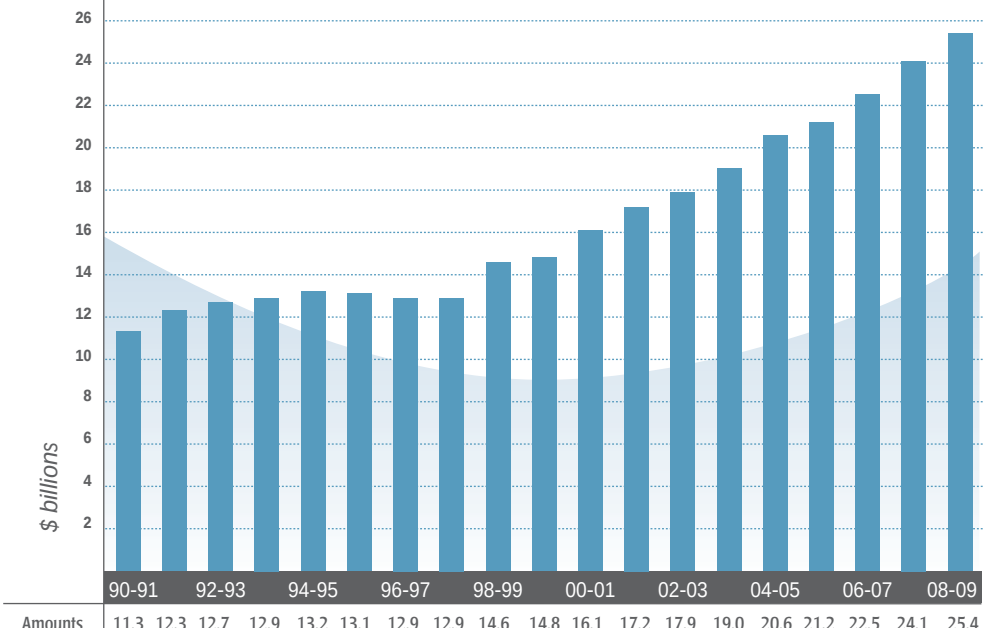
For the Health and Social Services mission, the third level is currently (2008) comprised of the following programs: *Québec-wide functions*, which include, among other things, the MSSS's management; *Regional functions*, which encompasses the management of regional agencies and the operation of institutions; the OPHQ, limited to the organization's administrative expenditures since 2006-2007; the RAMQ, where the Régie's administrative expenses are presented, as well as the sums allocated to each of the programs it manages; and *Promotion and Development of the National Capital Region*, a program associated with the minister responsible for the National Capital Region, in this instance the current minister of Health and Social Services, and not with the Health and Social Services mission itself.

First of all, the financial resources allocated to health and social services by the Government of Québec must be outlined, both with regard to its budget as a whole and in terms of the public collective wealth it administers.

In 2008-2009, the Government of Québec devoted over 25.4 billion dollars to its Health and Social Services mission, i.e., more than double the amount granted at the beginning of the 1990s. Today, this represents an amount of $3,311 per person, compared to $1,615 in 1990-1991. That means that 8.2% of Québec's collective wealth, as measured by the GDP, will go to this mission in 2008-2009, or that this mission will monopolize close to 40% of the Government of Québec's entire budget—44.4% if we consider only program missions. Comparatively, in 1997-1998, these two proportions were respectively 6.8% and 30.6%—36.5% if we consider only program missions. These figures show a clear trend by the Government of Québec of increasing the financial resources allocated to this area of activity compared to its other major governmental missions.

Figure 57

Amounts allocated
to the Health and Social Services mission,
Québec,
1990-1991 to 2008-2009



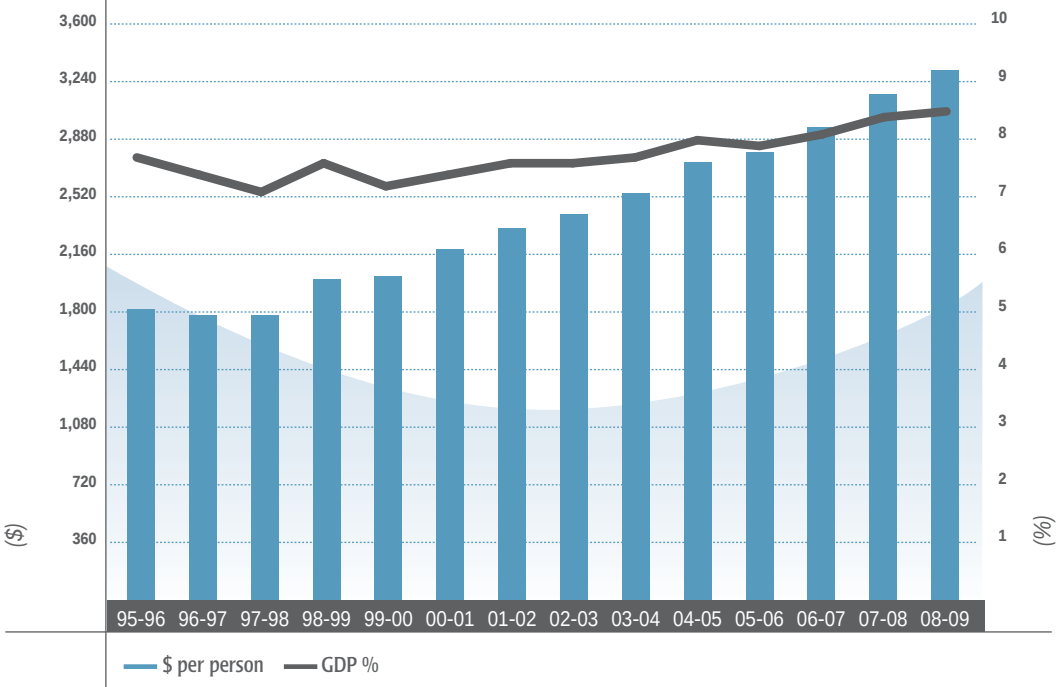
Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**, and Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008.

Data: Statistical book, Table C1.

Figure 58

Amounts allocated
to the Health and Social Services mission
per person and in proportion to the GDP, Québec,
1995-1996 to 2008-2009

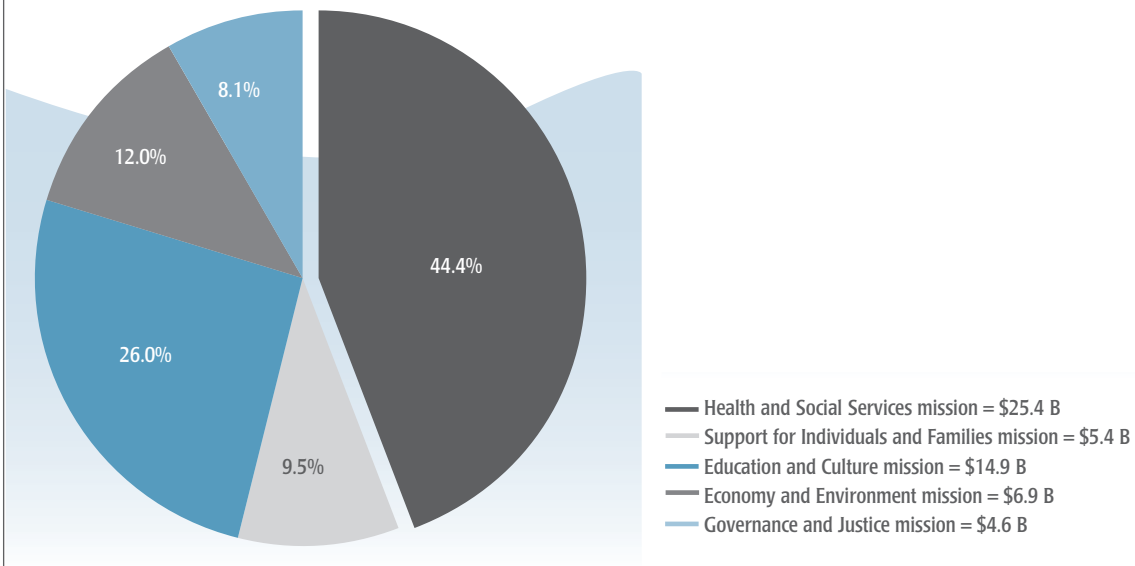


Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**, and Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Table C1.

Figure 59-A

Percentage breakdown
of the Government of Québec's budgeted expenditures,
by major program mission,
2008-2009

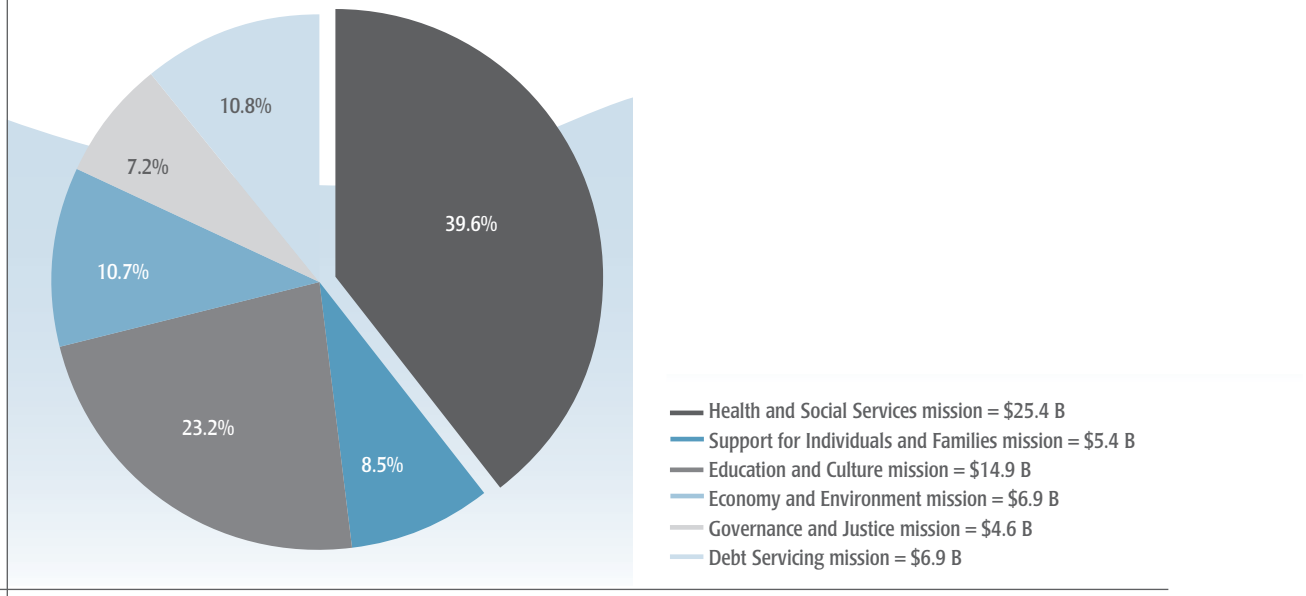


Sources: Public Accounts, ministère des Finances du Québec **www.finances.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Table C2.

Figure **59-B**

Percentage breakdown
of the Government of Québec's budgeted expenditures,
by major mission,
2008-2009



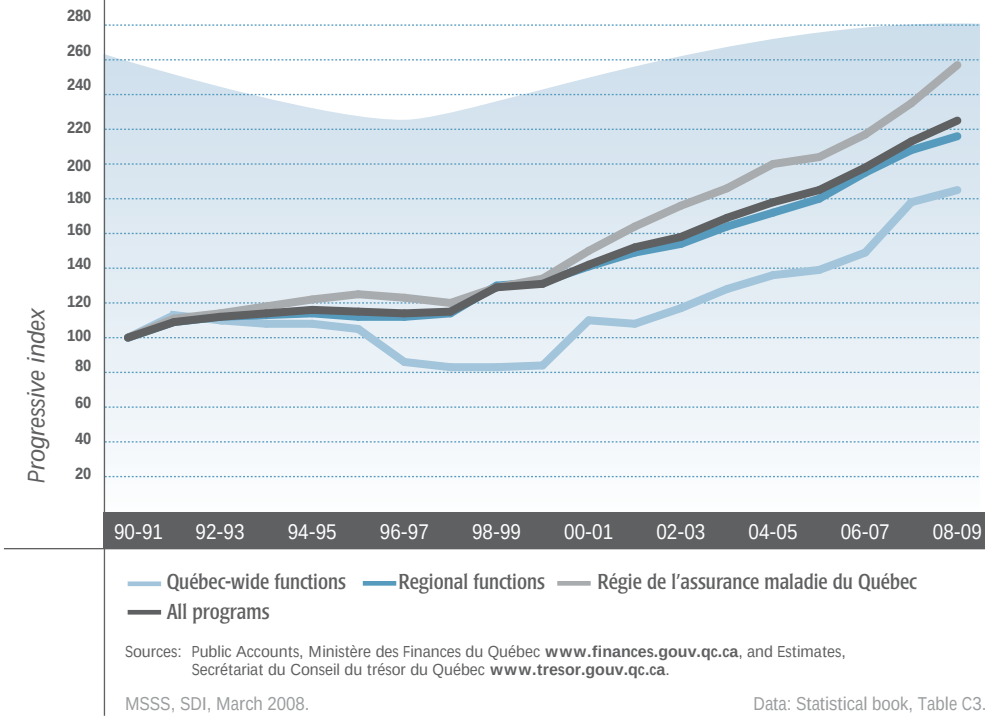
Sources: Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Table C2.

In the budget structure of the Health and Social Services portfolio, the Regional Functions program represents close to 72% of the amounts allocated for this mission in 2008-2009, a proportion that is slightly inferior to what it was at the beginning of the 1990s (75%). The amounts allocated to this program have slightly more than doubled in that period of time. The RAMQ accounts for just over a quarter of the total, in 2008-2009; this proportion was 23% in 1990-1991. It constitutes the program that saw the greatest budget increase (157%) in this period of time. At the same time, the *Québec-wide functions* saw an increase of 85%. In total, the amounts granted to the health and social services portfolio went from 11.3 billion in 1990-1991 to over 25.4 billion in 2008-2009, i.e., a 125% increase.

Figure 60

Change in
the amounts granted to the health and social services portfolio,
by program of the official Québec Public Accounts budget structure,
1990-1991 to 2008-2009



Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**, and Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Table C3.

If we consider only the expenses associated with the network's operation, and we take a look at the breakdown of gross direct costs associated with institutions' primary activities based on the departmental mission, we will see—not surprisingly—that the hospital centre mission accounts for 55% of the total in 2006-2007, followed by the residential and long-term care centre mission with about 19%, two proportions that have seen little change since 1997-1998. The three other missions, i.e., local community services centre (CLSC), rehabilitation centre (CR) and youth centre (CJ), share the remaining 26%, with the CLSC having its share increase the most, going from 9 to 12% between 1997-1998 and 2006-2007.

Since the early 1990s, the share of expenses associated with the primary activities of institutions and devoted to clinical services has seen constant growth. In 1990-1991, this share represented 63% of the total; in 2006-2007, it reached 71%. Of course, in return, the expenses granted for support (administration, operations, etc.) have seen a steady decline over that same period of time.

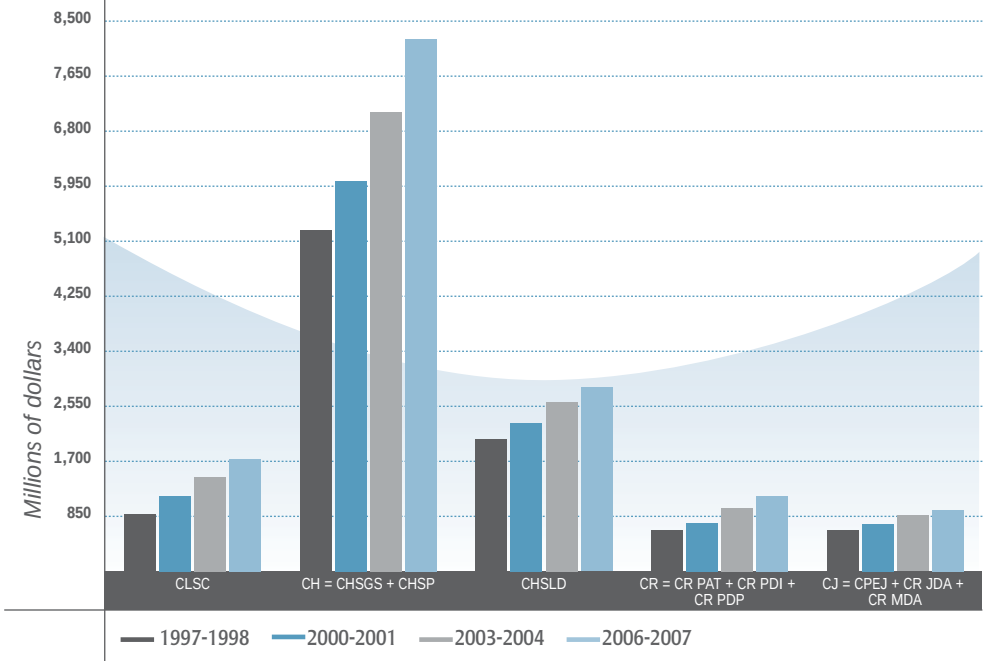
Figure 61

Operating expenses

for under-agreement public and private institutions of the Québec health and social services network,

by exclusive mission, no matter the institution responsible,

1997-1998, 2000-2001, 2003-2004 and 2006-2007



Source: M30 system, grouping together the annual financial reports of under-agreement public and private institutions within the network (AS-471 form), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

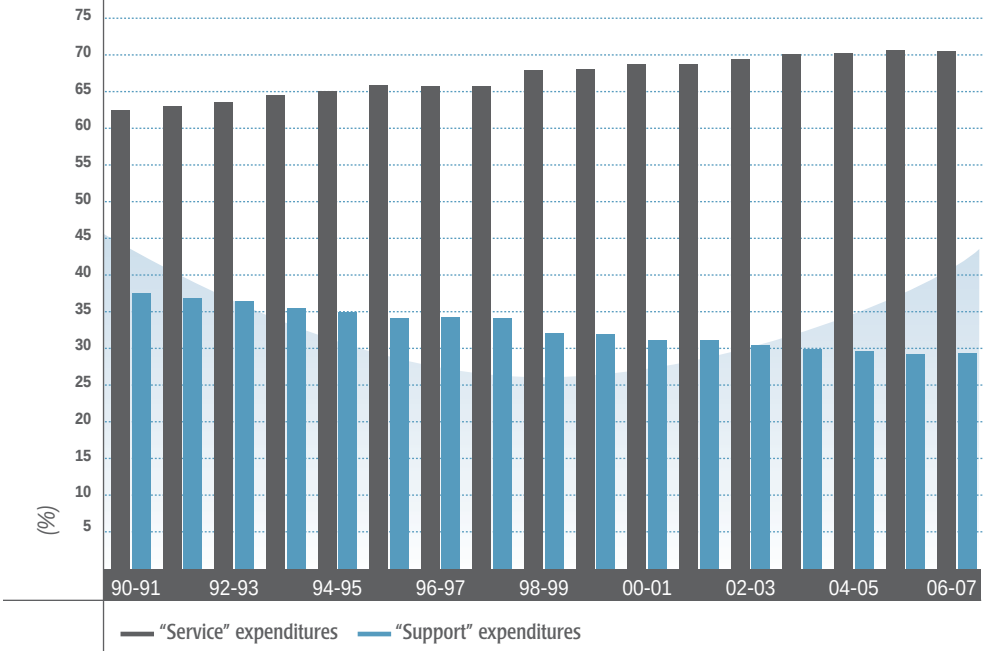
MSSS, SDI, April 2008. Data: Statistical book, Table C4.

Another way of following the evolution of health and social services spending is to examine it from the viewpoint of the financial outlines of client programs, service programs and support programs, an expenditure breakdown that has been in effect at the MSSS since 1993-1994. It should be noted that in 2001-2002, we went from breakdown by client program, where the support expenditures were included in each program, to the notion of service programs with support programs kept separate. It is no surprise that the *Physical health* service program accounts for the biggest share, i.e., 35% in 2006-2007, followed by the *Administration and support support* program (16%) and the *Loss of autonomy linked to aging* service program (15%).

In 2006-2007, the primary activities of institutions required some 388 million paid hours (corresponding to the sum of salaries and benefits), of which 76% were worked (corresponding to only salaries). Over 68% of gross direct costs comprise salaries and benefits, a proportion that has been declining since the mid-1990s; in 1994-1995, this proportion reached close to 77%. Accordingly, between 1994-1995 and 2006-2007, each hour worked saw its average value increase, going from less than $35 to over $50, as the overall costs increased more rapidly than the number of hours worked.

Figure 62

Percentage breakdown
of the net actual spending of the Québec network of health and social services institutions,
by expenditure coverage,
1990-1991 to 2006-2007



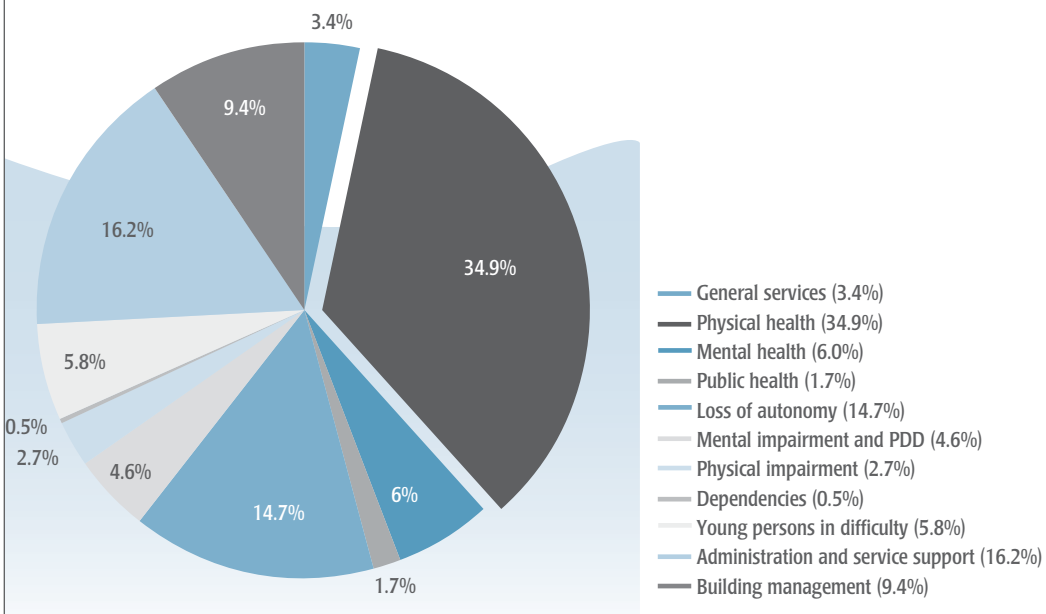
Source: SIFO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table C5.

Figure 63

Percentage breakdown
of net spending on health and social services,
by service program and support program, Québec,
2006-2007



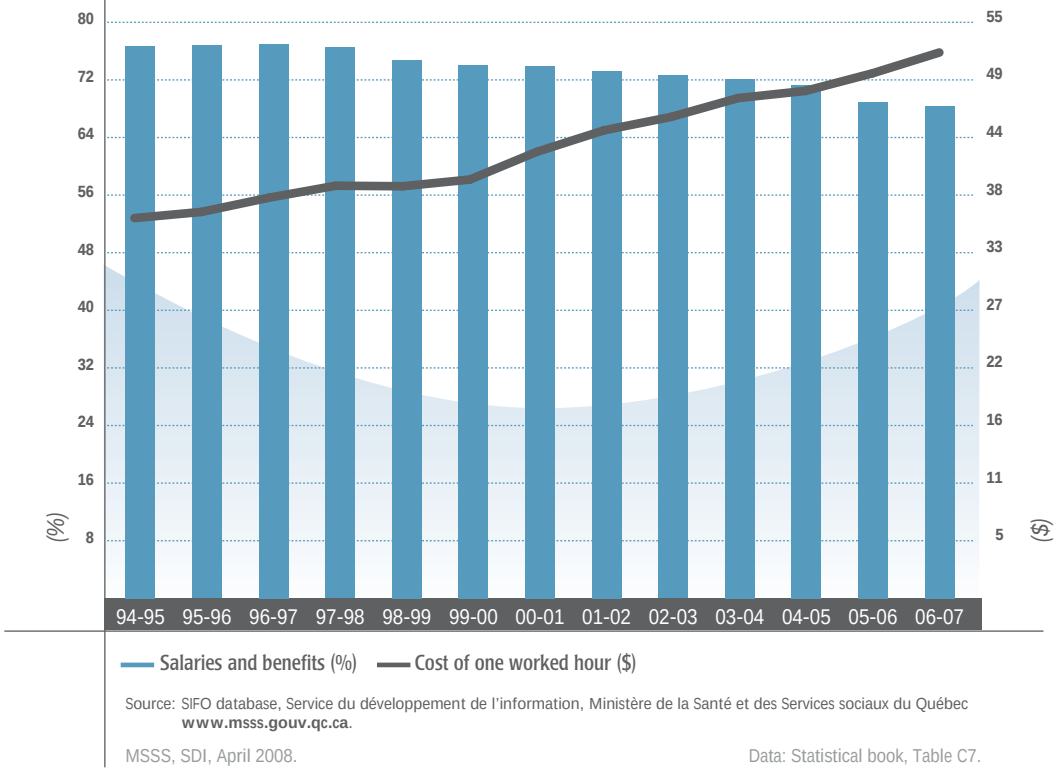
Source: Financial outline, Les programmes-services et les programmes-soutien du réseau de la santé et des services sociaux, 2006-2007, René Kirouac and Linda Cyr, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**, March 2008.

MSSS, SDI, March 2008.

Data: Statistical book, Table C6.

Figure 64

Proportion of
gross direct costs allocated to salaries and benefits
in under-agreement public and private establishments of the Québec health and social services network, and cost of one worked hour,
1994-1995 to 2006-2007



Source: SIFO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008. Data: Statistical book, Table C7.

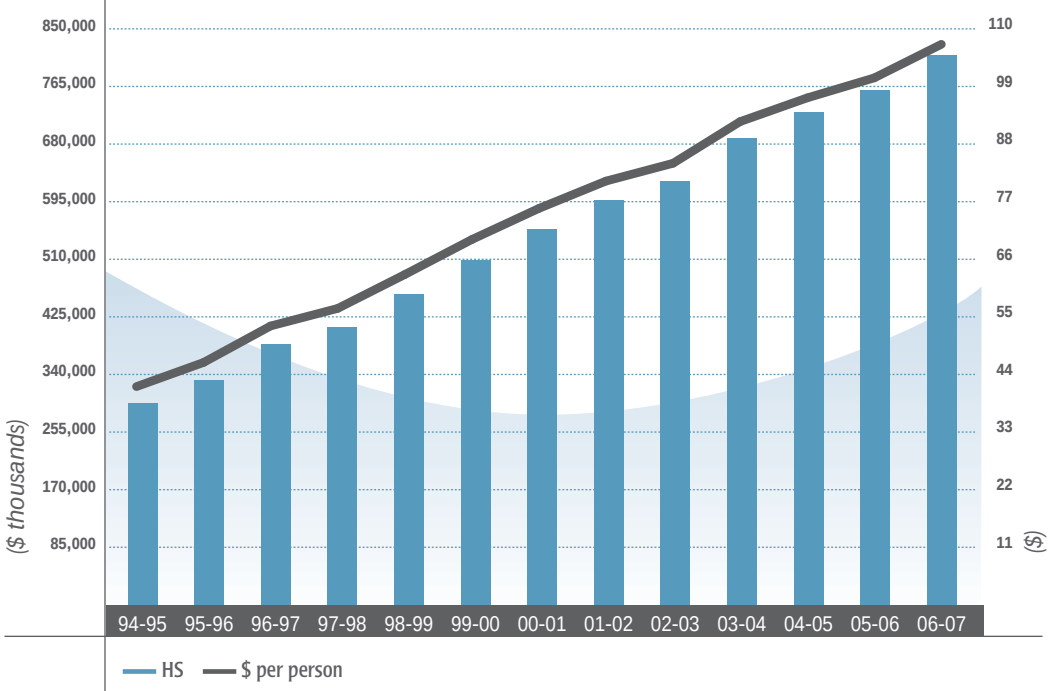
Home support

Home support refers to the net spending incurred for home care and assistance, including administrative and operational expenses, as well as subsidies granted to community organizations providing home services, but excluding the tax credits for users who purchase home services as well as the amounts paid to social economy enterprises. These expenditures are calculated based on the financial outline of the MSSS's client programs (between 1994-1995 and 2000-2001), and service programs and support programs (starting in 2001-2002). These numbers are used to make comparisons at the national level.

In 1994-1995, Québec devoted slightly less than 300 million to home support, i.e., 2.3% of the amounts allocated to the Health and Social Services mission as a whole. In 2006-2007, close to 812 million were allocated to these services, corresponding to 3.6% of all expenditures for this mission. In the course of this twelve-year period, the growth rate varied from 4.5% (in 2005-2006) to 15.6% (in 1996-1997), i.e., an average annual increase in the order of 8.7%. We thus went from a per-capita amount of $41.34 allocated to home support to an amount of $106.74 between 1994-1995 and 2006-2007.

Figure 65

Amounts allocated **for home support,** Québec, *1994-1995 to 2006-2007*



Source: Direction de l'allocation des ressources, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, March 2008. Data: Statistical book, Table C8.

Programs administered by the RAMQ

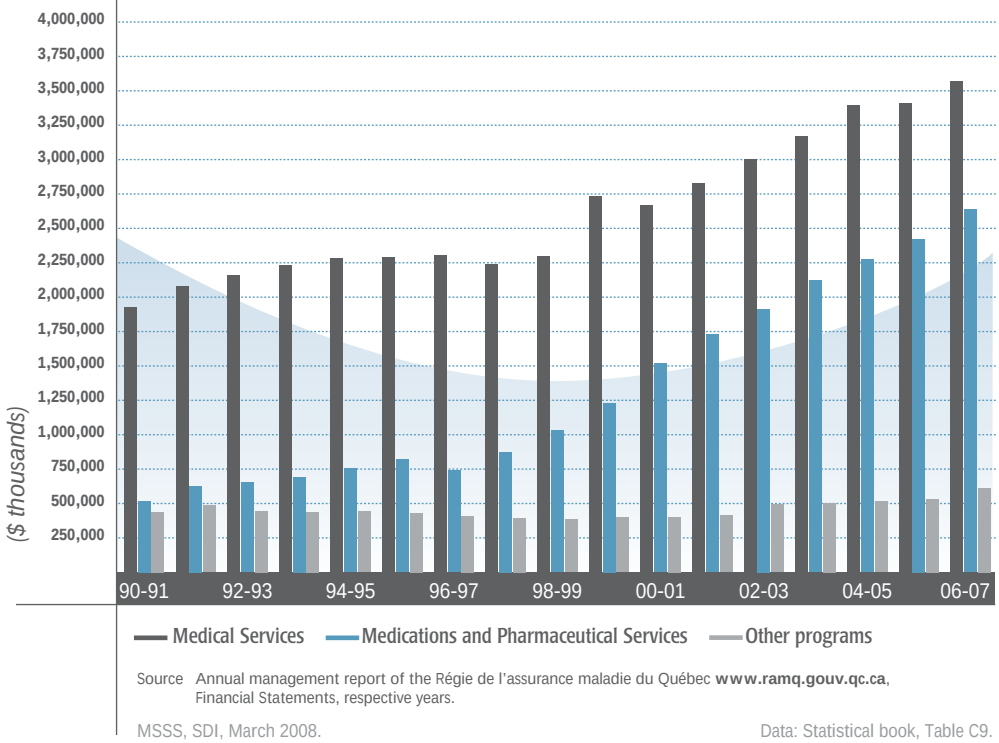
The cost of the programs administered by the RAMQ reached over $6.8 billion in 2006-2007, a 137% increase compared to 1990-1991, for an average annual increase of 5.5%. Currently (2006-2007), the "Medical Services" program accounts for over 52% of the RAMQ's costs, and close to 94% of this share of the costs was used to compensate physicians; sixteen years before, these two proportions were, respectively, 67% and 90%. In 2006-2007, close to 79% of the compensation for physicians took the form of "fee-for-service and by unit" payments; in 1990-1991, this percentage was of 88%. Salary-based compensation has been declining (-14% since 1990-1991), while the "flat rate fees" method has seen significant growth (fivefold increase since 1990-1991).

On average, in 1990, a general practitioner earned $98,637 a year, while a specialist earned $150,323. In 2006, the average amount paid by the RAMQ to a general practitioner was of $160,542, while that paid to a specialist was of $240,524.

Between 1990-1991 and 2006-2007, the costs of the "Medications and Pharmaceutical Services" program increased by a factor of slightly more than 4. This represents an average annual increase of close to 11%. The creation of the prescription drug insurance plan in 1997 obviously played a large part in this increase. In 2006-2007, the costs of this program were over $2.6 billion. It should be noted that the plan is partly funded through the financial contributions of participants to the Drug Insurance Fund.

Figure **66**

Compared costs
of the programs administered
by the Régie de l'assurance maladie du Québec,
1990-1991 to 2006-2007



Source Annual management report of the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca**, Financial Statements, respective years.

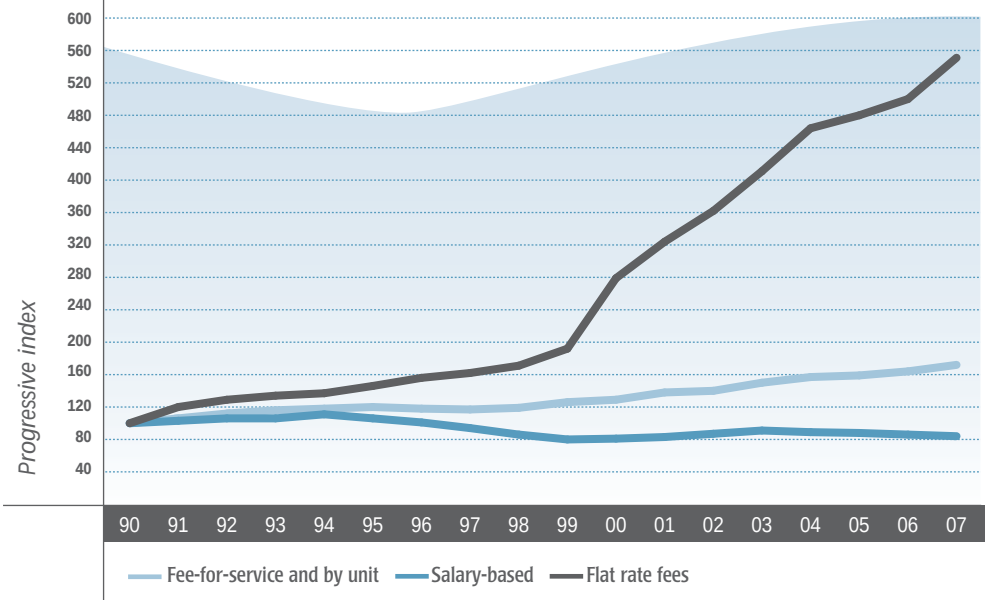
MSSS, SDI, March 2008.

Data: Statistical book, Table C9.

For the most part, i.e., close to 80% of all amounts paid, physicians are paid according to the "fee-for-service and by unit" method, although there has been a slight decline of this proportion since the start of the millennium. After declining somewhat in the second half of the 1990s, salary-based compensation has since shown relative stability. However, the "flat rate fees" method, after having seen moderate growth throughout the 1990s, has seen a significant increase since the start of the millennium. Today (2007), this method of compensation covers 20% of the amounts paid to physicians in Québec.

Figure **67**

Change in the compensation
of "active" Québec physicians,
by method of compensation,
1990-2007



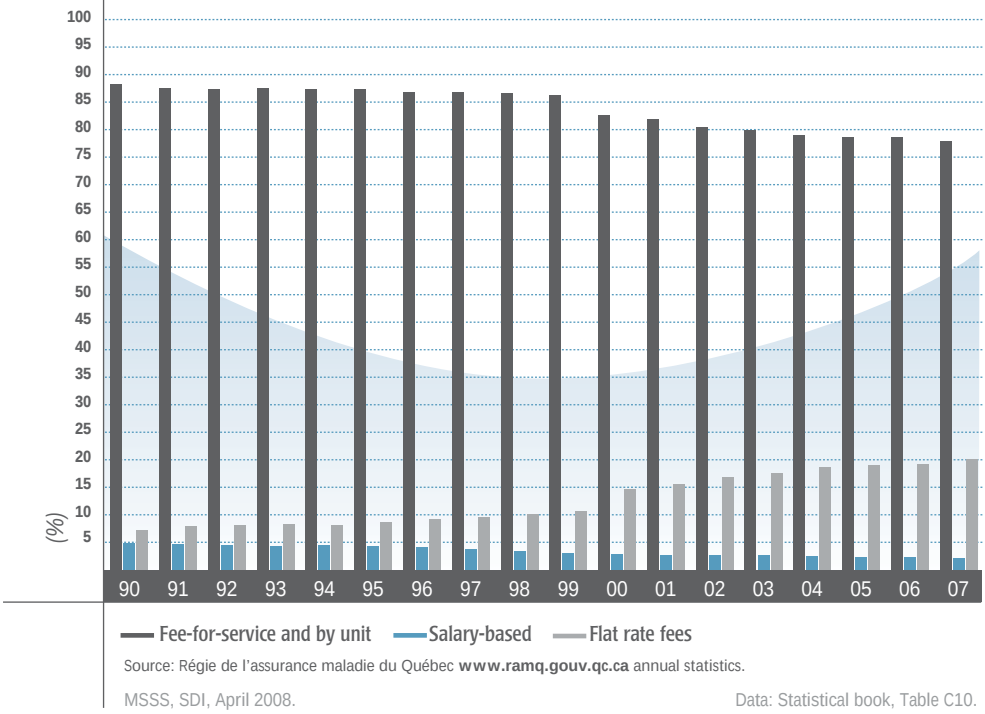
Source: Information extracted from the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Data: Statistical book, Table C10.

Figure 68

Percentage breakdown
of the amounts paid to "active" physicians,
by method of compensation,
Québec, 1990 to 2007



Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008. Data: Statistical book, Table C10.

Pre-hospital emergency services

The total budget devoted to pre-hospital emergency services for the 2006-2007 fiscal year reached some 357.7 million, compared to 345.4 million the year before. In addition to this are the expenses associated with emergency air transportation, which reached 22 million in 2006-2007 and 23 million in 2007-2008. In 2006-2007, the per-capita budget for pre-hospital emergency services rose to $47.05, compared to $45.64 the year before.

The Ministère de la Santé et des Services sociaux alone covers over 75% of the total budget for pre-hospital services.

The cost of an ambulance trip is generally paid by the user, except in the following cases, where the costs are the responsibility of a third-party payer:

- Persons injured in a road accident;
- Persons injured at work;
- Victims of a criminal act;
- Recipients of last-resort assistance;
- Veterans;
- Users transported between two institutions within the health and social services network;
- Seniors (or: persons 65 years of age or older);
- Members of the Canadian Armed Forces;
- Inmates of detention centres;
- Status and on-reserve aboriginals and Inuit.

Depending on the context, third-party payers may be provincial or federal government organizations, band councils, employers or institutions within the health and social services network. Third-party payers provide revenues covering 19% of the emergency pre-hospital services budget; users and their insurers cover 6%.

In 2005-2006, the average cost for an ambulance trip was $616.62; in 2006-2007, it was $610.78.

Subsidized community organizations

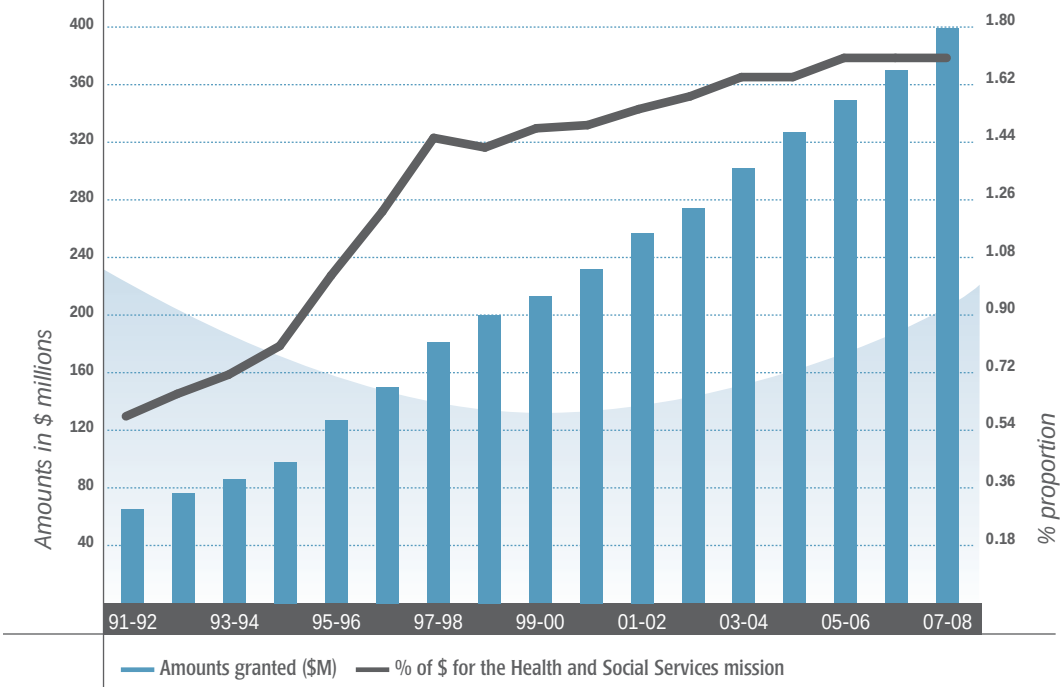
In the last fifteen years, the amounts granted to subsidized community organizations increased sixfold, rising from 65 million in 1991-1992 to over 399 million in 2007-2008, for an average annual growth rate of over 12%.

In 1991-1992, subsidies granted to community organizations corresponded to 0.5% of all amounts devoted to the Health and Social Services mission; in 2007-2008, this proportion more than tripled to reach 1.6%.

Of the $399 million granted to the 3,397 community organizations in 2007-2008, 8.8 million, or 2.2% of the total amount, went to the 122 organizations subsidized at the national level; the remaining number were subsidized at the regional level.

Figure **69**

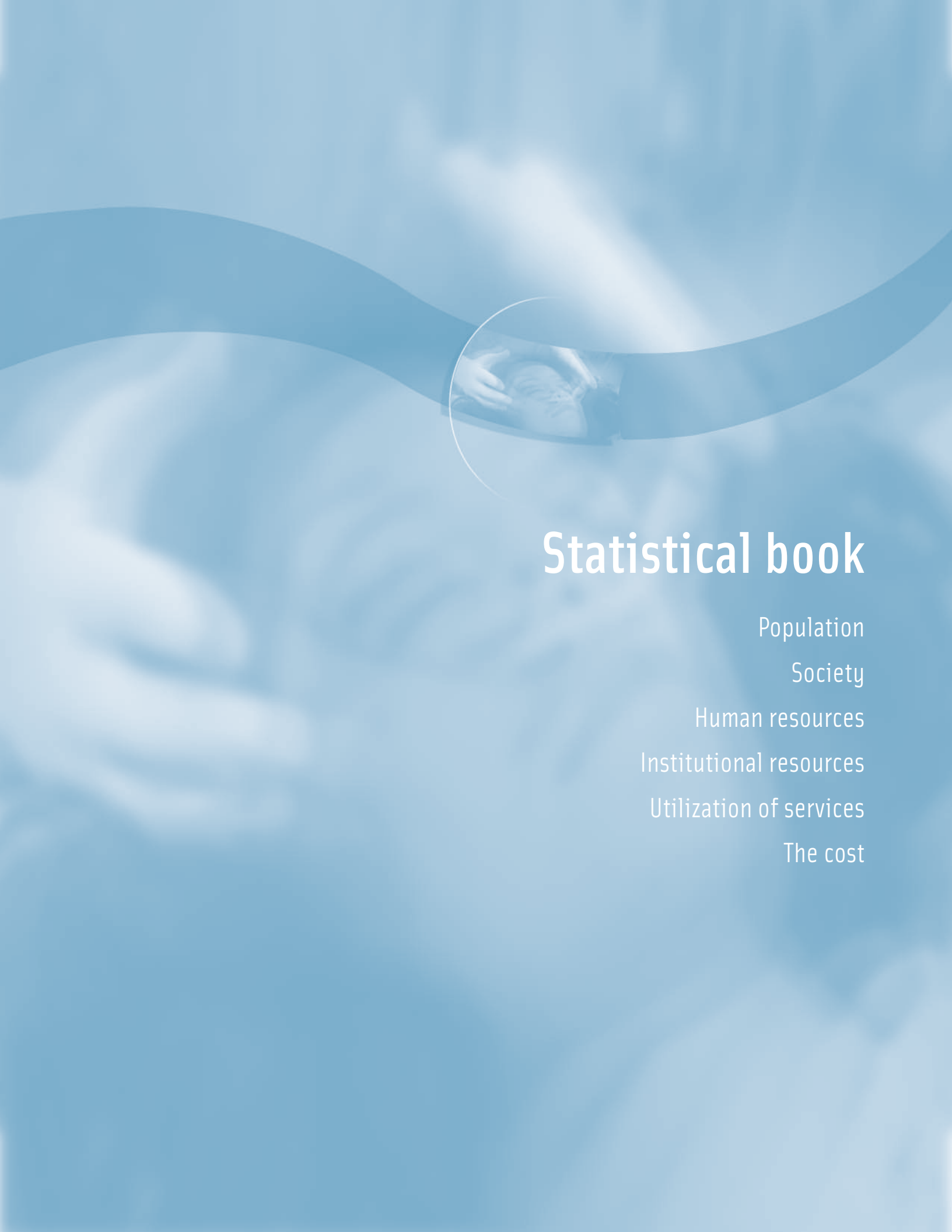
Amounts granted
to community organizations and proportion compared to spending under
the Health and Social Services mission, Québec,
1991-1992 to 2007-2008



Source: Budgetary and financial system by region (SBF-R), Service des activités communautaires, Ministère de la Santé et des Services sociaux **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Data: Statistical book, Table C15.



Statistical book

Population

Society

Human resources

Institutional resources

Utilization of services

The cost

STATISTICAL BOOK

POPULATION

The population data presented in the following tables were compiled by the Institut de la statistique du Québec, in collaboration with the Ministère, based on five-year Canadian censuses (e.g., 1971, 1976, 1981, 1986, 1991, 1996 and 2001); at the time of publication of this document, the data from the 2006 Canadian census were not yet entirely available. The corresponding data for the years between two censuses are the result of intercensal estimates, while those pertaining to the years 2002 and later were obtained through postcensal projections. Much of the data presented in these tables were obtained from the ISQ's website **www.stat.gouv.qc.ca**. Other data were drawn from the works of the MSSS's Service de développement de l'information.

Table **P1**

Population of
Québec by five-yearly age group and gender,
situation observed on July 1st,
1961, 2008 and 2051

Groupe group	1961 Women	1961 Men	1961 Total	2008 Women	2008 Men	2008 Total	2051 Women	2051 Men	2051 Total
4 years or less	328,683	342,573	**671,256**	183,708	192,078	**375,786**	157,806	164,821	**322,627**
5 to 9 years	305,072	319,002	**624,074**	184,372	194,058	**378,430**	164,808	171,730	**336,538**
10 to 14 years	278,414	289,651	**568,065**	215,821	226,813	**442,634**	169,586	176,886	**346,472**
15 to 19 years	231,634	235,792	**467,426**	241,809	253,134	**494,943**	176,204	184,041	**360,245**
20 to 24 years	188,557	181,076	**369,633**	229,665	241,328	**470,993**	189,641	198,011	**387,652**
25 to 29 years	181,772	180,795	**362,567**	255,647	268,640	**524,287**	205,328	214,367	**419,695**
30 to 34 years	187,996	185,262	**373,258**	249,165	262,882	**512,047**	217,780	227,671	**445,451**
35 to 39 years	180,713	176,928	**357,641**	242,405	253,831	**496,236**	224,129	233,975	**458,104**
40 to 44 years	155,742	152,351	**308,093**	285,019	294,198	**579,217**	226,988	236,182	**463,170**
45 to 49 years	137,279	137,795	**275,074**	324,636	327,902	**652,538**	225,825	234,139	**459,964**
50 to 54 years	117,910	118,350	**236,260**	310,655	306,139	**616,794**	229,107	239,258	**468,365**
55 to 59 years	95,508	94,155	**189,663**	273,063	263,133	**536,196**	259,999	266,553	**526,552**
60 to 64 years	76,474	73,426	**149,900**	237,497	224,403	**461,900**	254,308	257,798	**512,106**
65 to 69 years	60,215	56,708	**116,923**	181,635	165,236	**346,871**	245,923	245,986	**491,909**
70 to 74 years	46,681	41,549	**88,230**	144,201	120,186	**264,387**	250,946	242,490	**493,436**
75 to 79 years	29,691	26,211	**55,902**	130,699	96,283	**226,982**	212,564	193,424	**405,988**
80 to 84 years	16,052	13,567	**29,619**	100,355	60,256	**160,611**	191,752	158,268	**350,020**
85 to 89 years	6,753	5,294	**12,047**	60,239	27,962	**88,201**	178,876	129,178	**308,054**
90 years or more	2,209	1,371	**3,580**	31,718	10,611	**42,329**	174,951	100,919	**275,870**
TOTAL	**2,627,355**	**2,631,856**	**5,259,211**	**3,882,309**	**3,789,073**	**7,671,382**	**3,956,521**	**3,875,697**	**7,832,218**

Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table P2

Ten-year proportion **of persons aged 65 or older** in the population of Québec, *situation observed on July 1st, 1961 to 2051*

Year	Total population	Seniors (or: persons 65 years of age or older);	Proportion (%)
1961	5,259,211	306,301	5.8
1971	6,155,600	419,300	6.8
1981	6,547,705	573,209	8.8
1991	7,064,586	782,272	11.1
2001	7,396,988	965,143	13.0
2011	7,766,718	1,237,844	15.9
2021	8,014,407	1,703,582	21.3
2031	8,106,967	2,183,655	26.9
2041	8,017,350	2,275,282	28.4
2051	7,832,218	2,325,277	29.7

Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, January 2007.

Table P3

Population of **Québec by selected age groups,** situation observed on July 1st, 1971 to 2026 (in thousands of persons)

Year	Total population	Population aged under 15	Population aged 15 to 64	Population aged 65 or older	Active population
1971	6,155.6	1,802.9	3,933.4	419.3	2,347.0
1972	6,194.4	1,751.7	4,010.2	432.4	2,383.0
1973	6,235.2	1,699.6	4,090.3	445.4	2,499.0
1974	6,290.6	1,652.1	4,179.8	458.8	2,570.0
1975	6,352.4	1,612.2	4,267.7	472.5	2,647.0
1976	6,420.5	1,579.9	4,350.8	489.9	2,785.5
1977	6,455.1	1,542.3	4,407.2	505.9	2,852.0
1978	6,463.4	1,497.0	4,443.7	520.6	2,917.6
1979	6,488.8	1,458.7	4,491.8	538.2	2,982.6
1980	6,528.2	1,429.0	4,543.8	555.4	3,062.8
1981	6,547.7	1,407.7	4,566.8	573.2	3,120.0
1982	6,579.3	1,395.2	4,595.0	589.2	3,069.5
1983	6,602.3	1,384.2	4,614.9	603.3	3,127.2
1984	6,631.2	1,375.3	4,637.0	618.9	3,178.4
1985	6,665.7	1,365.8	4,662.2	637.7	3,237.1
1986	6,708.5	1,358.0	4,692.6	657.8	3,294.4
1987	6,782.5	1,363.3	4,735.9	683.3	3,363.9
1988	6,839.0	1,367.8	4,765.3	705.9	3,404.6
1989	6,928.7	1,378.2	4,819.4	731.2	3,461.2
1990	7,003.9	1,387.7	4,859.5	756.7	3,505.4
1991	7,064.6	1,396.7	4,885.6	782.3	3,510.9
1992	7,108.0	1,404.3	4,902.8	801.0	3,481.0
1993	7,155.3	1,407.8	4,928.3	819.2	3,493.7
1994	7,191.9	1,403.7	4,952.7	835.5	3,529.9
1995	7,219.4	1,391.3	4,975.5	852.6	3,540.9
1996	7,246.9	1,380.9	4,997.1	869.0	3,551.7
1997	7,274.6	1,365.3	5,019.1	890.3	3,582.3
1998	7,296.0	1,351.5	5,035.1	909.3	3,631.5
1999	7,323.3	1,334.7	5,062.2	926.4	3,670.5
2000	7,357.0	1,319.5	5,091.7	945.9	3,717.5
2001	7,397.0	1,305.1	5,126.8	965.1	3,771.1
2002	7,443.2	1,296.4	5,164.9	981.9	3,907.7
2003	7,486.1	1,286.8	5,198.6	1,000.7	3,992.8

Sources: Données populationnelles, Service du développe ment de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table P3 (cont.)

Population of
Québec by selected age groups,
situation observed on July 1st, 1971 to 2026
(in thousands of persons)

Year	Total population	Population aged under 15	Population aged 15 to 64	Population aged 65 or older	Active population
2004	7,527.5	1,274.6	5,231.0	1,021.8	4,024.1
2005	7,566.4	1,256.0	5,266.4	1,044.0	4,052.7
2006	7,603.1	1,234.6	5,298.6	1,069.9	4,094.2
2007	7,637.7	1,214.2	5,325.6	1,097.9	4,150.1
2008	7,671.4	1,196.9	5,345.2	1,129.4	4,184.3[1]
2009	7,704.1	1,182.4	5,358.8	1,162.9	N/A
2010	7,735.9	1,169.8	5,367.4	1,198.7	N/A
2011	7,766.7	1,159.0	5,370.0	1,237.8	N/A
2012	7,796.5	1,151.9	5,362.9	1,281.7	N/A
2013	7,825.3	1,149.3	5,350.6	1,325.4	N/A
2014	7,853.0	1,149.7	5,333.5	1,369.8	N/A
2015	7,879.6	1,150.4	5,315.6	1,413.5	N/A
2016	7,905.0	1,152.6	5,293.4	1,459.0	N/A
2017	7,929.4	1,154.0	5,271.3	1,504.1	N/A
2018	7,952.5	1,155.8	5,246.0	1,550.6	N/A
2019	7,974.4	1,155.4	5,218.4	1,600.6	N/A
2020	7,995.1	1,154.7	5,187.7	1,652.7	N/A
2021	8,014.4	1,153.6	5,157.2	1,703.6	N/A
2022	8,032.2	1,152.1	5,122.1	1,758.0	N/A
2023	8,048.4	1,149.8	5,085.2	1,813.4	N/A
2024	8,062.8	1,146.9	5,048.2	1,867.7	N/A
2025	8,075.3	1,143.1	5,010.8	1,921.4	N/A
2026	8,085.8	1,138.4	4,973.3	1,974.1	N/A

1. Average, January to April 2008.

Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table P4

Five-year dependency ratio
within the population of Québec,
situation observed on July 1st, 1971 to 2051

Year	14 years and younger	15 to 64 years	65 years or older	Total	Dependency ratio[1]
1971	1,799,631	3,919,151	418,524	6,137,306	56.6
1976	1,575,557	4,332,407	488,803	6,396,767	47.6
1981	1,407,676	4,566,820	573,209	6,547,705	43.4
1986	1,358,022	4,692,641	657,805	6,708,468	43.0
1991	1,396,670	4,885,644	782,272	7,064,586	44.6
1996	1,380,862	4,997,072	868,962	7,246,896	45.0
2001	1,305,110	5,126,735	965,143	7,396,988	44.3
2006	1,234,565	5,298,514	1,070,012	7,603,091	43.5
2011	1,158,989	5,369,885	1,237,844	7,766,718	44.6
2016	1,152,519	5,293,434	1,459,078	7,905,031	49.3
2021	1,153,624	5,157,201	1,703,582	8,014,407	55.4
2026	1,138,448	4,973,184	1,974,218	8,085,850	62.6
2031	1,104,380	4,818,932	2,183,655	8,106,967	68.2
2036	1,061,532	4,765,141	2,253,443	8,080,116	69.6
2041	1,027,754	4,714,314	2,275,282	8,017,350	70.1
2046	1,012,360	4,597,541	2,320,869	7,930,770	72.5
2051	1,005,637	4,501,304	2,325,277	7,832,218	74.0

1. The ratio of the sum of persons under 15 years of age and 65 years or older and that of persons aged 15 to 64, multiplied by 100.

Sources: Population data, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2007.

Table P5

Net migration
within the population of Québec, net national and international migrations,
1971 to 2007

Year	International migration			Interprovincial migration			Total net migration
	Immigrants	Emigrants	Balance	Incoming persons	Outgoing persons	Balance	
1971	19,222	12,722	6,500	38,738	63,743	-25,005	**-18,505**
1972	18,592	4,384	14,208	36,150	56,042	-19,892	**-5,684**
1973	26,871	6,856	20,015	39,632	54,362	-14,730	**5,285**
1974	33,458	7,039	26,419	39,310	51,162	-11,852	**14,567**
1975	28,042	5,688	22,354	34,457	46,797	-12,340	**10,014**
1976	29,282	4,666	24,616	31,592	52,393	-20,801	**3,815**
1977	19,248	4,781	14,467	24,424	70,960	-46,536	**-32,069**
1978	14,290	5,165	9,125	24,482	57,906	-33,424	**-24,299**
1979	19,534	3,956	15,578	23,627	53,652	-30,025	**-14,447**
1980	22,591	2,731	19,860	21,913	46,196	-24,283	**-4,423**
1981	21,213	3,642	17,571	23,564	46,113	-22,549	**-4,978**
1982	21,387	4,715	16,672	19,941	48,110	-28,169	**-11,497**
1983	16,416	5,098	11,318	22,348	41,428	-19,080	**-7,762**
1984	14,698	4,563	10,135	25,230	36,173	-10,943	**-808**
1985	14,885	3,522	11,363	25,426	31,449	-6,023	**5,340**
1986	19,476	4,298	15,178	26,012	29,032	-3,020	**12,158**
1987	26,846	4,010	22,836	26,039	33,449	-7,410	**15,426**
1988	25,588	3,506	22,082	27,839	34,842	-7,003	**15,079**
1989	33,946	3,909	30,037	29,454	37,833	-8,379	**21,658**
1990	41,043	3,593	37,450	26,864	36,431	-9,567	**27,883**
1991	51,947	6,667	45,280	24,524	37,571	-13,047	**32,233**
1992	48,838	7,799	41,039	25,480	35,265	-9,785	**31,254**
1993	44,977	7,983	36,994	24,545	31,971	-7,426	**29,568**
1994	28,094	9,527	18,567	22,718	32,970	-10,252	**8,315**
1995	27,228	9,028	18,200	23,115	33,363	-10,248	**7,952**
1996	29,806	8,871	20,935	20,848	36,206	-15,358	**5,577**
1997	27,934	11,166	16,768	20,354	37,913	-17,559	**-791**
1998	26,626	10,299	16,327	20,156	34,668	-14,512	**1,815**
1999	29,179	9,176	20,003	19,977	31,689	-11,712	**8,291**
2000	32,502	9,306	23,196	22,051	33,284	-11,233	**11,963**
2001	37,572	8,024	29,548	23,184	29,572	-6,388	**23,160**
2002	37,579	6,578	31,001	23,195	27,423	-4,228	**26,773**
2003	39,558	5,804	33,754	23,526	23,308	218	**33,972**
2004	44,244	7,089	37,155	23,215	26,512	-3,297	**33,858**
2005	43,314	7,228	36,086	21,998	28,832	-6,834	**29,252**
2006[p]	44,681	7,282	37,399	24,148	37,063	-12,915	**24,484**
2007[p]	45,224	7,330	37,894	24,932	39,376	-14,444	**23,450**

p: Provisional data.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, April 2008.

SOCIETY

This section contains basic progressive data associated with selective demographic, economic and social characteristics of Québec's population. These data were essentially drawn directly from the Institut de la statistique du Québec's website **www.stat.gouv.qc.ca**. Only the data on employment insurance came from another source, namely the Ministère de l'Emploi et de la Solidarité sociale's website **www.mess.gouv.qc.ca**.

Table S1

Number of marriages[1] and marriage rate[2], Québec, *1900 to 2006*

Year	Marriages (n)	Rate (0/00)	Year	Marriages (n)	Rate (0/00)	Year	Marriages (n)	Rate (0/00)
1900	10,103	6.5	1936	21,654	7.0	1972	53,967	8.7
1901	10,075	6.1	1937	24,876	7.9	1973	52,133	8.4
1902	10,671	6.4	1938	25,044	7.9	1974	51,890	8.3
1903	11,125	6.6	1939	28,911	9.0	1975	51,690	8.2
1904	11,900	7.0	1940	35,069	10.7	1976	50,961	8.0
1905	11,565	6.7	1941	32,782	9.8	1977	48,182	7.5
1906	12,131	7.0	1942	33,857	10.0	1978	46,189	7.2
1907	11,668	6.6	1943	33,856	9.8	1979	46,154	7.1
1908	11,971	6.5	1944	31,922	9.1	1980	44,849	6.9
1909	13,467	7.1	1945	33,211	9.3	1981	41,006	6.3
1910	14,333	7.3	1946	36,650	10.1	1982	38,360	5.8
1911	15,254	7.6	1947	35,494	9.6	1983	36,147	5.5
1912	16,055	7.9	1948	34,646	9.1	1984	37,416	5.6
1913	17,253	8.3	1949	33,485	8.6	1985	37,026	5.6
1914	16,121	7.7	1950	34,093	8.6	1986	33,108	4.9
1915	15,437	7.2	1951	35,704	8.8	1987	32,588	4.8
1916	16,643	7.6	1952	35,374	8.5	1988	33,469	4.9
1917	16,936	7.7	1953	35,968	8.4	1989	33,305	4.8
1918	12,975	5.8	1954	35,516	8.1	1990	32,059	4.6
1919	21,590	9.4	1955	35,356	7.8	1991	28,922	4.1
1920	21,587	9.3	1956	37,290	8.1	1992	25,821	3.6
1921	18,659	7.9	1957	37,135	7.8	1993	25,018	3.5
1922	16,609	6.9	1958	36,229	7.4	1994	24,984	3.5
1923	17,361	7.1	1959	37,124	7.4	1995	24,237	3.3
1924	17,591	7.1	1960	36,211	7.0	1996	23,963	3.3
1925	17,427	6.8	1961	35,943	6.8	1997	23,918	3.3
1926	17,827	6.8	1962	37,038	6.9	1998	22,940	3.1
1927	18,551	7.0	1963	37,358	6.8	1999	22,910	3.1
1928	19,126	7.0	1964	39,400	7.1	2000	24,911	3.4
1929	19,610	7.1	1965	40,893	7.2	2001	21,961	3.0
1930	18,543	6.6	1966	44,411	7.7	2002	21,986	3.0
1931	16,783	5.8	1967	46,275	7.9	2003	21,145	2.8
1932	15,115	5.2	1968	46,004	7.8	2004	21,279	2.8
1933	15,337	5.2	1969	47,545	7.9	2005	22,244	2.9
1934	18,242	6.0	1970	49,607	8.2	2006[p]	21,918	2.9
1935	19,967	6.5	1971	49,695	8.1			

p: Provisional data.

1. Same-sex marriages are included from 2004 onward.
2. The marriage rate is equal to the number of marriages divided by the total population, expressed in "rate per 1,000 persons."

Source: Institut de la statistique du Québec, from 1975 **www.stat.gouv.qc.ca**; Statistics Canada, 1926 to 1974; Annuaires du Québec, 1900 to 1925.

MSSS, SDI, April 2008

Table S2

Number of divorces and total divorce rate[1], Québec, *1969 to 2004*

Year	Divorces (n)	Total rate per 100 marriages
1969	2,947	8.8
1970	4,865	14.0
1971	5,203	14.6
1972	6,426	17.5
1973	8,091	21.5
1974	12,272	32.1
1975	14,093	36.1
1976	15,186	37.8
1977	14,501	35.2
1978	14,865	35.1
1979	14,379	33.2
1980	13,899	31.7
1981	19,193	43.5
1982	18,579	40.8
1983	17,365	39.3
1984	16,845	37.9
1985	15,814	35.8
1986	19,026	43.5
1987	22,098	51.2
1988	20,340	47.8
1989	19,829	47.3
1990	20,474	49.6
1991	20,277	49.6
1992	19,695	49.2
1993	19,662	50.2
1994	18,224	47.5
1995	20,133	54.0
1996	18,078	49.0
1997	17,478	48.7
1998	16,916	48.9
1999	17,144	50.3
2000	17,054	51.4
2001	17,094	52.4
2002	16,499	50.4
2003	16,738	53.6
2004	15,999	52.4

1. Proportion of marriages ending in divorce based on the conditions for divorce in a given year; sum of divorce rates by marriage duration.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table S3

Unemployment rate[1] within the population of Québec,

by gender, annual average,
1976 to 2008

Year	Men	Women	Both sexes
1976	8.1	9.7	8.7
1977	9.7	11.5	10.4
1978	10.4	12.0	11.0
1979	9.0	11.0	9.7
1980	9.5	10.9	10.0
1981	10.0	11.4	10.5
1982	14.0	14.0	14.0
1983	14.3	14.0	14.2
1984	12.9	13.3	13.1
1985	12.5	12.1	12.3
1986	10.8	11.5	11.1
1987	9.9	10.5	10.2
1988	9.0	10.2	9.5
1989	9.6	9.7	9.6
1990	10.3	10.5	10.4
1991	12.6	11.6	12.1
1992	13.4	11.8	12.7
1993	13.9	12.4	13.2
1994	13.1	11.4	12.3
1995	11.8	11.0	11.5
1996	12.5	11.2	11.9
1997	12.0	10.7	11.4
1998	10.4	10.1	10.3
1999	9.7	8.9	9.3
2000	8.7	8.2	8.5
2001	9.0	8.5	8.8
2002	9.1	8.1	8.6
2003	9.7	8.5	9.1
2004	9.1	7.8	8.5
2005	9.0	7.5	8.3
2006	8.5	7.5	8.0
2007	7.9	6.4	7.2
2008[2]	..	..	7.2

1. In % of active population, i.e., employable persons 15 years of age or older looking for work.
2. Average, January to May 2008.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table S4

Number of households and users receiving employment insurance, adults and children, Québec, annual average, *1997-1998 to 2007-2008*

Year	Households	Beneficiaries		
		Adults	Children	Total
1997-1998[1]	453,195	512,031	234,234	**746,265**
1998-1999	417,011	476,370	204,070	**680,440**
1999-2000	396,141	450,344	181,766	**632,110**
2000-2001	376,523	426,688	163,454	**590,142**
2001-2002	363,995	411,351	150,884	**562,235**
2002-2003	358,164	403,671	142,929	**546,600**
2003-2004	353,485	397,191	136,078	**533,269**
2004-2005	348,687	390,723	130,516	**521,239**
2005-2006	341,314	381,130	124,615	**505,745**
2006-2007	338,695	376,934	120,866	**497,800**
2007-2008	335,010	371,991	117,479	**489,470**

1. Statistics from September 1997

Source: Ministère de l'Emploi et de la Solidarité sociale **www.mess.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table S5

Number of births[1] and birth rate[2], Québec, *1900 to 2007*

Year	Births (n)	Rate (0/00)	Year	Births (n)	Rate (0/00)
1900	61,834	39.5	1954	135,975	31.0
1901	62,245	37.8	1955	136,270	30.2
1902	63,568	38.2	1956	138,631	30.0
1903	62,440	37.1	1957	144,432	30.3
1904	64,750	38.2	1958	143,710	29.3
1905	67,068	39.1	1959	144,459	28.8
1906	67,890	39.4	1960	141,224	27.5
1907	66,474	37.3	1961	139,857	26.6
1908	69,228	37.7	1962	138,163	25.7
1909	77,144	40.6	1963	136,491	24.9
1910	77,349	39.3	1964	133,863	24.0
1911	77,466	38.6	1965	123,279	21.7
1912	78,906	38.7	1966	112,757	19.5
1913	81,744	39.5	1967	104,803	17.9
1914	83,188	39.5	1968	100,548	17.0
1915	85,055	39.7	1969	99,503	16.6
1916	83,634	38.4	1970	96,512	16.1
1917	84,595	38.2	1971	93,743	15.3
1918	87,075	38.7	1972	88,118	14.3
1919	82,566	36.1	1973	89,412	14.4
1920	85,271	36.7	1974	91,433	14.6
1921	88,749	37.6	1975	96,268	15.2
1922	88,377	36.7	1976	98,022	15.3
1923	83,579	34.2	1977	97,266	15.1
1924	86,930	34.8	1978	96,202	14.9
1925	87,527	34.3	1979	99,893	15.4
1926	82,165	31.6	1980	97,498	15.0
1927	83,064	31.3	1981	95,247	14.5
1928	83,621	30.8	1982	90,540	13.8
1929	81,380	29.4	1983	87,739	13.3
1930	83,625	29.6	1984	87,610	13.2
1931	83,606	29.1	1985	86,008	12.9
1932	82,216	28.1	1986	84,579	12.6
1933	76,920	25.9	1987	83,600	12.3
1934	76,432	25.3	1988	86,358	12.6
1935	75,267	24.6	1989	91,751	13.2
1936	75,285	24.3	1990	98,013	14.0
1937	75,635	24.1	1991	97,348	13.8
1938	78,145	24.6	1992	96,054	13.5
1939	79,621	24.7	1993	92,322	12.9
1940	83,857	25.6	1994	90,417	12.6
1941	89,209	26.8	1995	87,258	12.1
1942	95,031	28.0	1996	85,130	11.7
1943	98,744	28.6	1997	79,724	11.0
1944	102,262	29.2	1998	75,865	10.4
1945	104,283	29.3	1999	73,599	10.0
1946	111,285	30.7	2000	72,010	9.8
1947	115,553	31.1	2001	73,699	10.0
1948	114,709	30.3	2002	72,478	9.7
1949	116,824	30.1	2003	73,916	9.9
1950	121,842	30.7	2004	74,068	9.8
1951	123,196	30.4	2005	76,341	10.0
1952	127,939	30.7	2006[p]	82,100	10.7
1953	130,583	30.6	2007[p]	84,200	10.9

p: Provisional data.

1. Live births.
2. Number of live births divided by total population, expressed in "rate per 1,000 persons."

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table S6

Statistical indicators of births,

Québec,

1951 to 2007

Year	Births[1] (n)	Birth rate[2] (0/00)	Total fertility rate[3]	Average age of the mother[4]	Average age of the mother[5] at 1st child
1951	123,196	30.4	3.85	29.6	...
1952	127,939	30.7	3.91	29.5	...
1953	130,583	30.6	3.96	29.4	...
1954	135,975	31.0	4.04	29.4	...
1955	136,270	30.2	4.00	29.3	...
1956	138,631	30.0	3.99	29.3	...
1957	144,432	30.3	4.09	29.2	...
1958	143,710	29.3	4.01	29.1	...
1959	144,459	28.8	3.99	29.0	...
1960	141,224	27.5	3.86	28.9	...
1961	139,857	26.6	3.78	28.8	...
1962	138,163	25.7	3.67	28.8	...
1963	136,491	24.9	3.56	28.7	...
1964	133,863	24.0	3.42	28.6	...
1965	123,279	21.7	3.07	28.5	...
1966	112,757	19.5	2.72	28.4	...
1967	104,803	17.9	2.45	28.2	...
1968	100,548	17.0	2.28	28.0	...
1969	99,503	16.6	2.20	28.0	...
1970	96,512	16.1	2.09	27.9	...
1971	93,743	15.3	1.94	27.9	...
1972	88,118	14.3	1.77	27.9	...
1973	89,412	14.4	1.74	27.7	...
1974	91,433	14.6	1.72	27.6	..
1975	96,268	15.2	1.75	27.4	25.0
1976	98,022	15.3	1.74	27.3	25.2
1977	97,266	15.1	1.69	27.4	25.3
1978	96,202	14.9	1.66	27.4	25.4
1979	99,893	15.4	1.70	27.4	25.4
1980	97,498	15.0	1.63	27.4	25.4
1981	95,247	14.5	1.57	27.5	25.5
1982	90,540	13.8	1.48	27.4	25.5
1983	87,739	13.3	1.43	27.4	25.6
1984	87,610	13.2	1.42	27.5	25.7
1985	86,008	12.9	1.39	27.5	25.7
1986	84,579	12.6	1.37	27.5	25.8
1987	83,600	12.3	1.36	27.6	25.9
1988	86,358	12.6	1.42	27.6	25.9
1989	91,751	13.2	1.51	27.6	25.9
1990	98,013	14.0	1.63	27.7	26.0
1991	97,348	13.8	1.65	27.8	26.1
1992	96,054	13.5	1.67	27.9	26.2
1993	92,322	12.9	1.64	27.9	26.2
1994	90,417	12.6	1.64	28.0	26.3
1995	87,258	12.1	1.62	28.1	26.4
1996	85,130	11.7	1.61	28.2	26.4
1997	79,724	11.0	1.54	28.3	26.6
1998	75,865	10.4	1.49	28.3	26.7
1999	73,599	10.0	1.47	28.5	26.8
2000	72,010	9.8	1.45	28.5	27.0
2001	73,699	10.0	1.49	28.7	27.1
2002	72,478	9.7	1.47	28.9	27.3
2003	73,916	9.9	1.49	29.1	27.6
2004	74,068	9.8	1.48	29.3	27.8
2005	76,341	10.0	1.52	29.3	27.8
2006[p]	82,100	10.7	1.62	29.5	27.9
2007[p]	84,200	10.9	1.65	29.6	28.0

p: Provisional data.

. . . : Data non available.

1. Live births.
2. Number of births divided by total population, expressed in "rate per 1,000 persons."
3. Average number of children per woman based on fertility conditions for a given year; sum of fertility rates by age, 13 to 49 years.
4. At time of birth.
5. At time of birth of the first child.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table S7

Number of voluntary terminations **of pregnancy, hysterectomies, tubal ligations and vasectomies,** Québec, *1976 to 2006*

Year	VTP[1]	Hysterectomy	Tubal ligation	Vasectomy[2]
1971	1,275	19,376	5,705	6,527
1972	2,412	20,144	13,389	15,329
1973	2,774	21,857	23,425	8,647
1974	4,093	20,576	28,394	8,305
1975	5,280	19,549	28,806	8,157
1976	7,139	17,373	27,395	7,771
1977	8,069	19,476	31,806	9,991
1978	9,704	19,137	32,368	13,777
1979	11,488	17,805	27,477	14,161
1980	14,288	20,210	26,705	15,317
1981	14,193	17,358	23,517	13,000
1982	15,385	17,845	24,636	15,541
1983	15,200	20,175	23,287	15,134
1984	16,004	19,528	22,880	17,189
1985	15,702	18,207	22,041	17,981
1986	15,971	15,174	19,818	6,519
1987	15,475	16,379	18,574	8,021
1988	17,068	15,344	15,379	15,918
1989	18,411	14,315	13,959	16,584
1990	22,219	15,680	14,514	18,336
1991	23,261	15,309	13,469	19,159
1992	24,619	15,126	13,771	20,678
1993	26,106	14,498	13,203	17,939
1994	26,131	14,720	13,152	18,247
1995	26,072	14,907	13,393	19,671
1996	27,184	13,715	13,090	20,006
1997	27,993	12,902	12,085	20,163
1998	28,833	13,004	11,401	18,974
1999	28,058	12,519	9,946	18,113
2000	28,245	12,791	9,479	17,270
2001	28,489	12,214	8,659	15,958
2002	29,140	12,389	7,997	14,966
2003	29,429	11,868	7,205	14,431
2004	29,460	11,661	6,242	13,510
2005	28,080	10,892	5,557	13,519
2006	28,255	10,442	4,660	12,752

1. VTPs performed in CLSCs and institutions where VTPs not compensated on a fee-for-service basis are practised are not included.
2. The RAMQ did not reimburse the costs for vasectomies for several months in 1986 and 1987.

Sources: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca**;
Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table S8

Voluntary termination of pregnancy, hysterectomy and sterilization rate, Québec, *1976 to 2006*

	VTP[1]				Hysterectomies[2]	Tubal ligations[3]		Vasectomies[4]	
Year	Rate[5] (0/0)	Rate[6] (0/00)	Total rate	Average age	Total rate	Total rate	Average age	Total rate	Average age
1976	7.3	7.3	128.4	27.3	337.0	614.2	35.1	184.1	35.5
1977	8.3	5.1	142.2	27.0	370.3	689.3	34.9	227.9	35.4
1978	10.1	6.1	168.8	26.9	364.5	684.1	34.8	306.6	35.5
1979	11.5	7.2	196.8	26.6	333.6	562.0	34.5	306.6	35.0
1980	14.7	8.8	241.9	26.5	375.3	530.8	34.4	317.7	34.5
1981	14.9	8.6	239.2	26.5	318.5	453.3	34.1	260.1	34.1
1982	17.0	9.3	259.9	26.4	319.7	462.1	33.8	302.8	34.1
1983	17.3	9.2	258.0	26.4	353.0	427.6	33.8	291.6	34.2
1984	18.3	9.7	273.2	26.2	333.1	412.4	33.8	324.4	34.4
1985	18.3	9.4	270.3	26.2	300.8	388.9	33.7	329.1	34.5
1986	18.9	9.6	276.7	26.1	246.0	343.9	33.6	118.4	34.0
1987	18.5	9.2	270.1	25.9	253.1	316.2	33.6	138.8	34.3
1988	19.8	10.2	302.4	25.8	227.9	258.6	33.7	270.9	35.0
1989	20.1	10.9	328.6	25.8	202.7	231.1	33.7	277.7	35.2
1990	22.7	13.1	400.2	25.8	213.4	238.1	33.7	303.3	35.2
1991	23.9	13.8	425.6	25.7	203.1	220.6	33.7	314.9	35.2
1992	25.6	14.6	456.6	25.8	193.9	226.5	33.5	338.2	35.1
1993	28.3	15.6	492.7	25.6	183.7	218.3	33.5	292.0	35.1
1994	28.9	15.7	497.9	25.8	180.0	219.2	33.5	297.5	35.1
1995	29.9	15.7	502.3	25.8	179.0	225.6	33.6	321.7	35.2
1996	31.9	16.4	528.4	25.9	162.7	222.9	33.7	330.0	35.4
1997	35.4	17.1	550.2	25.9	149.2	209.8	33.6	335.8	35.4
1998	38.1	17.7	573.0	25.9	150.7	200.7	33.9	321.6	35.4
1999	38.1	17.4	561.5	25.9	141.6	177.7	34.0	310.0	35.7
2000	39.2	17.7	568.6	25.9	142.6	171.0	34.4	298.3	35.9
2001	38.7	17.9	574.3	26.1	135.3	157.9	34.5	277.4	36.0
2002	40.2	18.5	587.7	26.2	135.7	146.7	34.7	261.6	36.2
2003	39.8	18.8	594.3	26.2	132.5	133.2	35.0	253.8	36.4
2004	39.8	18.9	593.9	26.2	131.3	115.8	35.3	238.9	36.4
2005	36.8	18.1	565.4	26.3	120.3	103.9	35.4	240.1	36.6
2006	34.4	18.3	568.3	26.3	113.3	87.5	35.7	227.4	36.6

1. VTPs performed in CLSCs and institutions where VTPs not compensated on a fee-for-service basis are practised are not included. The total rate corresponds to the sum of VTP rates by age.
2. For hysterectomies, the total rate is calculated up until the age of 49. The hysterectomy rate is calculated per 1,000 women aged 15 to 49. The total rate corresponds to the sum of hysterectomy rates by age.
3. The tubal ligation rate is calculated per 1,000 women aged 15 to 49. The total rate corresponds to the sum of ligation rates by age.
4. The RAMQ did not reimburse the costs for vasectomies for several months in 1986 and 1987. The vasectomy rate is calculated per 1,000 men aged 15 to 59. The total rate corresponds to the sum of vasectomy rates by age.
5. Number of VTPs per 100 live births.
6. Number of VTPs per 1,000 women aged 15 to 44.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table S9

Number of deaths and gross mortality rate[1], Québec, *1900 to 2007*

Year	Death (n)	Rate (‰)	Year	Death (n)	Rate (‰)	Year	Death (n)	Rate (‰)
1900	32,778	21.0	1936	31,853	10.3	1972	42,525	6.9
1901	32,219	19.6	1937	35,456	11.3	1973	43,052	6.9
1902	27,408	16.5	1938	32,609	10.2	1974	43,337	6.9
1903	30,876	18.3	1939	33,388	10.3	1975	43,537	6.9
1904	30,549	18.0	1940	32,799	10.0	1976	43,801	6.8
1905	29,071	17.0	1941	34,338	10.3	1977	43,182	6.7
1906	29,969	17.4	1942	33,799	10.0	1978	43,653	6.8
1907	29,007	16.3	1943	35,069	10.1	1979	42,793	6.6
1908	35,052	19.1	1944	34,813	9.9	1980	43,515	6.7
1909	33,231	17.5	1945	33,348	9.4	1981	42,765	6.5
1910	35,183	17.9	1946	33,690	9.3	1982	43,485	6.6
1911	35,904	17.9	1947	33,708	9.1	1983	44,150	6.7
1912	32,980	16.2	1948	33,603	8.9	1984	44,544	6.7
1913	36,200	17.5	1949	34,107	8.8	1985	45,662	6.9
1914	36,002	17.1	1950	33,507	8.4	1986	46,964	7.0
1915	35,933	16.8	1951	34,900	8.6	1987	47,626	7.0
1916	38,206	17.6	1952	34,854	8.4	1988	47,981	7.0
1917	35,501	16.0	1953	34,469	8.1	1989	48,336	7.0
1918	48,902	21.8	1954	33,169	7.6	1990	48,651	6.9
1919	35,170	15.4	1955	33,952	7.5	1991	49,243	7.0
1920	40,686	17.5	1956	35,042	7.6	1992	48,963	6.9
1921	33,433	14.2	1957	36,234	7.6	1993	51,831	7.2
1922	33,459	13.9	1958	35,774	7.3	1994	51,389	7.1
1923	35,148	14.4	1959	36,390	7.2	1995	52,722	7.3
1924	32,356	13.0	1960	35,129	6.8	1996	52,278	7.2
1925	32,300	12.7	1961	37,044	7.0	1997	54,281	7.5
1926	37,251	14.3	1962	37,142	6.9	1998	54,306	7.4
1927	36,175	13.6	1963	38,217	7.0	1999	54,959	7.5
1928	36,632	13.5	1964	37,552	6.7	2000	53,287	7.2
1929	37,221	13.4	1965	38,534	6.8	2001	54,372	7.4
1930	35,945	12.7	1966	38,680	6.7	2002	55,748	7.5
1931	34,487	12.0	1967	38,665	6.6	2003	54,972	7.3
1932	33,088	11.3	1968	39,537	6.7	2004	55,614	7.4
1933	31,636	10.6	1969	40,103	6.7	2005[p]	55,960	7.4
1934	31,929	10.6	1970	40,392	6.7	2006[p]	53,800	7.0
1935	32,839	10.7	1971	41,192	6.7	2007[p]	56,100	7.3

p: Provisional data.

1. Number of deaths divided by total population, expressed in "rate per 1,000 persons."

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table S10

Number of infantile deaths[1] and infantile mortality rate[2], by gender, Québec, *1971 to 2007*

Year	Number of deaths			Rate per 1,000 births		
	Males	Females	Both sexes	Males	Females	Both sexes
1971	938	686	1,624	19.4	15.1	17.3
1972	862	657	1,519	19.0	15.4	17.2
1973	803	581	1,384	17.4	13.5	15.5
1974	753	570	1,323	16.0	12.8	14.5
1975	765	519	1,284	15.4	11.3	13.4
1976	620	505	1,125	12.3	10.6	11.5
1977	650	507	1,157	12.9	10.8	11.9
1978	635	471	1,106	12.8	10.1	11.5
1979	598	424	1,022	11.7	8.8	10.3
1980	533	407	940	10.6	8.6	9.6
1981	442	355	797	9.0	7.7	8.3
1982	474	333	807	10.4	7.6	9.0
1983	378	290	668	8.3	6.8	7.6
1984	392	268	660	8.7	6.3	7.5
1985	337	280	617	7.6	6.7	7.2
1986	345	259	604	8.0	6.3	7.1
1987	373	228	601	8.7	5.6	7.2
1988	320	246	566	7.3	5.9	6.6
1989	365	264	629	7.8	5.9	6.9
1990	355	264	619	7.1	5.6	6.4
1991	321	257	578	6.4	5.4	5.9
1992	302	220	522	6.1	4.7	5.4
1993	308	224	532	6.4	5.0	5.7
1994	291	213	504	6.3	4.8	5.6
1995	273	200	473	6.1	4.7	5.4
1996	219	175	394	5.0	4.2	4.6
1997	244	195	439	6.0	5.0	5.5
1998	230	195	425	5.9	5.2	5.6
1999	197	166	363	5.2	4.6	4.9
2000	216	127	343	5.8	3.6	4.8
2001	194	156	350	5.1	4.3	4.7
2002	187	159	346	5.0	4.5	4.8
2003	164	158	322	4.3	4.4	4.4
2004	172	169	341	4.5	4.7	4.6
2005[p]	212	145	357	5.4	3.9	4.7
2006[p]	217	192	410	5.2	4.8	5.0
2007[p]	205	171	376	4.7	4.2	4.5

p: Provisional data.

1. Children born alive who die before their first birthday.
2. Proportion of children born alive who die before their first birthday, expressed in "rate per 1,000 live births."

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

Table S11

Stillbirth rate[1] and perinatal[2], neonatal[3] and infantile[4] mortality rate,

Québec,
1976 to 2005

Year	Stillbirth rate	Mortality rate (0/00)					
	(0/00)	perinatal	neonatal early[5]	neonatal late[6]	total	post-neonatal[7]	infant
1976	7.8	14.2	6.5	1.3	7.8	3.7	11.5
1977	7.8	14.8	7.1	1.3	8.3	3.5	11.9
1978	6.6	13.5	6.9	1.4	8.2	3.3	11.5
1979	6.8	12.9	6.2	1.0	7.2	3.0	10.2
1980	6.0	11.6	5.6	1.0	6.6	3.1	9.6
1981	6.5	11.5	5.1	1.0	6.0	2.3	8.4
1982	5.9	10.9	5.0	0.9	5.9	3.0	8.9
1983	5.6	10.1	4.5	0.9	5.4	2.2	7.6
1984	5.5	10.1	4.6	0.9	5.4	2.1	7.5
1985	5.2	9.4	4.2	0.8	5.0	2.2	7.2
1986	4.9	9.4	4.5	0.7	5.3	1.9	7.1
1987	5.5	9.6	4.2	0.7	4.8	2.4	7.2
1988	4.4	8.3	3.8	0.7	4.5	2.0	6.6
1989	4.8	8.8	4.0	0.8	4.7	2.1	6.9
1990	4.3	7.9	3.7	0.8	4.5	1.9	6.3
1991	4.7	8.0	3.3	0.7	4.0	1.9	5.9
1992	4.3	7.3	3.1	0.5	3.6	1.9	5.4
1993	4.1	7.3	3.2	0.6	3.9	1.9	5.7
1994	4.0	7.1	3.1	0.7	3.8	1.7	5.6
1995	4.2	7.3	3.2	0.7	3.9	1.5	5.4
1996	3.9	6.8	2.9	0.5	3.4	1.2	4.6
1997	4.1	7.2	3.1	0.8	3.9	1.6	5.5
1998	4.2	7.5	3.3	0.7	4.0	1.6	5.6
1999	4.3	7.0	2.7	0.6	3.3	1.6	4.9
2000	4.3	7.0	2.7	0.7	3.5	1.3	4.8
2001	4.3	7.3	3.0	0.5	3.6	1.2	4.7
2002	3.9	6.9	3.0	0.6	3.6	1.1	4.8
2003	3.6	6.3	2.8	0.6	3.4	1.0	4.4
2004	4.0	7.0	3.1	0.6	3.7	0.9	4.6
2005	3.8	6.7	2.9	0.5	3.4	0.9	4.3

p: Provisional data.

1. The stillbirth rate is equal to the number of stillbirths divided by the sum of births and stillbirths, multiplied by 1,000. It is expressed in "rate per 1,000 births (live and still)." A stillbirth is a child born dead.
2. The perinatal mortality rate is equal to the number of stillbirths added to the number of infant deaths occurring in children aged less than 7 days, divided by the sum of births and stillbirths, multiplied by 1,000. It is expressed in "rate per 1,000 births (live and still)."
3. The neonatal mortality rate is equal to the number of infant deaths occurring in children aged less than 28 days, divided by the number of live births, multiplied by 1,000. It is expressed in "rate per 1,000 live births."
4. The infant mortality rate is equal to the number of children born alive who die before their first birthday, divided by the number of live births, multiplied by 1,000. It is expressed in "rate per 1,000 live births."
5. The early neonatal mortality rate is equal to the number of infant deaths occurring in children aged less than 7 days, divided by the number of live births, multiplied by 1,000. It is expressed in "rate per 1,000 live births."
6. The late neonatal mortality rate is equal to the number of infant deaths occurring in children aged 7 to 27 days, divided by the number of live births, multiplied by 1,000. It is expressed in "rate per 1,000 live births."
7. The post-neonatal mortality rate is equal to the number of infant deaths occurring in children aged 28 days to less than one year, divided by the number of live births, multiplied by 1,000. It is expressed in "rate per 1,000 live births."

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, January 2008.

Table S12

Life expectancy at birth and at 65 years of age,

by gender, Québec,
for three-year periods from 1980-1982 to 2005-2007

Age and sex	1980-1982	1985-1987	1990-1992	1995-1997	2000-2002	2005-2007[p]
At birth						
Men	71.18	72.16	73.69	74.60	76.29	78.26
Women	78.87	79.65	80.84	80.99	81.88	83.18
Gap	7.69	7.49	7.15	6.39	5.59	4.92
Both sexes	74.97	75.90	77.32	77.87	79.18	80.83
At 65 years of age						
Men	14.08	14.22	15.20	15.46	16.48	17.95
Women	18.70	19.00	19.86	19.77	20.36	21.45
Gap	4.62	4.78	4.66	4.31	3.88	3.50
Both sexes	16.53	16.78	17.74	17.83	18.62	19.89

p: Provisional data.

Source: Institut de la statistique du Québec **www.stat.gouv.qc.ca**.

MSSS, SDI, June 2008.

HUMAN RESOURCES

Here the tables illustrate the changing volume of human resources within the Québec health and social services system. Three main employee groups were specifically defined: the professionals paid by the RAMQ, including, first and foremost, the physicians, general practitioners and specialists; the managers and unionized employees of the network of health and social services institutions, including in particular the three categories of nursing staff (nurses, nursing assistants and attendants); and the administrative personnel, managers and unionized employees of the MSSS and the RAMQ. The data presented in these tables were collected by the Ministère, the RAMQ, as well as in the professional records transmitted by the RAMQ.

Table **H1**

Number of "active"[1] physicians per 1,000 people, by category of physician, Québec, *1990 to 2007*

Calendar year	General practitioners		Specialists		All physicians	
	Number	/ 1,000 pers.	Number	/ 1,000 pers.	Number	/ 1,000 pers.
1990	7,093	1.01	6,772	0.97	13,865	1.98
1991	7,085	1.00	6,883	0.97	13,968	1.98
1992	7,131	1.00	6,941	0.98	14,072	1.98
1993	7,099	0.99	7,131	1.00	14,230	1.99
1994	7,153	0.99	7,256	1.01	14,409	2.00
1995	7,243	1.00	7,301	1.01	14,544	2.01
1996	7,346	1.01	7,354	1.01	14,700	2.03
1997	7,063	0.97	7,228	0.99	14,291	1.96
1998	6,953	0.95	7,159	0.98	14,112	1.93
1999	7,114	0.97	7,154	0.98	14,268	1.95
2000	7,235	0.98	7,266	0.99	14,501	1.97
2001	7,369	1.00	7,411	1.00	14,780	2.00
2002	7,461	1.00	7,555	1.02	15,016	2.02
2003	7,550	1.01	7,717	1.03	15,267	2.04
2004	7,600	1.01	7,827	1.04	15,427	2.05
2005	7,702	1.02	7,968	1.05	15,670	2.07
2006	7,685	1.01	8,156	1.07	15,841	2.08
2007	7,789	1.02	8,298	1.09	16,087	2.11

1. Physicians subject to an agreement with the RAMQ, practising in Québec, having submitted at least one request for payment during the year.

Sources: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics; unpublished data obtained form the Direction des professionnels de la santé du MSSS.

MSSS, SDI, April 2008.

Table H2

Number of "active"[1] physicians

by category of physician and gender, Québec, *1976 to 2007*

Calendar year	General practitioners			Specialists			All physicians		
	Men	Women	% women	Men	Women	% women	Men	Women	% women
1976	3,860	444	10.3	4,789	304	6.0	8,649	748	8.0
1977	4,014	562	12.3	4,742	317	6.3	8,756	879	9.1
1978	4,215	704	14.3	4,980	386	7.2	9,195	1,090	10.6
1979	4,382	828	15.9	5,004	427	7.9	9,386	1,255	11.8
1980	4,545	960	17.4	5,078	469	8.5	9,623	1,429	12.9
1981	4,644	1,077	18.8	5,151	528	9.3	9,795	1,605	14.1
1982	4,721	1,186	20.1	5,201	566	9.8	9,922	1,752	15.0
1983	4,838	1,362	22.0	5,300	617	10.4	10,138	1,979	16.3
1984	4,834	1,462	23.2	5,258	652	11.0	10,092	2,114	17.3
1985	4,945	1,605	24.5	5,354	709	11.7	10,299	2,314	18.3
1986	5,004	1,732	25.7	5,443	783	12.6	10,447	2,515	19.4
1987	5,057	1,855	26.8	5,491	855	13.5	10,548	2,710	20.4
1988	5,090	1,981	28.0	5,557	915	14.1	10,647	2,896	21.4
1989	4,992	2,022	28.8	5,638	990	14.9	10,630	3,012	22.1
1990	4,959	2,134	30.1	5,699	1,073	15.8	10,658	3,207	23.1
1991	4,893	2,192	30.9	5,732	1,151	16.7	10,625	3,343	23.9
1992	4,843	2,288	32.1	5,714	1,227	17.7	10,557	3,515	25.0
1993	4,763	2,336	32.9	5,782	1,349	18.9	10,545	3,685	25.9
1994	4,730	2,423	33.9	5,818	1,437	19.8	10,548	3,860	26.8
1995	4,706	2,537	35.0	5,778	1,523	20.9	10,484	4,060	27.9
1996	4,708	2,638	35.9	5,757	1,597	21.7	10,465	4,235	28.8
1997	4,379	2,684	38.0	5,504	1,724	23.9	9,883	4,408	30.8
1998	4,191	2,762	39.7	5,363	1,796	25.1	9,554	4,558	32.3
1999	4,221	2,893	40.7	5,276	1,878	26.3	9,497	4,771	33.4
2000	4,266	2,969	41.0	5,286	1,980	27.3	9,552	4,949	34.1
2001	4,281	3,088	41.9	5,314	2,097	28.3	9,595	5,185	35.1
2002	4,275	3,186	42.7	5,341	2,214	29.3	9,616	5,400	36.0
2003	4,274	3,276	43.4	5,397	2,320	30.1	9,671	5,596	36.7
2004	4,244	3,356	44.2	5,416	2,411	30.8	9,660	5,767	37.4
2005	4,249	3,453	44.8	5,456	2,512	31.5	9,705	5,965	38.1
2006	4,143	3,542	46.1	5,532	2,624	32.2	9,675	6,166	38.9
2007[2]	4,155	3,634	46.7	5,585	2,713	32.7	9,740	6,347	39.5

1. Physicians subject to an agreement with the RAMQ, practising in Québec, having submitted at least one request for payment during the year.
2. Estimates made based on preliminary data from the fourth quarter of 2007.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, avril 2008.

Table H3

Number of
professionals[1] paid by the Régie de l'assurance maladie and "population per professional"
ratio, by professional category, Québec,
1990 to 2007

	All professionals		General practitioners		Specialists		Dentists (and oral surgeons)		Optometrists		Owner-pharmacists	
Calendar year	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
1990	18,857	371	7,093	987	6,772	1,034	2,763	2,535	1,004	6,976	1,225	5,717
1991	19,162	369	7,085	997	6,883	1,026	2,874	2,458	1,021	6,919	1,299	5,438
1992	19,338	368	7,131	997	6,941	1,024	2,902	2,449	1,050	6,770	1,314	5,409
1993	19,655	364	7,099	1,008	7,131	1,003	2,979	2,402	1,069	6,693	1,377	5,196
1994	19,945	361	7,153	1,005	7,256	991	3,054	2,355	1,088	6,610	1,394	5,159
1995	20,239	357	7,243	997	7,301	989	3,140	2,299	1,102	6,551	1,453	4,969
1996	20,482	354	7,346	987	7,354	985	3,196	2,267	1,114	6,505	1,472	4,923
1997	20,108	362	7,063	1,030	7,228	1,006	3,213	2,264	1,138	6,392	1,491	4,879
1998	20,031	364	6,953	1,049	7,159	1,019	3,262	2,237	1,162	6,279	1,495	4,880
1999	20,278	361	7,114	1,029	7,154	1,024	3,323	2,204	1,177	6,222	1,510	4,850
2000	20,543	358	7,235	1,017	7,266	1,013	3,316	2,219	1,185	6,208	1,541	4,774
2001	20,888	354	7,369	1,004	7,411	998	3,337	2,217	1,208	6,123	1,563	4,733
2002	21,227	351	7,461	998	7,555	985	3,366	2,211	1,219	6,106	1,626	4,578
2003	21,486	348	7,550	992	7,717	970	3,360	2,228	1,194	6,270	1,665	4,496
2004	21,750	346	7,600	990	7,827	962	3,402	2,213	1,225	6,145	1,696	4,438
2005	22,062	343	7,702	982	7,968	950	3,433	2,204	1,237	6,117	1,722	4,394
2006	22,355	340	7,685	987	8,156	932	3,581	2,123	1,235	6,156	1,698	4,478
2007	22,631	337	7,789	981	8,298	920	3,601	2,121	1,244	6,140	1,699	4,495

1. Professionals subject to an agreement with the RAMQ, practising in Québec, having submitted at least one request for payment during the year.

Sources: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics; unpublished data obtained form the Direction des professionnels de la santé du MSSS.

MSSS, SDI, April 2008.

Table H4

Proportion of regular full-time employees
within the management and unionized workforce of the Québec health and social services network,
and number of unionized employees per manager,
1990-1991 to 2006-2007

Job categories	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03[2]	03-04	04-05	05-06	06-07
Total workforce[1]	**169,978**	**172,464**	**172,286**	**172,045**	**171,592**	**169,368**	**164,435**	**157,498**	**157,816**	**164,230**	**169,027**	**172,944**	**187,287**	**191,217**	**193,778**	**197,112**	**199,521**
% OF RFT[3]	**62.3**	**62.4**	**62.7**	**62.7**	**62.7**	**63.0**	**62.7**	**58.5**	**58.6**	**58.7**	**58.6**	**58.6**	**52.4**	**55.4**	**55.6**	**55.5**	**55.3**
Managers	12,774	12,672	12,570	12,385	11,820	10,969	10,407	9,317	8,538	8,558	8,668	9,162	9,364	9,518	9,740	10,208	10,645
% of RFT[3]	89.8	89.8	89.7	89.9	90.4	91.7	92.0	91.9	91.4	91.0	91.4	90.3	89.9	90.7	90.8	90.9	90.5
Unionized employees	157,204	159,792	159,716	159,660	159,772	158,399	154,028	148,181	149,278	155,672	160,359	163,782	177,923	181,699	184,038	186,905	188,876
% of RFT[3]	60.1	60.2	60.6	60.6	60.7	61.0	60.7	56.4	56.8	56.9	56.9	56.8	53.2	53.5	53.7	53.5	53.3
Nbr of unionized employees/manager	**12.3**	**12.6**	**12.7**	**12.9**	**13.5**	**14.4**	**14.8**	**15.9**	**17.5**	**18.2**	**18.5**	**17.9**	**19.0**	**19.1**	**18.9**	**18.3**	**17.7**

1. Calculated in full-time equivalents (FTE).
2. The method used to calculate FTEs for part-time employees changed starting in 2002-2003. The number of part-time employees was henceforth determined in a manner similar to full-time employees. On the whole, this modification led to an increase in the number of FTEs in the order of 7.5 % for 2002-2003. This resulted in a break in sequence, making the data as of 2002-2003 difficult to compare with those of previous years. However, there is no break in sequence when the number of people employed is used.
3. Regular full-time.

Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table H5

General statistics
on managers and unionized employees of the Québec health and social services network,
by employment category,
1990-1991 to 2006-2007

Job categories	Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99[1]	99-00[1]	00-01	01-02	02-03[2]	03-04	04-05	05-06	06-07
All workforce	**Managers**	**240,461**	**242,360**	**239,231**	**241,445**	**239,448**	**235,371**	**228,923**	**216,312**	**222,882**	**228,634**	**233,982**	**238,559**	**242,071**	**246,111**	**249,123**	**251,623**	**255,062**
	Number of FTEs	**169,978**	**172,463**	**172,287**	**172,308**	**171,586**	**169,359**	**164,426**	**157,496**	**157,815**	**164,229**	**169,027**	**172,943**	**187,287**	**191,217**	**193,778**	**197,112**	**199,521**
	Sal. paid ($)	**5,176,440,044**	**5,573,565,270**	**5,757,263,476**	**5,896,247,301**	**5,947,585,795**	**5,894,187,107**	**5,770,364,625**	**5,605,939,297**	**5,665,454,901**	**5,895,332,935**	**6,498,946,337**	**6,792,476,170**	**7,020,548,587**	**7,364,343,788**	**7,516,062,304**	**7,655,999,757**	**8,334,574,764**
	Overtime ($)	**68,006,062**	**70,021,423**	**65,575,925**	**59,197,201**	**53,536,238**	**48,497,769**	**51,604,984**	**74,967,093**	**96,194,838**	**120,490,057**	**152,711,344**	**177,498,315**	**185,204,484**	**202,406,591**	**218,613,952**	**225,985,476**	**277,662,400**
Managers	**Number staffed**	**14,874**	**14,686**	**14,455**	**14,254**	**13,472**	**12,263**	**11,371**	**9,878**	**9,593**	**9,525**	**9,523**	**10,106**	**10,140**	**10,314**	**10,498**	**11,196**	**11,684**
	Number of FTEs	**12,774**	**12,672**	**12,570**	**12,385**	**11,821**	**10,974**	**10,400**	**9,316**	**8,538**	**8,558**	**8,668**	**9,162**	**9,364**	**9,518**	**9,740**	**10,208**	**10,645**
	Average sal. ($)	**51,400**	**53,418**	**55,611**	**56,711**	**57,630**	**58,060**	**58,404**	**60,364**	**62,330**	**63,120**	**67,954**	**71,085**	**71,567**	**73,345**	**73,640**	**74,119**	**75,899**
	Sal. paid ($)	**658,847,920**	**687,381,787**	**707,802,136**	**711,668,902**	**690,102,216**	**645,626,914**	**600,414,095**	**557,625,448**	**528,236,355**	**540,430,072**	**577,386,508**	**651,255,342**	**657,438,024**	**688,491,416**	**705,245,836**	**741,888,412**	**794,069,180**
Unionized staff	**Number staffed**	**225,587**	**227,674**	**224,776**	**227,191**	**225,976**	**223,108**	**217,552**	**206,434**	**213,289**	**219,109**	**224,459**	**228,453**	**231,932**	**235,797**	**238,625**	**240,427**	**243,378**
	Number of FTEs	**157,204**	**159,791**	**159,717**	**159,923**	**159,765**	**158,385**	**154,026**	**148,180**	**149,277**	**155,671**	**160,359**	**163,781**	**177,923**	**181,699**	**184,038**	**186,905**	**188,876**
	Average sal. ($)	**30,470**	**31,017**	**32,367**	**32,957**	**33,348**	**33,712**	**34,405**	**34,926**	**35,000**	**35,038**	**37,957**	**38,940**	**38,763**	**39,994**	**40,112**	**40,223**	**42,873**
	Sal. paid ($)	**4,517,592,124**	**4,886,183,483**	**5,049,461,340**	**5,184,578,399**	**5,257,483,579**	**5,248,560,193**	**5,169,950,530**	**5,048,313,849**	**5,137,218,546**	**5,354,902,863**	**5,921,559,829**	**6,141,220,828**	**6,363,110,563**	**6,675,852,372**	**6,810,816,468**	**6,914,111,345**	**7,540,505,584**
	Overtime ($)	**68,006,062**	**70,021,423**	**65,575,925**	**59,197,201**	**53,536,238**	**48,497,769**	**51,604,984**	**74,967,093**	**96,194,838**	**120,490,057**	**152,711,344**	**177,498,315**	**185,204,484**	**202,406,591**	**218,613,952**	**225,985,476**	**277,662,400**
Professionals	**Number staffed**	**14,972**	**15,588**	**15,318**	**17,004**	**17,780**	**18,293**	**18,742**	**19,217**	**20,768**	**21,780**	**22,936**	**23,962**	**25,180**	**26,340**	**27,154**	**27,851**	**28,551**
	Number of FTEs	11,161	11,672	12,286	12,611	13,225	13,560	13,914	14,113	14,940	16,058	17,033	17,738	19,420	20,391	20,997	21,779	22,229
	Average sal. ($)	43,288	43,692	47,026	47,989	48,623	49,198	50,125	50,625	50,389	50,274	53,837	55,169	55,047	56,428	56,569	56,771	58,608
	Sal. paid ($)	459,664,233	501,718,837	551,119,662	589,193,337	649,141,613	652,948,907	677,147,066	692,781,972	736,513,672	790,206,232	889,740,586	940,900,916	1,003,429,988	1,081,315,044	1,113,853,818	1,156,621,806	1,221,957,854
	Overtime ($)	2,802,997	3,051,365	3,184,824	2,864,546	2,875,755	3,063,008	3,223,636	5,987,861	11,445,687	14,123,879	12,486,531	13,784,329	15,277,399	17,071,899	19,796,788	20,686,006	23,616,077
Graduate nurses	**Number staffed**	**3,859**	**4,454**	**5,009**	**5,405**	**5,935**	**6,527**	**7,058**	**7,322**	**8,046**	**8,845**	**11,189**	**12,224**	**12,467**	**12,447**	**13,181**	**13,662**	**14,001**
	Number of FTEs	2,779	3,228	3,658	4,010	4,416	4,920	5,271	5,588	6,099	6,932	8,654	9,411	10,001	10,068	10,531	11,069	11,427
	Average sal. ($)	40,222	41,633	43,878	45,183	46,216	47,032	48,050	48,702	48,634	48,492	54,513	56,074	55,574	58,203	58,088	58,069	59,776
	Sal. paid ($)	104,135,957	131,467,124	155,481,716	176,666,472	198,699,009	224,662,012	244,517,088	263,199,586	289,571,522	327,287,637	456,669,984	503,720,289	524,783,886	538,360,582	573,958,787	597,613,694	638,305,479
	Overtime ($)	1,473,069	1,569,351	1,801,557	1,609,272	1,443,783	1,416,750	1,582,846	3,128,369	4,569,880	6,888,959	12,352,948	18,568,412	19,179,000	20,207,875	23,277,856	24,434,994	29,305,894
Nurses	**Number staffed**	**47,714**	**47,998**	**47,602**	**47,934**	**47,585**	**47,019**	**45,753**	**43,482**	**44,501**	**44,552**	**42,298**	**41,054**	**41,255**	**41,793**	**41,394**	**41,047**	**40,956**
	Number of FTEs	32,032	32,329	32,243	32,381	32,249	31,910	30,652	29,913	30,478	31,395	30,594	29,921	32,251	32,806	32,591	32,343	32,305
	Average sal. ($)	36,700	37,620	38,987	39,660	40,000	40,327	41,096	41,316	41,009	40,927	45,073	46,269	46,109	47,128	47,097	47,052	51,715
	Sal. paid ($)	1,088,291,236	1,194,362,986	1,224,845,416	1,258,749,349	1,263,493,111	1,260,723,649	1,226,555,225	1,204,651,446	1,227,614,203	1,258,648,780	1,345,608,076	1,332,250,231	1,355,468,030	1,390,280,400	1,408,512,838	1,386,320,922	1,550,401,545
	Overtime ($)	28,901,442	29,948,883	27,272,268	24,424,964	22,049,656	19,183,610	20,986,174	29,930,951	36,855,655	46,208,380	63,595,025	73,949,646	75,751,280	80,770,039	83,733,996	84,023,714	102,415,197
Technicians	**Number staffed**	**29,968**	**30,529**	**30,589**	**31,425**	**32,037**	**32,101**	**31,782**	**30,972**	**31,983**	**32,794**	**33,432**	**34,602**	**35,599**	**36,330**	**36,733**	**36,730**	**37,370**
	Number of FTEs	21,457	22,042	22,327	22,630	23,135	23,260	22,915	22,472	22,944	23,962	24,523	25,485	27,701	28,381	28,856	29,127	29,668
	Average sal. ($)	33,850	34,293	35,575	36,173	36,452	36,772	37,447	37,819	37,698	37,598	40,449	41,374	41,188	42,407	42,501	42,586	45,779
	Sal. paid ($)	687,843,324	745,613,706	776,685,152	804,994,040	828,721,531	840,132,699	836,230,796	828,175,876	850,795,760	887,234,377	966,203,477	1,017,754,112	1,065,544,406	1,123,042,078	1,146,766,936	1,159,263,247	1,300,550,658
	Overtime ($)	13,198,895	13,981,282	13,516,190	12,849,571	11,794,952	11,244,547	11,115,949	14,922,233	19,060,763	22,230,550	24,821,997	28,451,687	30,397,947	33,108,233	35,915,844	36,284,887	42,962,449
Assistant technicians	**Number staffed**	**62,764**	**62,998**	**61,608**	**61,581**	**60,639**	**59,457**	**57,840**	**54,187**	**55,798**	**57,802**	**60,403**	**61,709**	**62,573**	**63,306**	**64,399**	**64,842**	**65,945**
	Number of FTEs	41,694	42,038	41,391	41,265	40,918	40,329	39,065	37,221	37,058	38,563	40,193	41,290	45,981	46,971	47,683	48,526	49,173
	Average sal. ($)	25,839	26,356	27,226	27,534	27,584	27,635	27,948	28,070	27,903	27,823	29,561	30,240	30,122	31,197	31,306	31,415	33,846
	Sal. paid ($)	1,014,127,065	1,085,293,096	1,105,244,034	1,119,054,532	1,110,885,523	1,096,765,511	1,064,913,477	1,017,190,737	1,015,582,341	1,051,776,699	1,151,884,916	1,199,917,942	1,242,152,778	1,315,608,370	1,333,038,072	1,360,400,759	1,507,753,664
	Overtime ($)	12,016,270	11,389,906	10,465,977	8,967,178	7,646,640	6,431,351	7,033,784	10,055,222	11,948,712	16,715,718	23,702,543	26,324,179	28,059,340	32,780,523	35,248,826	38,833,894	53,170,314
Office employees	**Number staffed**	**28,237**	**28,402**	**27,975**	**27,790**	**27,243**	**26,540**	**25,431**	**23,729**	**24,460**	**25,160**	**25,712**	**26,112**	**26,460**	**27,215**	**27,306**	**27,711**	**28,046**
	Number of FTEs	21,066	21,345	21,271	21,083	20,802	20,385	19,670	18,695	18,525	19,130	19,546	19,879	21,312	21,930	22,138	22,611	22,831
	Average sal. ($)	24,565	24,827	25,644	25,920	26,035	26,110	26,434	26,650	26,602	26,593	28,389	29,125	29,091	30,009	30,125	30,229	32,259
	Sal. paid ($)	492,222,994	525,044,899	536,338,313	540,746,639	534,846,184	526,408,599	510,515,230	489,510,178	487,404,092	501,885,713	540,551,764	559,567,555	578,557,983	616,206,352	621,924,071	636,115,122	689,805,388
	Overtime ($)	3,731,418	3,876,013	3,486,096	3,187,514	2,861,650	2,641,246	2,959,171	4,636,712	5,705,444	6,943,708	7,410,143	7,797,516	8,283,504	9,287,243	10,490,898	10,948,762	13,734,892
Auxiliary staff	**Number staffed**	**37,193**	**36,710**	**35,766**	**35,226**	**34,067**	**32,558**	**30,451**	**27,051**	**27,178**	**27,408**	**27,435**	**27,760**	**27,378**	**27,369**	**27,490**	**27,609**	**27,799**
	Number of FTEs	26,391	26,400	25,835	25,276	24,468	23,559	22,127	19,857	18,849	19,144	19,131	19,300	20,487	20,445	20,516	20,714	20,781
	Average sal. ($)	26,098	26,120	26,922	27,206	27,296	27,340	27,646	27,896	27,898	27,912	29,742	30,488	30,372	31,244	31,310	31,305	32,282
	Sal. paid ($)	661,726,054	690,289,507	687,533,100	683,918,274	662,318,839	638,978,985	602,803,243	546,653,477	521,959,853	528,636,724	555,896,478	570,614,584	577,731,623	593,938,938	594,880,937	599,198,099	621,526,512
	Overtime ($)	5,855,141	6,156,713	5,796,817	5,238,242	4,827,041	4,494,916	4,675,411	6,276,665	6,573,468	7,328,015	8,258,458	8,490,673	8,161,027	9,050,984	10,017,082	10,645,374	12,346,582
Students in training and students	**Number staffed**	**880**	**995**	**909**	**826**	**690**	**613**	**495**	**474**	**555**	**768**	**1,054**	**1,030**	**1,019**	**997**	**968**	**975**	**710**
	Number of FTEs	624	737	706	667	552	462	412	321	384	487	685	757	770	707	725	735	461
	Average sal. ($)	15,461	16,777	16,951	16,592	16,769	17,249	17,651	18,977	20,153	18,971	21,864	21,657	21,729	26,079	26,407	27,400	24,339
	Sal. paid ($)	9,581,261	12,393,328	12,213,947	11,255,756	9,377,769	7,939,831	7,268,405	6,150,577	7,777,103	9,226,701	15,004,548	16,495,199	15,441,869	17,100,608	17,881,009	18,577,696	10,204,484
	Overtime ($)	26,830	47,910	52,196	55,914	36,761	22,341	28,013	29,080	35,229	50,848	83,699	131,873	94,988	129,795	132,662	127,846	110,994

1. Average salaries from 1998-1999 and 1999-2000 do not take retroactivity into account. The retroactivity applied was of 1.5% in 1998-1999 and 2.5% in 1999-2000.
2. The method used to calculate FTEs changed starting in 2002-2003. The number of part-time employees was henceforth determined in a manner similar to full-time employees. On the whole, this modification led to an increase in the number of FTEs in the order of 7.5 % for 2002-2003. This resulted in a break in sequence, making the data as of 2002-2003 impossible to compare with those of previous years. However, there is no break in sequence when the number of people employed is used. The average salaries and salaries paid do not take into account the pay equity adjustment made in November 2001 and 2002.

Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table H5

General statistics
on managers and unionized employees of the Québec health and social services network,
by employment category,
1990-1991 to 2006-2007

Job categories	Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97
All workforce	**Managers**	**240,461**	**242,360**	**239,231**	**241,445**	**239,448**	**235,371**	**228,923**
	Number of FTEs	**169,978**	**172,463**	**172,287**	**172,308**	**171,586**	**169,359**	**164,426**
	Sal. paid ($)	**5,176,440,044**	**5,573,565,270**	**5,757,263,476**	**5,896,247,301**	**5,947,585,795**	**5,894,187,107**	**5,770,364,625**
	Overtime ($)	**68,006,062**	**70,021,423**	**65,575,925**	**59,197,201**	**53,536,238**	**48,497,769**	**51,604,984**
Managers	**Number staffed**	**14,874**	**14,686**	**14,455**	**14,254**	**13,472**	**12,263**	**11,371**
	Number of FTEs	**12,774**	**12,672**	**12,570**	**12,385**	**11,821**	**10,974**	**10,400**
	Average sal. ($)	**51,400**	**53,418**	**55,611**	**56,711**	**57,630**	**58,060**	**58,404**
	Sal. paid ($)	**658,847,920**	**687,381,787**	**707,802,136**	**711,668,902**	**690,102,216**	**645,626,914**	**600,414,095**
Unionized staff	**Number staffed**	**225,587**	**227,674**	**224,776**	**227,191**	**225,976**	**223,108**	**217,552**
	Number of FTEs	**157,204**	**159,791**	**159,717**	**159,923**	**159,765**	**158,385**	**154,026**
	Average sal. ($)	**30,470**	**31,017**	**32,367**	**32,957**	**33,348**	**33,712**	**34,405**
	Sal. paid ($)	**4,517,592,124**	**4,886,183,483**	**5,049,461,340**	**5,184,578,399**	**5,257,483,579**	**5,248,560,193**	**5,169,950,530**
	Overtime ($)	**68,006,062**	**70,021,423**	**65,575,925**	**59,197,201**	**53,536,238**	**48,497,769**	**51,604,984**
Professionals	**Number staffed**	**14,972**	**15,588**	**15,318**	**17,004**	**17,780**	**18,293**	**18,742**
	Number of FTEs	11,161	11,672	12,286	12,611	13,225	13,560	13,914
	Average sal. ($)	43,288	43,692	47,026	47,989	48,623	49,198	50,125
	Sal. paid ($)	459,664,233	501,718,837	551,119,662	589,193,337	649,141,613	652,948,907	677,147,066
	Overtime ($)	2,802,997	3,051,365	3,184,824	2,864,546	2,875,755	3,063,008	3,223,636
Graduate nurses	**Number staffed**	**3,859**	**4,454**	**5,009**	**5,405**	**5,935**	**6,527**	**7,058**
	Number of FTEs	2,779	3,228	3,658	4,010	4,416	4,920	5,271
	Average sal. ($)	40,222	41,633	43,878	45,183	46,216	47,032	48,050
	Sal. paid ($)	104,135,957	131,467,124	155,481,716	176,666,472	198,699,009	224,662,012	244,517,088
	Overtime ($)	1,473,069	1,569,351	1,801,557	1,609,272	1,443,783	1,416,750	1,582,846
Nurses	**Number staffed**	**47,714**	**47,998**	**47,602**	**47,934**	**47,585**	**47,019**	**45,753**
	Number of FTEs	32,032	32,329	32,243	32,381	32,249	31,910	30,652
	Average sal. ($)	36,700	37,620	38,987	39,660	40,000	40,327	41,096
	Sal. paid ($)	1,088,291,236	1,194,362,986	1,224,845,416	1,258,749,349	1,263,493,111	1,260,723,649	1,226,555,225
	Overtime ($)	28,901,442	29,948,883	27,272,268	24,424,964	22,049,656	19,183,610	20,986,174
Technicians	**Number staffed**	**29,968**	**30,529**	**30,589**	**31,425**	**32,037**	**32,101**	**31,782**
	Number of FTEs	21,457	22,042	22,327	22,630	23,135	23,260	22,915
	Average sal. ($)	33,850	34,293	35,575	36,173	36,452	36,772	37,447
	Sal. paid ($)	687,843,324	745,613,706	776,685,152	804,994,040	828,721,531	840,132,699	836,230,796
	Overtime ($)	13,198,895	13,981,282	13,516,190	12,849,571	11,794,952	11,244,547	11,115,949
Assistant technicians	**Number staffed**	**62,764**	**62,998**	**61,608**	**61,581**	**60,639**	**59,457**	**57,840**
	Number of FTEs	41,694	42,038	41,391	41,265	40,918	40,329	39,065
	Average sal. ($)	25,839	26,356	27,226	27,534	27,584	27,635	27,948
	Sal. paid ($)	1,014,127,065	1,085,293,096	1,105,244,034	1,119,054,532	1,110,885,523	1,096,765,511	1,064,913,477
	Overtime ($)	12,016,270	11,389,906	10,465,977	8,967,178	7,646,640	6,431,351	7,033,784
Office employees	**Number staffed**	**28,237**	**28,402**	**27,975**	**27,790**	**27,243**	**26,540**	**25,431**
	Number of FTEs	21,066	21,345	21,271	21,083	20,802	20,385	19,670
	Average sal. ($)	24,565	24,827	25,644	25,920	26,035	26,110	26,434
	Sal. paid ($)	492,222,994	525,044,899	536,338,313	540,746,639	534,846,184	526,408,599	510,515,230
	Overtime ($)	3,731,418	3,876,013	3,486,096	3,187,514	2,861,650	2,641,246	2,959,171
Auxiliary staff	**Number staffed**	**37,193**	**36,710**	**35,766**	**35,226**	**34,067**	**32,558**	**30,451**
	Number of FTEs	26,391	26,400	25,835	25,276	24,468	23,559	22,127
	Average sal. ($)	26,098	26,120	26,922	27,206	27,296	27,340	27,646
	Sal. paid ($)	661,726,054	690,289,507	687,533,100	683,918,274	662,318,839	638,978,985	602,803,243
	Overtime ($)	5,855,141	6,156,713	5,796,817	5,238,242	4,827,041	4,494,916	4,675,411
Students in training and students	**Number staffed**	**880**	**995**	**909**	**826**	**690**	**613**	**495**
	Number of FTEs	624	737	706	667	552	462	412
	Average sal. ($)	15,461	16,777	16,951	16,592	16,769	17,249	17,651
	Sal. paid ($)	9,581,261	12,393,328	12,213,947	11,255,756	9,377,769	7,939,831	7,268,405
	Overtime ($)	26,830	47,910	52,196	55,914	36,761	22,341	28,013

1. Average salaries from 1998-1999 and 1999-2000 do not take retroactivity into account. The retroactivity applied was of 1.5% in 1998-1999 and 2.5% in 1999-2000.
2. The method used to calculate FTEs changed starting in 2002-2003. The number of part-time employees was henceforth determined in a manner similar to full-time employees. On the whole, this modification led to an increase in the number of FTEs in the order of 7.5 % for 2002-2003. This resulted in a break in sequence, making the data as of 2002-2003 impossible to compare with those of previous years. However, there is no break in sequence when the number of people employed is used. The average salaries and salaries paid do not take into account the pay equity adjustment made in November 2001 and 2002.

Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

97-98	98-99[1]	99-00[1]	00-01	01-02	02-03[2]	03-04	04-05	05-06	06-07
216,312	**222,882**	**228,634**	**233,982**	**238,559**	**242,071**	**246,111**	**249,123**	**251,623**	**255,062**
157,496	**157,815**	**164,229**	**169,027**	**172,943**	**187,287**	**191,217**	**193,778**	**197,112**	**199,521**
5,605,939,297	**5,665,454,901**	**5,895,332,935**	**6,498,946,337**	**6,792,476,170**	**7,020,548,587**	**7,364,343,788**	**7,516,062,304**	**7,655,999,757**	**8,334,574,764**
74,967,093	**96,194,838**	**120,490,057**	**152,711,344**	**177,498,315**	**185,204,484**	**202,406,591**	**218,613,952**	**225,985,476**	**277,662,400**
9,878	**9,593**	**9,525**	**9,523**	**10,106**	**10,140**	**10,314**	**10,498**	**11,196**	**11,684**
9,316	**8,538**	**8,558**	**8,668**	**9,162**	**9,364**	**9,518**	**9,740**	**10,208**	**10,645**
60,364	**62,330**	**63,120**	**67,954**	**71,085**	**71,567**	**73,345**	**73,640**	**74,119**	**75,899**
557,625,448	**528,236,355**	**540,430,072**	**577,386,508**	**651,255,342**	**657,438,024**	**688,491,416**	**705,245,836**	**741,888,412**	**794,069,180**
206,434	**213,289**	**219,109**	**224,459**	**228,453**	**231,931**	**235,797**	**238,625**	**240,427**	**243,378**
148,180	**149,277**	**155,671**	**160,359**	**163,781**	**177,923**	**181,699**	**184,038**	**186,905**	**188,876**
34,926	**35,000**	**35,038**	**37,957**	**38,940**	**38,763**	**39,994**	**40,112**	**40,223**	**42,873**
5,048,313,849	**5,137,218,546**	**5,354,902,863**	**5,921,559,829**	**6,141,220,828**	**6,363,110,563**	**6,675,852,372**	**6,810,816,468**	**6,914,111,345**	**7,540,505,584**
74,967,093	**96,194,838**	**120,490,057**	**152,711,344**	**177,498,315**	**185,204,484**	**202,406,591**	**218,613,952**	**225,985,476**	**277,662,400**
19,217	**20,768**	**21,780**	**22,936**	**23,962**	**25,180**	**26,340**	**27,154**	**27,851**	**28,551**
14,113	14,940	16,058	17,033	17,738	19,420	20,391	20,997	21,779	22,229
50,625	50,389	50,274	53,837	55,169	55,047	56,428	56,569	56,771	58,608
692,781,972	736,513,672	790,206,232	889,740,586	940,900,916	1,003,429,988	1,081,315,044	1,113,853,818	1,156,621,806	1,221,957,854
5,987,861	11,445,687	14,123,879	12,486,531	13,784,329	15,277,399	17,071,899	19,796,788	20,686,006	23,616,077
7,322	**8,046**	**8,845**	**11,189**	**12,224**	**12,467**	**12,447**	**13,181**	**13,662**	**14,001**
5,588	6,099	6,932	8,654	9,411	10,001	10,068	10,531	11,069	11,427
48,702	48,634	48,492	54,513	56,074	55,574	58,203	58,088	58,069	59,776
263,199,586	289,571,522	327,287,637	456,669,984	503,720,289	524,783,886	538,360,582	573,958,787	597,613,694	638,305,479
3,128,369	4,569,880	6,888,959	12,352,948	18,568,412	19,179,000	20,207,875	23,277,856	24,434,994	29,305,894
43,482	**44,501**	**44,552**	**42,298**	**41,054**	**41,255**	**41,793**	**41,394**	**41,047**	**40,956**
29,913	30,478	31,395	30,594	29,921	32,251	32,806	32,591	32,343	32,305
41,316	41,009	40,927	45,073	46,269	46,109	47,128	47,097	47,052	51,715
1,204,651,446	1,227,614,203	1,258,648,780	1,345,608,076	1,332,250,231	1,355,468,030	1,390,280,400	1,408,512,838	1,386,320,922	1,550,401,545
29,930,951	36,855,655	46,208,380	63,595,025	73,949,646	75,751,280	80,770,039	83,733,996	84,023,714	102,415,197
30,972	**31,983**	**32,794**	**33,432**	**34,602**	**35,599**	**36,330**	**36,733**	**36,730**	**37,370**
22,472	22,944	23,962	24,523	25,485	27,701	28,381	28,856	29,127	29,668
37,819	37,698	37,598	40,449	41,374	41,188	42,407	42,501	42,586	45,779
828,175,876	850,795,760	887,234,377	966,203,477	1,017,754,112	1,065,544,406	1,123,042,078	1,146,766,936	1,159,263,247	1,300,550,658
14,922,233	19,060,763	22,230,550	24,821,997	28,451,687	30,397,947	33,108,233	35,915,844	36,284,887	42,962,449
54,187	**55,798**	**57,802**	**60,403**	**61,709**	**62,573**	**63,306**	**64,399**	**64,842**	**65,945**
37,221	37,058	38,563	40,193	41,290	45,981	46,971	47,683	48,526	49,173
28,070	27,903	27,823	29,561	30,240	30,122	31,197	31,306	31,415	33,846
1,017,190,737	1,015,582,341	1,051,776,699	1,151,884,916	1,199,917,942	1,242,152,778	1,315,608,370	1,333,038,072	1,360,400,759	1,507,753,664
10,055,222	11,948,712	16,715,718	23,702,543	26,324,179	28,059,340	32,780,523	35,248,826	38,833,894	53,170,314
23,729	**24,460**	**25,160**	**25,712**	**26,112**	**26,460**	**27,215**	**27,306**	**27,711**	**28,046**
18,695	18,525	19,130	19,546	19,879	21,312	21,930	22,138	22,611	22,831
26,650	26,602	26,593	28,389	29,125	29,091	30,009	30,125	30,229	32,259
489,510,178	487,404,092	501,885,713	540,551,764	559,567,555	578,557,983	616,206,352	621,924,071	636,115,122	689,805,388
4,636,712	5,705,444	6,943,708	7,410,143	7,797,516	8,283,504	9,287,243	10,490,898	10,948,762	13,734,892
27,051	**27,178**	**27,408**	**27,435**	**27,760**	**27,378**	**27,369**	**27,490**	**27,609**	**27,799**
19,857	18,849	19,144	19,131	19,300	20,487	20,445	20,516	20,714	20,781
27,896	27,898	27,912	29,742	30,488	30,372	31,244	31,310	31,305	32,282
546,653,477	521,959,853	528,636,724	555,896,478	570,614,584	577,731,623	593,938,938	594,880,937	599,198,099	621,526,512
6,276,665	6,573,468	7,328,015	8,258,458	8,490,673	8,161,027	9,050,984	10,017,082	10,645,374	12,346,582
474	**555**	**768**	**1,054**	**1,030**	**1,019**	**997**	**968**	**975**	**710**
321	384	487	685	757	770	707	725	735	461
18,977	20,153	18,971	21,864	21,657	21,729	26,079	26,407	27,400	24,339
6,150,577	7,777,103	9,226,701	15,004,548	16,495,199	15,441,869	17,100,608	17,881,009	18,577,696	10,204,484
29,080	35,229	50,848	83,699	131,873	94,988	129,795	132,662	127,846	110,994

Table H6

Nursing staff calculated in positions filled and full-time equivalents

in the Québec health and social services network, by category of nursing staff, *1990-1991 to 2006-2007*

Year	Unit	Nurses	Nursing assistants	Health care attendants	All nursing staff
1990-1991	Employed	51,573	17,682	31,313	**100,568**
	FTE	34,813	11,729	20,264	**66,806**
1991-1992	Employed	52,452	17,590	31,575	**101,617**
	FTE	35,555	11,794	20,581	**67,930**
1992-1993	Employed	52,611	17,411	31,021	**101,043**
	FTE	35,902	11,627	20,189	**67,718**
1993-1994	Employed	53,339	17,385	30,957	**101,681**
	FTE	36,388	11,548	20,128	**68,064**
1994-1995	Employed	53,520	17,460	30,894	**101,874**
	FTE	36,666	11,619	20,323	**68,608**
1995-1996	Employed	53,546	17,235	30,211	**100,992**
	FTE	36,830	11,456	20,079	**68,365**
1996-1997	Employed	52,811	16,379	30,010	**99,200**
	FTE	35,924	10,872	19,718	**66,515**
1997-1998	Employed	50,804	14,226	29,192	**94,222**
	FTE	35,500	9,878	19,336	**64,714**
1998-1999	Employed	52,547	14,090	30,901	**97,538**
	FTE	36,576	9,281	20,070	**65,927**
1999-2000	Employed	53,397	14,029	32,515	**99,941**
	FTE	38,327	9,358	21,113	**68,797**
2000-2001	Employed	53,487	14,046	34,514	**102,047**
	FTE	39,248	9,395	22,351	**70,995**
2001-2002	Employed	53,278	13,844	35,633	**102,755**
	FTE	39,332	9,395	23,080	**71,808**
2002-2003[1]	Employed	53,722	13,794	36,224	**103,740**
	FTE	42,253	10,357	26,075	**78,685**
2003-2004	Employed	54,240	13,862	36,484	**104,586**
	FTE	42,874	10,510	26,515	**79,899**
2004-2005	Employed	54,575	14,230	36,886	**105,691**
	FTE	43,122	10,721	26,800	**80,643**
2005-2006	Employed	54,709	14,638	36,850	**106,197**
	FTE	43,412	10,970	27,149	**81,531**
2006-2007	Employed	54,957	14,848	37,587	**107,392**
	FTE	43,733	11,163	27,546	**82,441**

1. The method used to calculate FTEs for part-time employees changed starting in 2002-2003. The number of part-time employees was henceforth determined in a manner similar to full-time employees. On the whole, this modification led to an increase in the number of FTEs in the order of 7.5 % for 2002-2003. This resulted in a break in sequence, making the data as of 2002-2003 difficult to compare with those of previous years. However, there is no break in sequence when the number of people employed is used.

Source: Network staff: employees and managers, R22 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table H7

Administrative workforce[1] of the Ministère de la Santé et des Services sociaux du Québec and of the Régie de l'assurance maladie du Québec,

by employment category, situation observed on March 31,
1990 to 2008

Job categories	90	91	92	93	94	95	96	97	98	99
MSSS[2]										
All	**1,093**	**1,078**	**1 067**	**997**	**942**	**926**	**886**	**803**	**700**	**678**
Manager	116	119	116	108	101	102	79	66	57	52
Professional	544	540	540	513	491	481	476	434	382	375
Public servant	433	419	411	376	350	343	331	303	261	251
Nbr of employees per manager	8.4	8.1	8.2	8.2	8.3	8.1	10.2	11.2	11.3	12.0
RAMQ[3]										
All	**1,085**	**1,101**	**1,078**	**1,113**	**1,114**	**1,121**	**1,114**	**1,057**	**1,007**	**1,021**
Manager	98	95	99	96	89	83	80	67	61	64
Professional	226	244	258	279	275	282	282	275	260	265
Public servant	761	762	721	738	750	756	752	715	686	692
Nbr of employees per manager	10.1	10.6	9.9	10.6	11.5	12.5	12.9	14.8	15.5	15.0

Job categories	00	01	02	03	04	05	06	07	08
MSSS[2]									
All	**660**	**706**	**699**	**751**	**780**	**750**	**720**	**676**	**662**
Manager	49	59	59	62	69	65	71	67	71
Professional	366	400	401	434	454	441	420	390	387
Public servant	245	247	239	255	257	244	229	219	204
Nbr of employees per manager	12.5	11.0	10.8	11.1	10.3	10.5	9.1	9.1	8.3
RAMQ[3]									
All	**1,023**	**1,062**	**1,248**	**1,288**	**1,267**	**1,295**	**1,240**	**1,213**	**1,161**
Manager	68	66	66	72	66	70	74	76	72
Professional	278	333	395	420	434	444	451	470	468
Public servant	677	663	787	796	767	781	715	667	621
Nbr of employees per manager	14.0	15.1	17.9	16.9	18.2	17.5	15.8	15.0	15.1

1. Staffed authorized positions.
2. Regular staff, excluding casual employees, contract staff, students in training, political cabinet employees and employees on loan.
3. Regular permanent staff.

Sources: Direction des services au personnel du ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** human resources department.

MSSS, SDI, April 2008.

INSTITUTIONAL RESOURCES

The tables grouped together in this section present progressive data on the distribution of network health and social services institutions, i.e., public and private businesses that take on missions devolved to them by law, on the distribution of the facilities they oversee, i.e., the physical sites where the health and social services required by the population are provided, as well as on the distribution of beds, whether registered with an operating permit issued by the MSSS or set-up beds, i.e., beds that are staffed and ready for use. All of the data presented in these tables come from various Ministère publications.

Table **I1**

Change in the number
of public and private institutions in the Québec health and social services network,
network, by grouping of missions assumed, situation observed on March 31,
1990 to 2008

Amalgamation of missions	90	91	92	93	94	95	96	97	98	99
Total institutions	**920**	**895**	**884**	**880**	**843**	**774**	**700**	**574**	**531**	**503**
CLSC	129	128	128	128	127	128	128	100	82	72
CH	27	27	27	26	29	29	27	23	19	19
CPEJ	14	13	13	16	14	12	5	1	1	1
CHSLD	465	442	430	424	382	333	294	218	195	181
CR	124	124	122	120	125	108	82	65	62	57
CLSC-CH	5	6	6	5	7	7	7	4	1	1
CLSC-CPEJ				1						
CLSC-CHSLD	15	15	15	15	14	14	14	29	40	45
CLSC-CR	2	2	2	2	3	3	3	4	3	3
CH-CHSLD	108	107	110	112	110	109	103	81	77	70
CH-CR				1	1	1				
CPEJ-CHSLD		1								
CPEJ-CR[1]		1	1	2	4	11	15	15	15	15
CHSLD-CR	8	7	8	8	7	6	5	5	4	3
CLSC-CH-CHSLD	5	5	5	6	5	5	5	14	18	22
CLSC-CHSLD-CR										1
CH-CPEJ-CHSLD	1	1								
CH-CHSLD-CR	15	15	14	14	13	12	12	12	10	9
CLSC-CH-CPEJ-CHSLD			1	1	1	1				
CLSC-CH-CHSLD-CR									1	1
CH-CPEJ-CHSLD-CR	1									
CLSC-CH-CPEJ-CHSLD-CR	1	2	2	2	2	2	3	3	3	3

1. This amalgamation of missions makes up the youth centres (CJ).

Source: Fichier des établissements de santé et de services sociaux du Québec, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Table I1 (cont.)

Change in the number
of public and private institutions in the Québec health and social services network,
network, by grouping of missions assumed, situation observed on March 31, *1990 to 2008*

Amalgamation of missions	00	01	02	03	04	05	06	07	08
Total institutions	**480**	**477**	**473**	**467**	**458**	**317**	**304**	**297**	**294**
CLSC	67	67	65	60	57	2	2	2	2
CH	20	20	20	20	20	12	12	12	11
CPEJ	1	1	1	1	1				
CHSLD	163	159	157	154	152	115	101	95	93
CR	57	56	55	55	52	49	50	50	50
CLSC-CH	1	1	1	1	1	1	1	1	1
CLSC-CPEJ									
CLSC-CHSLD	46	47	48	52	51	14	14	14	14
CLSC-CR	2	2	1	1	1				
CH-CHSLD	68	68	66	63	60	21	21	21	21
CH-CR				1	1	1			
CPEJ-CHSLD									
CPEJ-CR[1]	15	15	15	15	16	16	16	16	
CHSLD-CR	3	4	4	4	4	2	2	1	1
CLSC-CH-CHSLD	22	22	24	26	29	67	67	67	67
CLSC-CHSLD-CR	1	1	2	1	1	1	1	1	1
CH-CPEJ-CHSLD									
CH-CHSLD-CR	8	7	7	7	7	2	2	2	2
CLSC-CH-CPEJ-CHSLD									
CLSC-CH-CHSLD-CR	2	3	3	3	3	11	11	11	11
CH-CPEJ-CHSLD-CR									
CLSC-CH-CPEJ-CHSLD-CR	4	4	4	4	4	4	4	4	4

1. This amalgamation of missions makes up the youth centres (CJ).

Source: Fichier des établissements de santé et de services sociaux du Québec, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Table I2

Number of institutions and facilities
in the Québec health and social services network, as well as number of authorized beds with permit for residential and long-term care,
by status and funding method of the institution, situation observed on March 31, *1990 to 2008*

Resource type	90	91	92	93	94	95	96	97	98	99
Institutions										
Total	**920**	**895**	**884**	**880**	**843**	**774**	**700**	**574**	**531**	**503**
Public	684	677	672	673	663	614	543	419	385	364
Private	236	218	212	207	180	160	157	155	146	139
Under agreement	125	113	108	110	104	101	98	96	95	85
Not under agreement	111	105	104	97	76	59	59	59	51	54
Facilities[1]										
Total	**2,093**	**2,058**	**2,105**	**2,112**	**2,097**	**2,074**	**2,128**	**2,136**	**2,056**	**2,009**
Public	1,843	1,818	1,868	1,878	1,889	1,886	1,938	1,945	1,877	1,837
Private	250	240	237	234	208	188	190	191	179	172
Under agreement	146	138	134	135	132	129	129	129	121	111
Not under agreement	104	102	103	99	76	59	61	62	58	61
Approved beds with permit for HSLD [2]										
Total	**55,408**	**54,830**	**54,435**	**54,330**	**52,376**	**52,088**	**51,374**	**51,678**	**48,970**	**48,631**
Public	43,737	43,745	43,334	43,317	42,012	42,388	41,732	41,988	39,273	38,929
Private	11,671	11,085	11,101	11,013	10,364	9,700	9,642	9,690	9,697	9,702
Under agreement	7,528	7,062	7,065	7,085	7,001	6,955	6,911	6,943	7,007	6,835
Not under agreement	4,143	4,023	4,036	3,928	3,363	2,745	2,731	2,747	2,690	2,867

Resource type	00	01	02	03	04	05	06	07	08
Institutions									
Total	**480**	**477**	**473**	**467**	**458**	**317**	**304**	**297**	**294**
Public	350	349	346	340	335	195	194	193	191
Private	130	128	127	127	123	122	110	104	103
Under agreement	77	77	76	75	67	72	64	55	55
Not under agreement	53	51	51	52	56	50	46	49	48
Facilities[1]									
Total	**2,014**	**2,006**	**1,790**	**1,786**	**1,789**	**1,782**	**1,752**	**1,752**	**1,754**
Public	1,854	1,847	1,631	1,627	1,634	1,628	1,604	1,606	1,607
Private	160	159	159	159	155	154	148	146	147
Under agreement	100	99	99	98	94	94	89	89	89
Not under agreement	60	60	60	61	61	60	59	57	58
Approved beds with permit for HSLD[2]									
Total	**48,662**	**48,288**	**48,038**	**47,989**	**47,141**	**47,027**	**46,309**	**46,260**	**46,358**
Public	38,961	38,520	38,295	38,177	37,292	37,113	36,318	35,737	35,620
Private	9,701	9,768	9,743	9,812	9,849	9,914	9,991	10,523	10,738
Under agreement	6,906	6,946	6,897	6,898	6,912	6,991	6,821	7,417	7,433
Not under agreement	2,795	2,822	2,846	2,914	2,937	2,923	3,170	3,106	3,305

1. The 194 active residential pavilions ceased to be facilities; they became intermediate resources as of April 1st, 2001.
2. The great majority (91%) of approved beds with permit in private institutions are devoted to residential and long-term care.

Source: Fichier des établissements de santé et de services sociaux du Québec, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Table I3

Change in the number of public and private facilities within the Québec health and social services network,

by mission assumed by the facility, situation observed on March 31, *1990 to 2008*

Mission	Unit	90	91	92	93	94	95	96	97	98	99
Total[1]	**Number**	**2,093**	**2,058**	**2,105**	**2,112**	**2,097**	**2,074**	**2,128**	**2,136**	**2,056**	**2,009**
	Index	**100**	**98**	**101**	**101**	**100**	**99**	**102**	**102**	**98**	**96**
CLSC	Number	365	363	358	356	368	372	381	384	377	378
	Index	100	99	98	98	101	102	104	105	103	104
CJ	Number	406	391	454	463	471	468	475	490	433	414
	Index	100	96	112	114	116	115	117	121	107	102
CH[2]	Number	180	167	172	173	177	178	175	164	206	206
	Index	100	93	96	96	98	99	97	91	114	114
CHSLD	Number	674	665	660	657	629	621	617	606	588	578
	Index	100	99	98	97	93	92	92	90	87	86
PAV[3]	Number	237	239	235	235	236	235	233	230	222	203
	Index	100	101	99	99	100	99	98	97	94	86
CR PDI	Number	291	285	282	284	306	288	325	326	313	314
	Index	100	98	97	98	105	99	112	112	108	108
CR PDP	Number	48	47	48	55	53	54	60	66	74	79
	Index	100	98	100	115	110	113	125	138	154	165
CR PAT	Number	44	46	49	48	57	56	60	61	62	65
	Index	100	105	111	109	130	127	136	139	141	148

Mission	Unit	00	01	02	03	04	05	06	07	08
Total[1]	**Number**	**2,014**	**2,006**	**1,790**	**1,786**	**1,789**	**1,782**	**1,752**	**1,752**	**1,754**
	Index	**96**	**96**	**86**	**85**	**85**	**85**	**84**	**84**	**84**
CLSC	Number	391	390	390	402	416	433	429	434	440
	Index	107	107	107	110	114	119	118	119	121
CJ	Number	401	413	391	359	320	318	281	285	285
	Index	99	102	96	88	79	78	69	70	70
CH[2]	Number	206	207	205	213	215	217	222	224	225
	Index	114	115	114	118	119	121	123	124	125
CHSLD	Number	560	552	554	552	544	541	532	524	526
	Index	83	82	82	82	81	80	79	78	78
PAV[3]	Number	199	194	…	…	…	…	…	…	…
	Index	84	82	…	…	…	…	…	…	…
CR PDI	Number	336	333	328	325	360	349	359	357	357
	Index	115	114	113	112	124	120	123	123	123
CR PDP	Number	84	85	90	96	95	103	108	107	107
	Index	175	177	188	200	198	215	225	223	223
CR PAT	Number	84	84	82	99	100	97	98	97	97
	Index	191	191	186	225	227	220	223	220	220

. . . : Not relevant.

1. The total does not correspond to the sum of the missions, because many facilities take on more than one mission.

2. Sum of CHSGSs and CHSPs.

3. The pavilions became intermediate resources as of April 1st, 2001.

Source: Fichier des établissements de santé et de services sociaux du Québec, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Table I4

Number of
approved beds and places with permit in public and private institutions of the Québec health and social services network,
by unit of services, situation observed on March 31,
1990 to 2008

Service unit	Unit	90	91	92	93	94	95	96	97	98	99
SGS[1]	Number	28,835	29,036	28,832	29,051	27,750	27,699	27,706	25,260	20,686	20,581
	Progressive index	100	101	100	101	96	96	96	88	72	71
SP[2]	Number	2,736	2,451	2,229	1,913	1,538	1,538	1,813	1,716	1,328	1,299
	Progressive index	100	90	81	70	56	56	66	63	49	47
HSLD[3]	Number	52,672	52,379	52,206	52,417	52,376	52,088	51,374	51,678	48,970	48,631
	Progressive index	100	99	99	100	99	99	98	98	93	92
CJ[4]	Number	4,551	4,518	4,482	4,512	4,580	4,761	4,680	4,972	3,899	3,994
	Progressive index	100	99	98	99	101	105	103	109	86	88
PDI[5]	Number	4,385	4,430	3,867	3,867	3,014	2,958	2,151	2,082	1,253	1,063
	Progressive index	100	101	88	88	69	67	49	47	29	24
PDP[6]	Number	526	518	538	548	519	509	502	491	385	390
	Progressive index	100	98	102	104	99	97	95	93	73	74
PAT[7]	Number	457	466	506	492	462	492	501	497	422	462
	Progressive index	100	102	111	108	101	108	110	109	92	101

Service unit	Unit	00	01	02	03	04	05	06	07	08
SGS[1]	Number	20,639	20,551	20,543	20,560	20,477	20,475	20,456	20,420	20,421
	Progressive index	72	71	71	71	71	71	71	71	71
SP[2]	Number	1,280	1,273	1,243	1,209	1,209	1,209	1,209	975	975
	Progressive index	47	47	45	44	44	44	44	36	36
HSLD[3]	Number	48,662	48,288	48,038	47,989	47,141	47,027	46,309	46,260	46,358
	Progressive index	92	92	91	91	89	89	88	88	88
CJ[4]	Number	3,687	3,999	3,845	3,590	3,580	3,477	3,477	3,473	3,452
	Progressive index	81	88	84	79	79	76	76	76	76
PDI[5]	Number	991	955	840	781	758	557	529	563	484
	Progressive index	23	22	19	18	17	13	12	13	11
PDP[6]	Number	445	437	437	426	438	494	493	499	452
	Progressive index	85	83	83	81	83	94	94	95	86
PAT[7]	Number	460	457	457	507	496	507	507	557	557
	Progressive index	101	100	100	111	109	111	111	122	122

1. Beds for general and specialized care, including those in psychiatrics (except those in CHSPs), hostel units and neonatology.
2. Short-term psychiatric care beds in CHSPs; 1990 to 1994, estimated data.
3. Residential and long-term physical and psychiatric care beds, permanent and temporary, excluding places in residential pavilions; 1990 to 1994, estimated data. The rate per 1,000 persons 65 years of age or older.
4. Internal spaces offered in youth centres. The rate per 1,000 persons 17 years of age or younger.
5. Internal spaces offered in rehabilitation facilities for persons with mental impairments.
6. Internal spaces offered in rehabilitation facilities for persons with physical impairments.
7. Internal spaces offered in rehabilitation facilities for persons suffering from alcoholism and other addictions.

Source: Fichier des établissements de santé et de services sociaux du Québec, M02 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

Table I5

Number of set-up beds and internal places in under-agreement public and private institutions of the Québec health and social services network, by unit of services, situation observed on March 31, *1991 to 2007*

Service Unit	Unit	91	92	93	94	95	96	97	98	99
SSPG[1]	n	23,612	23,547	23,381	23,044	22,178	20,211	17,216	16,390	16,163
	0/00	3.37	3.33	3.29	3.22	3.08	2.80	2.38	2.25	2.22
SPCD[2]	n	21,899	21,931	21,603	21,820	21,122	19,217	16,341	14,877	15,396
	0/00	3.13	3.10	3.04	3.05	2.94	2.66	2.25	2.05	2.11
SP[3]	n	7,879	7,679	7,237	6,188	5,788	5,565	5,165	4,888	4,251
	0/00	1.12	1.09	1.02	0.86	0.80	0.77	0.71	0.67	0.58
SNN[4]	n	2,362	2,343	2,309	2,264	2,223	2,163	1, 874	1,735	1,696
	0/00	0.34	0.33	0.32	0.32	0.31	0.30	0.26	0.24	0.23
RFI[5]	n	…	…	…	366	478	606	707	762	789
	0/00	…	…	…	0.05	0.07	0.08	0.10	0.10	0.11
HSLD[6]	n	46,164	46,145	45,970	45,262	45,542	45,155	44,118	42,478	42,199
	0/00	61,01	58,99	57,39	55,25	54,51	52,96	50,77	47,71	46,41
PDI[7]	n	496	481	434	398	449	455	458	395	316
	0/00	0.07	0.07	0.06	0.06	0.06	0.06	0.06	0.05	0.04
PDP[8]	n	3,259	3,157	2,979	2,785	2,651	2,022	1,618	973	1,005
	0/00	0.47	0.45	0.42	0.39	0.37	0.28	0.22	0.13	0.14
PAT[9]	n	404	386	438	447	445	445	510	434	459
	0/00	0.06	0.05	0.06	0.06	0.06	0.06	0.07	0.06	0.06
CJ[10]	n	4,566	4,408	4,453	4,380	4,456	4,444	4 119	3,741	3,862
	0/00	2.77	2.65	2.65	2.59	2.62	2.62	2.44	2.22	2.32

. . . : Not relevant.

1. Beds for physical and geriatric care.
2. Beds for short-term physical care. In fact, this refers to a subset of SSPG beds; this subset is determined by eliminating the institutions with an annual average of 15 departures or less per bed.
3. Beds for psychiatric care.
4. Beds for newborn care.
5. Internal spaces in intensive functional rehabilitation.
6. Internal spaces for residential and long-term care. In the case of HSLD beds, the number of beds per 1,000 persons 65 years of age or older.
7. Internal spaces in rehabilitation centres for persons with mental impairments.
8. Internal spaces in rehabilitation centres for persons with physical impairments.
9. Internal spaces in rehabilitation centres for persons suffering from alcoholism and other addictions.
10. Internal spaces in youth centres. Youth centres are the amalgamation of child and youth protection centres (CPEJ), rehabilitation centres for young persons with adjustment problems (CR JDA) and rehabilitation centres for young mothers with adjustment problems (CR MDA).In the case of youth centres, the number of internal spaces per 1,000 persons 17 years of age or younger.

Sources: STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; population data obtained from the Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table I5 (cont.)

Number of
set-up beds and internal places in under-agreement public and private institutions of the Québec health and social services network,
by unit of services, situation observed on March 31,
1991 to 2007

Service Unit	Unit	00	01	02	03	04	05	06	07
SSPG[1]	n	16,146	16,082	15,715	15,618	15,785	15,815	15,798	15,705
	0/00	2.20	2.19	2.12	2.10	2.11	2.10	2.09	2.07
SPCD[2]	n	15,386	15,097	14,781	14,737	14,885	14,946	14,909	14,745
	0/00	2.10	2.05	2.00	1.98	1.99	1.99	1.97	1.94
SP[3]	n	4,186	4,180	4,075	4,013	3,776	3 ,440	3,207	3,197
	0/00	0.57	0.57	0.55	0.54	0.50	0.46	0.42	0.42
SNN[4]	n	1,699	1,694	1,657	1,648	1,639	1,572	1,559	1,573
	0/00	0.23	0.23	0.22	0.22	0.22	0.21	0.21	0.21
RFI[5]	n	712	701	711	727	709	683	677	743
	0/00	0.10	0.10	0.10	0.10	0.09	0.09	0.09	0.10
HSLD[6]	n	42,555	41,938	41,777	41,602	41,687	41,467	41,470	41,211
	0/00	45.93	44.34	43.29	42.37	41.66	40.58	39.72	38.52
PDI[7]	n	393	469	463	457	459	471	534	448
	0/00	0.05	0.06	0.06	0.06	0.06	0.06	0.07	0.06
PDP[8]	n	902	884	722	730	648	525	461	430
	0/00	0.12	0.12	0.10	0.10	0.09	0.07	0.06	0.06
PAT[9]	n	449	446	527	518	453	453	462	510
	0/00	0.06	0.06	0.07	0.07	0.06	0.06	0.06	0.07
CJ[10]	n	4,053	4,078	3,557	3,561	3,571	3,443	3,473	3,807
	0/00	2.47	2.52	2.23	2.25	2.28	2.21	2.26	2.49

1. Beds for physical and geriatric care.
2. Beds for short-term physical care. In fact, this refers to a subset of SSPG beds; this subset is determined by eliminating the institutions with an annual average of 15 departures or less per bed.
3. Beds for psychiatric care.
4. Beds for newborn care.
5. Internal spaces in intensive functional rehabilitation.
6. Internal spaces for residential and long-term care. In the case of HSLD beds, the number of beds per 1,000 persons 65 years of age or older.
7. Internal spaces in rehabilitation centres for persons with mental impairments.
8. Internal spaces in rehabilitation centres for persons with physical impairments.
9. Internal spaces in rehabilitation centres for persons suffering from alcoholism and other addictions.
10. Internal spaces in youth centres. Youth centres are the amalgamation of child and youth protection centres (CPEJ), rehabilitation centres for young persons with adjustment problems (CR JDA) and rehabilitation centres for young mothers with adjustment problems (CR MDA).In the case of youth centres, the number of internal spaces per 1,000 persons 17 years of age or younger.

Sources: STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; population data obtained from the Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table I6

Availability of **specific alternative resources complementing the network of health and social services institutions,** by resource category, Québec, situation observed on March 31, *2003 to 2008*

Resource category	Indicators	03	04	05	06	07	08
Residence for the elderly[1]	Number of resources	2,562	2,519	2,489	2,439	2,285	2,279
	Number of housing units	77,304	79,911	84,951	86,341	87,255	95,742
Intermediate resources[2]	Number of resources	1,517	1,631	1,727	1,767	1,823	1,927
	Number of spaces	9,625	10,317	10,755	10,932	11,347	12,212
Family-type resources[3]	Number of resources	3,554	3,875	3,964	3,794	3,616	3,485
	Number of spaces	13,717	14,702	14,864	14,197	13,489	12,950
Community organizations[4]	Number of organizations	3,104	3,186	3,181	3,248	3,263	3,397

1. Private residences outside the network but certified by the Ministère providing, in exchange for paid rent, accommodation services as well as a range of domestic services to independent and semi-independent seniors.
2. Resources attached to a public network institution providing support and assistance services to keep or integrate the user in the community. The number of resources and the number of spaces in 2005 were estimated.
3. Resources to which a public institution entrusts users to afford them living conditions as close to a natural environment as possible; they are foster families for children in difficulty and foster homes for adults and seniors. It should be noted that these numbers exclude the family-type resources associated with youth centres, i.e., approximately 5,650 FTRs. The number of resources and the number of spaces in 2005 were estimated.
4. Includes organizations subsidized at the regional level as well as those subsidized at the national level.

Sources: Registre des résidences pour personnes âgées, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Système d'information des ressources intermédiaires et de type familial (SIRTF), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; budgetary and financial system by region (SBF-R), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, May 2008.

UTILIZATION OF SERVICES

The aim of the following tables is to illustrate changes in the utilization of the various health and social services provided to the population by the Government of Québec. These tables have been chosen as most likely to be of interest to the readers since they are based on requests for information received yearly by the Ministry. The data were drawn from various works of the Ministère as well as from the RAMQ's website **www.ramq.gouv.qc.ca**.

Table **U1**

Utilization of
home support services,
i.e., doctor's visits and services provided by CLSCs, Québec,
2001-2002 to 2006-2007

Indicators	Unit	01-02	02-03	03-04	04-05	05-06	06-07
Physician house calls							
Number of house calls[1]		588,019	572,627	561,758	550,914	531,922	520,876
	Progressive index	100	97	96	94	90	89
Home services provided by CLSCs							
Number of users		401,133	416,919	435,397	481,217	485,948	500,447
	Progressive index	100	104	109	120	121	125
Number of separate users		264,706	270,785	287,124	299,011	295,670	301,848
	Progressive index	100	102	108	113	112	114
Number of interventions		5,398,178	5,648,039	6,004,344	6,475,337	6,868,105	7,227,610
	Progressive index	100	105	111	120	127	134

1. The numbers for 2006-2007 were forecasted.

Sources: Data extracted from the CLSC integration system (I - CLSC), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U2

Utilization of **specific ambulatory services,** by service type, Québec, *2001-2002 to 2006-2007*

Indicators Unit	Indicators	01-02	02-03	03-04	04-05	05-06	06-07
Emergency[1]							
	Number of visits	3,879,408	3,810,126	3,821,827	3,843,088	3,871,130	3,910,928
Outpatient services[2]							
	Number of visits	7,589,348	7,644,506	8,000,585	7,812,661	8,057,955	7,955,874
Day hospital[3]							
	Number of visits	251,144	243,721	240,584	234,025	242,424	206,899
Day centre[4]							
	Number of visits	1,826,058	1,924,605	1,983,914	1,906,915	1,941,727	1,917,730
Day medicine[5]							
	Number of care-days	603,643	675,457	728,498	802,680	887,887	950,321
Day surgery[6]							
	Number of surgeries	286,246	287,065	300,480	295,707	304,937	307,246
Services at a CLSC[7]							
	Number of interventions	10,952,757	11,058,148	11,832,440	12,740,766	13,368,839	13,766,916
	Total number of users	2,267,632	2,448,547	2,640,785	2,897,107	3,057,780	3,103,542
	Number of separate users	1,734,256	1,791,005	1,979,469	2,101,289	2,174,194	2,204,562
Medical services[8] **(physicians)**							
	Number of consultations	3,567,236	3,573,659	3,666,624	3,827,935	3,874,315	3,962,484
	Number of office visits (outpatient and emergency)	30,445,192	30,059,344	29,524,366	29,407,217	29,069,756	28,680,275

1. The number of visits by patients to the emergency room corresponds to unit of measure 'A' of the "Emergency" (6240) cost objective in the financial report of the institution.
2. The number of visits by patients to the outpatient clinic corresponds to unit of measure 'A' of the "Outpatient consultation" (6300) cost objective in the financial report of the institution.
3. The number of patients visiting the day hospital corresponds to unit of measure 'A' of the "Mental health day hospital" (6280) and "Geriatric day hospital" (6290) cost objectives in the financial report of the institution.
4. The number of patients visiting the day centre corresponds to unit of measure 'A' of the "Day centre for persons with decreasing independence" (6960), "Day centre" (6970) and "Day activity centre" (7000) cost objectives in the financial report of the institution.
5. The number of care-days in day medicine corresponds to unit of measure 'A' of the "Day medicine" (7090) cost objective in the financial report of the institution.
6. The total number of day surgeries reported in the MED-ÉCHO system.
7. All activities reported by CLSCs.
8. Meetings, consultations and visits with a physician compensated by the RAMQ, in a private office as well as in the emergency room and outpatient departments of a hospital. The numbers for 2006-2007 were forecasted.

Sources: Annual financial reports of network institutions, M30 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; MED-ÉCHO system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; CLSC integration system (I - CLSC), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U3

Number of **medical services dispensed by physicians paid** under the Québec health insurance plan, **all compensation methods, and level of participation in medical services dispense** dispensed pursuant to the fee-for-service method of compensation in medicine and surgery, *1990 to 2007*

	Number of services for all compensation methods	Fee-for-service compensation in medicine and surgery			
Year		Number of services	Number of participants	Participation rate (%)	Number of services per participant
1990	80,625,182	59,705,326	5,727,701	81.8	10.4
1991	82,381,538	61,256,232	5,766,600	81.6	10.6
1992	84,840,843	62,954,163	5,762,626	81.1	10.9
1993	86,681,156	64,466,546	5,849,650	81.8	11.0
1994	82,654,116	60,428,320	5,856,648	81.4	10.3
1995	83,018,559	60,612,278	5,909,628	81.9	10.3
1996	81,964,765	59,580,571	5,857,085	80.8	10.2
1997	81,108,695	58,609,188	5,835,882	80.2	10.0
1998	81,276,106	58,470,497	5,820,089	79.8	10.0
1999	81,135,289	57,488,053	5,814,946	79.4	9.9
2000	83,695,058	58,204,566	5,833,471	79.3	10.0
2001	80,545,152	56,802,775	5,874,634	79.4	9.7
2002	80,954,509	56,137,796	5,867,223	78.8	9.6
2003	81,770,975	56,194,282	5,880,808	78.6	9.6
2004	83,783,663	56,830,946	5,917,838	78.6	9.6
2005	85,288,902	57,601,223	5,961,399	78.8	9.7
2006	86,579,691	58,098,153	5,984,510	78.7	9.7
2007[1]	87,672,672	58,570,777	6,016,905	78.7	9.7

1. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U4

Number of **dental services dispensed** under the Québec health insurance plan, **and level of participation in the children's dental services program,** *1990 to 2007*

Calendar year	Number of services[1]	Number of participants[2]	Participation rate[3] (%)	Number of services per participant[4]
1990	4,579,728	1,085,206	60.2	4.22
1991	4,775,133	1,109,126	59.6	4.31
1992	4,072,992	969,328	47.7	4.20
1993	3,585,622	810,919	50.0	4.42
1994	3,740,723	833,575	50.0	4.49
1995	3,862,672	852,696	51.4	4.53
1996	3,879,945	870,397	54.6	4.46
1997	2,727,042	696,901	45.5	3.91
1998	2,730,478	715,848	49.4	3.81
1999	2,613,198	702,559	50.1	3.72
2000	2,468,204	676,726	51.3	3.65
2001	2,365,941	657,067	51.2	3.60
2002	2,275,126	634,146	50.5	3.59
2003	2,222,834	615,843	49.8	3.61
2004	2,226,289	607,404	49.1	3.67
2005	2,145,806	595,391	48.7	3.60
2006	2,091,371	587,027	50.9	3.56
2007[5]	2,058,924	573,555	49.7	3.59

1. Sum of dental services for children, income security recipients and oral surgery services. The drop in the number of services is due to the reduced coverage of insured services in 1992 and 1997.
2. Sum of participants for dental services programs. The drop in the number of participants is due to the reduced coverage of insured services in 1992 and 1997.
3. Only for the dental services program for children.
4. Sum of services divided by the sum of participants.
5. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U5

Number of
optometric services dispensed
under the Québec health insurance plan, and level of participation in the program,
1990 to 2007

Calendar year	Number of services[1]	Number of participants	Participation rate (%)	Number of services per participant
1990	3,613,693	1,556,150	22.9	2.32
1991	3,756,057	1,597,929	23.7	2.35
1992	3,256,111	1,359,352	20.2	2.40
1993	1,999,652	903,514	12.6	2.21
1994	1,567,459	735,143	10.3	2.13
1995	1,592,476	745,415	N/A	2.14
1996	1,633,476	764,675	N/A	2.14
1997	1,581,585	757,350	25.5	2.09
1998	1,606,423	782,731	26.6	2.05
1999	1,661,722	806,485	27.8	2.06
2000	1,704,064	820,519	28.5	2.08
2001	1,758,605	837,591	28.5	2.10
2002	1,825,392	853,828	29.9	2.14
2003	1,882,491	864,914	30.3	2.18
2004	1,982,234	897,090	31.4	2.21
2005	2,011,238	911,139	31.9	2.21
2006	2,095,031	935,471	32.8[2]	2.24
2007[3]	2,132,857	950,192	32.8	2.24

1. The eligibility for optometric services was modified in May 1992 and May 1993.
2. This is an estimate.
3. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U6

Number of
drug prescriptions and level of participation in the pharmaceutical services program dispensed
under the Québec prescription drug insurance plan, by client category,
1990 to 2007

	Employment assistance recipients				Persons 65 years	of age or older			Members of the prescription drug insurance plan			
Calendar year	Number of prescriptions	Number of empl. assist. recipients	Number of participants	Number of prescription-days[1]	Number of prescriptions	Number of persons aged 65+	Number of participants	Number of prescription-days[1]	Number of prescriptions	Number of members	Number of participants	Number of prescription-days[1]
1990	6,954,192	556,561	418,994	…	21,710,641	756,722	653,481	…	…	…	…	…
1991	7,590,717	610,595	463,233	…	23,584 225	782,272	673,953	…	…	…	…	…
1992	8,356,739	688,581	505,454	…	22,931,305	800,957	685,564	…	…	…	…	…
1993	8,714,738	748,816	551,195	…	22,540,168	819,217	710,250	…	…	…	…	…
1994	9,256,904	782,682	582,652	…	23,775,582	835,473	734,684	…	…	…	…	…
1995	9,800,409	801,245	606,735	…	25,363,390	852,610	757,526	…	…	…	…	…
1996	9,698,222	801,344	591,917	…	26,784,594	868,962	777,940	…	…	…	…	…
1997	9,205,239	746,265	498,328	…	26,565,539	890,276	728,960	…	9 548 024	1,391,941	824,743	…
1998	9,725,595	680,440	467,292	…	28,739,100	909,316	739,221	…	11 266 119	1,510,485	907,325	…
1999	10,458,418	632,110	436,837	226,908,905	31,641,365	926,433	755,159	838,198,389	12 713 749	1,609,848	969,182	320,737,227
2000	11,696,297	590,142	414,706	250,038,515	36,027,927	945,859	771,121	943,335,055	14 326 361	1,675,605	1,007,572	365,328,393
2001	13,009,471	562,235	398,038	270,627,607	41,187,683	965,111	789,950	1,053,725,003	15 785 593	1,723,204	1,033,625	403,412,004
2002	14,223,305	546,600	387,648	286,278,823	45,953,330	981,887	803,365	1,142,813,916	16 822 638	1,725,331	1,031,008	429,813,385
2003	15,375,143	533,269	379,828	296,348,254	51,163,797	1,000,688	818,632	1,220,109,025	17 386 226	1,714,897	1,014,330	439,578,706
2004	16,675,403	521,239	372,004	309,526,921	56,963,651	1,021,777	835,902	1,314,183,595	18 198 995	1,715,058	1,009,234	458,844,697
2005	17,684,882	505,745	362,401	316,216,413	61,847,463	1,043 970	854,163	1,387,566,163	18 774 627	1,718,464	1,015,784	471,412,091
2006	18,851,187	497,800	355,395	325,960,180	68,226,542	1,069,921	877,982	1,489,645,911	19 852 025	1,699,649	1,022,890	495,844,062
2007	20,713,757	489,470	373,398	341,140,213	77,533,481	1,097,879	911,932	1,591,334,635	20 819 774	1,703,437	1,145,173	516,242,310

. . . : Not relevant.

1. Statistics regarding prescription-days are not published in the RAMQ annual statistics, nor are they posted on its website.
The total number of days covered by prescriptions in a given year. This concept eliminates the biases inherent to the evolution over time of the number of prescriptions, such as increases in short-term prescriptions and changes in the composition of user clienteles.

Sources: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics and unpublished data;
Direction de la statistique et du soutien aux expérimentations, Ministère de l'Emploi et de la Solidarité sociale du Québec **www.mess.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U7

Number of beneficiaries and number of goods and services dispensed under the technical aid programs offered under the Québec health insurance plan, by program, *1990 to 2007*

	Devices that Compensate for Physical Disabilities[1]			External Breastforms Program[2]			Hearing Devices Program[3]		
Calendar year	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary
1990	174,645	44,198	3.95	2,426	2,280	1.06	49,214	8,790	5.60
1991	189,026	47,436	3.98	2,255	2,069	1.09	55,275	9,680	5.71
1992	215,927	51,179	4.22	4,236	2,834	1.49	57,301	10,184	5.63
1993	235,764	52,651	4.48	13,595	7,411	1.83	156,318	34,128	4.58
1994	237,033	46,625	5.08	11,471	8,579	1.34	278,608	58,164	4.79
1995	244,353	47,726	5.12	12,920	9,647	1.34	286,877	66,279	4.33
1996	98,089	49,618	1.98	9,310	7,744	1.20	281,967	71,982	3.92
1997	98,790	50,858	1.94	3,435	3,010	1.14	152,904	44,705	3.42
1998	104,986	53,476	1.96	9,461	8,845	1.07	93,675	18,058	5.19
1999	107,391	53,656	2.00	4,411	4,192	1.05	124,377	23,143	5.37
2000	119,896	58,429	2.05	8,680	8,151	1.06	150,266	28,018	5.36
2001	127,876	62,384	2.05	5,004	4,729	1.06	46,154	27,676	1.67
2002	133,828	64,785	2.07	8,677	8,133	1.07	86,139	45,303	1.90
2003	137,213	65,899	2.08	5,345	5,048	1.06	101,521	48,425	2.10
2004	144,756	69,307	2.09	8,840	8,259	1.07	111,067	50,329	2.21
2005	150,628	71,423	2.11	5,991	5,657	1.06	118,913	52,837	2.25
2006	158,125	74,688	2.12	8,930	8,346	1.07	127,961	56,002	2.28
2007[5]	163,803	76,917	2.13	6,651	6,372	1.04	136,657	58,208	2.35

1. In 1996, the way the goods and services provided as part of this program are recorded changed.
2. In 1992, 1993 and 1997, several changes were made, either to the coverage or to the way the goods and services provided as part of this program are recorded.
3. In 1993, 1997, 1998, 2001, 2002 and 2003, several changes were made, either to the coverage or to the way the goods and services provided as part of this program are recorded.
4. The program includes maintenance costs for guide dogs from 1999 onward.
5. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U7 (cont.)

Number of
beneficiaries and number of goods and services dispensed under the technical aid programs
offered under the Québec health insurance plan, by program, *1990 to 2007*

	Ostomy Appliances Program Program			Visual Devices Program[4]			Ocular Prostheses		
Calendar year	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary	Number of goods and services	Number of beneficiaries	Number of goods and services per beneficiary
1990	7,319	6,727	1.09	13,275	2,674	4.96	2,003	1,893	1.06
1991	7,493	6,798	1.10	14,843	3,053	4.86	1,901	1,790	1.06
1992	8,375	7,376	1.14	17,045	3,293	5.18	2,019	1,871	1.08
1993	9,242	8,138	1.14	25,651	4,136	6.20	2,067	1,919	1.08
1994	8,916	8,202	1.09	30,726	5,098	6.03	2,125	1,957	1.09
1995	9,813	8,436	1.16	25,418	5,721	4.44	2,134	1,999	1.07
1996	8,611	7,922	1.09	33,650	6,062	5.55	2,142	2,019	1.06
1997	9,396	8,639	1.09	31,149	5,833	5.34	2,099	1,980	1.06
1998	10,340	8,927	1.16	33,139	6,241	5.31	2,046	1,931	1.06
1999	9,889	9,037	1.09	33,259	6,631	5.02	2,127	1,963	1.08
2000	9,958	9,227	1.08	25,636	7,372	3.48	2,157	2,011	1.07
2001	10,337	9,443	1.09	25,385	7,263	3.50	2,216	2,058	1.08
2002	10,596	9,608	1.10	27,130	7,789	3.48	2,214	2,039	1.09
2003	10,769	9,730	1.11	28,346	7,991	3.55	2,334	2,143	1.09
2004	11,219	10,001	1.12	28,775	8,149	3.53	2,341	2,149	1.09
2005	11,444	10,211	1.12	27,860	8,147	3.42	2,442	2,253	1.08
2006	11,694	10,319	1.13	30,158	8,680	3.47	2,426	2,225	1.09
2007[5]	11,964	10,538	1.14	30,493	8,778	3.47	2,502	2,286	1.09

4. The program includes maintenance costs for guide dogs from 1999 onward.

5. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table U8

Assessment of
specific benchmark indicators relating
to the application of the *Youth Protection Act* in Québec,
1994-1995 to 2006-2007

Indicators	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Number of reports processed	51,045	49,388	47,620	49,500	49,191	51,728	53,758	55,945	59,114	62,980	63,583	68,233	67,730
Number of reports acted on	24,901	24,553	23,786	24,249	24,948	25,451	26,063	25,993	27,910	29,516	29,028	31,401	31,740
Proportion of reports acted on (%)	48.8	49.7	49.9	49.0	50.7	49.2	48.5	46.5	47.2	46.9	45.7	46.0	46.9
Number of assessments conducted	21,179	21,500	20,991	21,114	22,661	23,047	23,523	23,649	24,230	25,758	25,963	26,679	27,681
Number of assessments conducted with SDCD[1]	9,112	9,042	8,734	8,837	10,154	10,626	10,577	10,272	10,735	10,773	10,469	10,591	10,844
Proportion of assessments conducted with SDCD[1] (%)	43.0	42.1	41.6	41.9	44.8	46.1	45.0	43.4	44.3	41.8	40.3	39.7	39.2
Average waiting period for an assessment (in days)	27.3	26.6	27.7	29.6	29.2	25.2	22.9	22.7	22.2	25.1	22.6	16.8	17.6
Number of new situations taken in charge	7,123	7,266	7,110	7,219	8,244	8,822	8,747	8,802	8,599	8,641	8,681	8,341	8,651
Number of new situations taken in charge and directed to the courts	2,779	3,280	3,370	3,654	4,262	4,563	4,423	4,735	4,272	4,410	4,596	4,600	4,693
Proportion of new situations taken in charge and directed to the courts (%)	39.0	45.1	47.4	50.6	51.7	51.7	50.6	53.8	49.7	51.0	52.9	55.1	54.2
Total number of new situations taken in charge	I/D	I/D	I/D	I/D	I/D	I/D	I/D	I/D	32,928	32,509	32,929	32,375	31,928
Total number of new situations taken in charge and directed to the courts	I/D	I/D	I/D	I/D	I/D	I/D	I/D	I/D	24,833	24,659	25,381	25,329	25,101
Proportion of new situations taken in charge and directed to the courts (%)	56.4	65.9	71.9	73.5	72.6	72.6	73.3	74.9	75.4	75.9	77.1	78.2	78.6
Number of situations taken in charge with placement	I/D	I/D	I/D	I/D	I/D	I/D	I/D	I/D	15,018	15,639	15,830	15,398	15,027
Number of situations taken in charge and directed to the courts with placement	I/D	I/D	I/D	I/D	I/D	I/D	I/D	I/D	13,435	14,100	14,385	14,179	13,914
Proportion of situations taken in charge and directed to the courts with placement (%)	71.1	82.2	87.0	88.1	87.6	88.2	88.5	89.5	89.5	90.2	90.9	92.1	92.6
Average time to process reports and complete the intervention (in months)	24.2	25.1	24.2	23.7	23.4	23.5	23.8	24.7	24.7	25.5	25.5	25.9	27.0

I/D: incomplete data.

1. Safety or development of the child in danger.

Sources: Benchmark indicators relating to the application of the *Youth Protection Act*, 1993-1994 to 2000-2001, Carolle Lessard, Direction des indicateurs et du pilotage d'orientation, MSSS, September 2002;
Benchmark indicators relating to the application of the *Youth Protection Act*, 1997-1998 to 2004-2005, Carolle Lessard, Direction de la jeunesse et de la toxicomanie, MSSS, December 2005;
Benchmark indicators relating to the application of the *Youth Protection Act*, 2005-2006, tables, Carolle Lessard;
Benchmark indicators relating to the application of the *Youth Protection Act*, 2006-2007, tables, Carolle Lessard.

MSSS, SDI, May 2008.

Table U9

Hospitalizations for short-term care[1] in general and specialized care facilities[2] taking part in the MED-ÉCHO system, Québec, *1982-1983 to 2006-2007*

	Hospitalizations		Visit-days		Average stay	
Year	Number	chan. % year	Number	chan. % year	In days	chan. % year
1982-1983	782,178		6,652,990		8.51	
1983-1984	796,316	1.8	6,942,457	4.4	8.72	2.5
1984-1985	785,820	-1.3	6,940,520	-0.03	8.83	1.3
1985-1986	791,961	0.8	6,997,018	0.8	8.84	0.03
1986-1987	791,222	-0.1	6,944,796	-0.7	8.78	-0.7
1987-1988	805,806	1.8	6,997,547	0.8	8.68	-1.1
1988-1989	802,635	-0.4	6,924,841	-1.0	8.63	-0.6
1989-1990	799,803	-0.4	6,763,189	-2.3	8.46	-2.0
1990-1991	830,545	3.8	6,923,812	2.4	8.34	-1.4
1991-1992	849,858	2.3	6,932,010	0.1	8.16	-2.2
1992-1993	848,921	-0.1	6,897,984	-0.5	8.13	-0.4
1993-1994	863,502	1.7	6,934,058	0.5	8.03	-1.2
1994-1995	865,525	0.2	6,731,339	-2.9	7.78	-3.2
1995-1996	818,997	-5.4	6,107,942	-9.3	7.46	-4.1
1996-1997	774,255	-5.5	5,623,266	-7.9	7.26	-2.6
1997-1998	760,717	-1.7	5,362,742	-4.6	7.05	-2.9
1998-1999	749,858	-1.4	5,341,743	-0.4	7.12	1.1
1999-2000	736,481	-1.8	5,277,738	-1.2	7.17	0.6
2000-2001	725,623	-1.5	5,272,042	-0.1	7.27	1.4
2001-2002	706,368	-2.7	5,092,589	-3.4	7.21	-0.8
2002-2003	685,602	-2.9	4,994,098	-1.9	7.28	1.0
2003-2004	705,255	2.9	5,155,334	3.2	7.31	0.4
2004-2005	699,735	-0.8	5,080,246	-1.5	7.26	-0.7
2005-2006	713,732	2.0	5,111,799	0.6	7.16	-1.4
2006-2007	716,191	0.3	5,124,049	0.2	7.15	-0.1
AAC[3] in %		-0.4		-1.1		-0.7

1. Includes physical care, psychiatric care and newborn care provided in facilities taking part in the MED-ÉCHO system.
2. Only "active" general and specialized care facilities, i.e., excluding those that primarily dispense long-term, rehabilitation, convalescence and psychiatric care. Moreover, long-term care provided in the facilities analyzed, whether in beds assigned to short- or long-term care, was also excluded.
3. Average annual change expressed in percentage.

Source: MED-ÉCHO system statistics, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U10

Hospitalizations for short-term care[1]
in general and specialized care facilities[2]
taking part in the MED-ÉCHO system, by user age group, Québec,
2000-2001 and 2006-2007

	2000-2001					2006-2007				
Age group	Hosp.	Dist. %	Visit-days	Dist. %	Average stay	Hosp.	Dist. %	Visit-days	Dist. %	Average stay
All ages	**725,623**	**100.0**	**5,272,042**	**100.0**	**7.3**	**716,191**	**100.0**	**5,124,049**	**100.0**	**7.2**
Newborns	70,052	9.7	240,726	4.6	3.4	79,948	11.2	263,453	5.1	3.3
Less than 1 year	17,861	2.5	92,020	1.7	5.2	18,262	2.5	86,336	1.7	4.7
1 to 4 years	20,348	2.8	59,343	1.1	2.9	18,907	2.6	51,248	1.0	2.7
5 to 9 years	12,476	1.7	45,184	0.9	3.6	9,382	1.3	31,451	0.6	3.4
10 to 14 years	10,543	1.5	48,141	0.9	4.6	9,119	1.3	36,979	0.7	4.1
15 to 19 years	17,830	2.5	89,492	1.7	5.0	14,794	2.1	78,861	1.5	5.3
20 to 24 years	32,049	4.4	146,325	2.8	4.6	26,752	3.7	131,510	2.6	4.9
25 to 29 years	42,608	5.9	174,939	3.3	4.1	46,322	6.5	192,155	3.8	4.1
30 to 34 years	40,840	5.6	182,267	3.5	4.5	42,395	5.9	173,117	3.4	4.1
35 to 39 years	36,229	5.0	205,581	3.9	5.7	29,358	4.1	152,232	3.0	5.2
40 to 44 years	33,563	4.6	219,255	4.2	6.5	27,411	3.8	174,098	3.4	6.4
45 to 49 years	34,014	4.7	246,107	4.7	7.2	31,964	4.5	225,944	4.4	7.1
50 to 54 years	38,541	5.3	289,245	5.5	7.5	35,861	5.0	270,275	5.3	7.5
55 to 59 years	40,450	5.6	323,591	6.1	8.0	41,320	5.8	323,912	6.3	7.8
60 to 64 years	41,131	5.7	350,803	6.7	8.5	44,972	6.3	369,461	7.2	8.2
65 to 69 years	50,159	6.9	468,424	8.9	9.3	45,879	6.4	413,097	8.1	9.0
70 to 74 years	56,488	7.8	576,967	10.9	10.2	50,315	7.0	496,138	9.7	9.9
75 to 79 years	55,033	7.6	601,438	11.4	10.9	53,913	7.5	576,216	11.2	10.7
80 to 84 years	39,619	5.5	466,975	8.9	11.8	46,191	6.4	538,660	10.5	11.7
85 to 89 years	24,390	3.4	304,237	5.8	12.5	28,295	4.0	348,774	6.8	12.3
90+	11,399	1.6	140,982	2.7	12.4	14,831	2.1	190,132	3.7	12.8

1. Includes physical care, psychiatric care and newborn care provided in facilities taking part in the MED-ÉCHO system.
2. Only "active" general and specialized care facilities, i.e., excluding those that primarily dispense long-term, rehabilitation, convalescence and psychiatric care. Moreover, long-term care provided in the facilities analyzed, whether in beds assigned to short- or long-term care, was also excluded.

Source: MED-ÉCHO system statistics, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U11

Hospitalizations for short-term care[1] in general and specialized care facilities[2] taking part in the MED-ÉCHO system, by diagnostic grouping in 23 chapters, Québec, *2006-2007*

Diagnostic grouping in 23 chapters (ICD-10)	Number	Days	Dist. %	Avg. stay
All chapters	**716,191**	**5,124,049**	**100**	**7.2**
Certain infectious and parasitic diseases (A00-B99)	14,525	108,585	2.1	7.5
Neoplasms (C00-D48)	57,594	616,834	12.0	10.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	6,117	43,322	0.8	7.1
Endocrine, nutritional and metabolic diseases (E00-E90)	10,740	90,136	1.8	8.4
Mental and behavioural disorders (F00-F99)	34,885	624,547	12.2	17.9
Diseases of the nervous system (G00-G99)	12,826	133,964	2.6	10.4
Diseases of the eye and adnexa (H00-H59)	1,861	6,843	0.1	3.7
Diseases of the ear and mastoid process (H60-H95)	3,047	9,461	0.2	3.1
Diseases of the circulatory system (I00-I99)	95,817	771,929	15.1	8.1
Diseases of the respiratory system (J00-J99)	60,938	425,091	8.3	7.0
Diseases of the digestive system(K00-K93)	64,738	408,829	8.0	6.3
Diseases of the skin and subcutaneous tissue (L00-L99)	7,587	63,837	1.2	8.4
Diseases of the musculoskeletal system and connective tissue(M00-M99)	28,089	235,569	4.6	8.4
Diseases of the genitourinary system (N00-N99)	32,301	159,934	3.1	5.0
Pregnancy, childbirth and the puerperium (O00-O99)	87,865	252,893	4.9	2.9
Certain conditions originating in the perinatal period (P00-P96)	17,035	105,517	2.1	6.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	4,563	29,179	0.6	6.4
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	30,907	243,508	4.8	7.9
Injury, poisonings and certain other consequences of external causes (S00-T98)	48,973	421,388	8.2	8.6
Factors influencing health status and contact with health services (Z00-Z99)	95,782	372,676	7.3	3.9
Provisional codes for research and temporary assignment (U00-U99)	1	7	0.0001	7.0

1. Includes physical care, psychiatric care and newborn care provided in facilities taking part in MED-ÉCHO.
2. Only "active" general and specialized care facilities, i.e., excluding those that primarily dispense long-term, rehabilitation, convalescence and psychiatric care. Moreover, long-term care provided in the facilities analyzed, whether in beds assigned to short- or long-term care, was also excluded.

Source: MED-ÉCHO system statistics, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U12

Use of residential and long-term care services within the Québec network

of under-agreement public and private health and social services institutions, *1990-1991 to 2006-2007*

Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99
Users admitted[1]									
Number	43,569	43,292	43,288	42,538	42,842	42,122	41,385	40,359	39,927
Progressive index	100	99	99	98	98	97	95	93	92
Current users[2]									
Number	66,879	67,090	69,605	66,440	65,748	67,526	69,332	70,440	70,171
Progressive index	100	100	104	99	98	101	104	105	105
Visit-days[3]									
Number	16,120,933	16,130,429	16,029,128	15,784,641	15,969,098	15,845,012	15,284,237	14,921,911	14,752,761
Progressive index	100	100	99	98	99	98	95	93	92
Average stay[4] (days)	241.0	240.4	230.3	237.6	242.9	234.7	220.4	211.8	210.2

Indicators	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Users admitted[1]								
Number	40,660	40,213	40,009	40,086	40,227	39,670	39,844	39,739
Progressive index	93	92	92	92	92	91	91	91
Current users[2]								
Number	70,608	71,584	70,396	71,043	72,236	72,720	71,417	71,653
Progressive index	106	107	105	106	108	109	107	107
Visit-days[3]								
Number	14,801,783	14,776,647	14,697,579	14,680,523	14,802,562	14,650,592	14,735,131	14,706,145
Progressive index	92	92	91	91	92	91	91	91
Average stay[4] (days)	209.6	206.4	208.8	206.6	204.9	201.5	206.3	205.2

1. The number of users accommodated, as observed on March 31.
2. The total number of users accommodated at some time during the fiscal year. This is the volume of users.
3. The number of visit-days generated by current users at any given time during the fiscal year.
4. The average stay of users is equal to the number of visit-days recorded for a given fiscal year divided by the number of current users at a given time during this fiscal year.

Source: STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U13

Use of services provided
to persons suffering from alcoholism and other problems of addiction,
within the Québec network of under-agreement public and private health and social services institutions,
1990-1991 to 2006-2007

Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99
Users admitted[1]									
Number	306	317	352	359	314	299	343	294	294
Progressive index	100	104	115	117	103	98	112	96	96
Users registered[2]									
Number	16,160	16,574	18,084	20,031	22,459	25,000	25,896	26,792	27,688
Progressive index	100	103	112	124	139	155	160	166	171
Current users[3]									
Number	5,190	5,085	5,504	5,441	5,383	5,123	5,696	5,447	5,023
Progressive index	100	98	106	105	104	99	110	105	97
Visit-days[4]									
Number	115,493	114,337	124,518	127,760	115,764	119,252	137,270	115,096	108,315
Progressive index	100	99	108	111	100	103	119	100	94
Average stay (days)	22.3	22.5	22.6	23.5	21.5	23.3	24.1	21.1	21.6

Indicators	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Usagers admis[1]								
Number	292	297	328	325	329	366	352	390
Progressive index	95	97	107	106	108	120	115	127
Users registered[2]								
Number	31,281	30,887	35,705	39,055	39,243	41,845	44,404	47,269
Progressive index	194	191	221	242	243	259	275	293
Current users[3]								
Number	4,916	4,681	4,742	4,740	4,625	4,679	5,130	5,075
Progressive index	95	90	91	91	89	90	99	98
Visit-days[4]								
Number	109,090	110,437	117,302	123,136	117,294	123,443	133,865	140,910
Progressive index	94	96	102	107	102	107	116	122
Average stay (days)	22.2	23.6	24.7	26.0	25.4	26.4	26.1	27.8

1. Users admitted; situation observed on March 31.

2. Users registered at the beginning of and during the fiscal year. The volume of users registered.

3. Users admitted at the beginning of and during the fiscal year. The volume of users admitted.

4. Visit-days generated by the volume of users admitted.

Sources: Annual statistical reports from rehabilitation centres for persons suffering from alcoholism and other problems of addiction (AS-481 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U14

Use of services provided to persons with physical deficiencies

within the Québec network of under-agreement public and private health and social services institutions, *1990-1991 to 2006-2007*

Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99
Users admitted[1]									
Number	340	337	332	318	296	281	278	272	252
Progressive index	100	111	98	94	87	83	82	80	74
Users registered[2]									
Number	33,328	35,291	38,362	42,230	37,114	40,247	44,249	46,662	49,179
Progressive index	100	106	115	127	111	121	133	140	148
Current users[3]									
Number	1,957	2,078	2,008	2,305	2,212	2,273	2,478	2,171	1,905
Progressive index	100	106	103	118	113	116	127	111	97
Visit-days[4]									
Number	119,592	123,541	120,702	110,995	91,252	88,669	87,172	87,772	87,096
Progressive index	100	103	101	93	76	74	73	73	73
Average stay (days)	61.1	59.5	60.1	48.2	41.3	39.0	35.2	40.4	45.7

Indicators	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Users admitted[1]								
Number	320	360	321	320	334	346	322	337
Progressive index	94	106	94	94	98	102	95	99
Users registered[2]								
Number	57,077	53,670	57,162	59,202	62,983	66,598	70,442	75,924
Progressive index	171	161	172	178	189	200	211	228
Current users[3]								
Number	2,526	2,837	2,675	2,595	2,734	2,848	2,690	2,594
Progressive index	129	145	137	133	140	146	137	133
Visit-days[4]								
Number	111,396	128,790	122,006	117,479	115,710	109,455	119,950	116,157
Progressive index	93	108	102	98	97	92	100	97
Average stay (days)	44.1	45.4	45.6	45.3	42.3	38.4	44.6	44.8

1. Users admitted; situation observed on March 31.
2. Users registered at the beginning of and during the fiscal year. The volume of users registered.
3. Users admitted at the beginning of and during the fiscal year. The volume of users admitted.
4. Visit-days generated by the volume of users admitted.

Sources: Annual statistical reports from rehabilitation centres for persons with a physical impairment (AS-484 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table U15

Use of services provided
to persons with mental deficiencies
within the Québec network of under-agreement public and private health and social services institutions,
1990-1991 to 2006-2007

Indicators	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99
Users admitted[1]									
Number	2,740	2,723	2,465	2,100	1,719	1,534	1,090	767	731
Progressive index	100	99	90	77	63	56	40	28	27
Users registered[2]									
Number[3]	12,330	13,658	14,752	16,985	18,638	20,305	19,804	20,509	23,410
Progressive index	100	111	120	138	151	165	161	166	190
Current users[3]									
Number	3,652	3,539	3,433	3,302	2,834	2,436	1,831	1,202	1,081
Progressive index	100	97	94	90	78	67	50	33	30
Visit-days[4]									
Number	1,032,688	1,022,258	943,201	851,501	663,678	598,596	440,664	297,507	288,091
Progressive index	100	99	91	82	64	58	43	29	28
Average stay (days)	282.8	288.9	274.7	257.9	234.2	245.7	240.7	247.5	266.5

Indicators	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Users admitted[1]								
Number	600	527	506	449	414	455	403	349
Progressive index	22	19	18	16	15	17	15	13
Users registered[2]								
Number[3]	24,195	25,151	25,529	26,680	27,650	28,860	30,108	30,599
Progressive index	196	204	207	216	224	234	244	248
Current users[3]								
Number	983	683	601	736	721	701	581	589
Progressive index	27	19	16	20	20	19	16	16
Visit-days[4]								
Number	241,793	202,388	189,885	175,184	160,735	154,903	156,229	128,838
Progressive index	23	20	18	17	16	15	15	12
Average stay (days)	246.0	296.3	315.9	238.0	222.9	221.0	268.9	218.7

1. Users admitted; situation observed on March 31.
2. Users registered at the beginning of and during the fiscal year. The volume of users registered.
3. Users admitted at the beginning of and during the fiscal year. The volume of users admitted.
4. JVisit-days generated by the volume of users admitted.

Sources: Annual statistical reports from rehabilitation centres for persons with a mental impairment (AS-485 form), S16 system, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**;
STATEVO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

THE COST

The last section contains tables illustrating changes in the cost of Québec's health and social services system. It starts with an outline of the financial resources allocated by Québec for the Health and Social Services mission. The costs are then broken down according to the various components of this mission. The data were drawn directly from documents posted on the websites of the Secrétariat du Conseil du trésor **www.tresor.gouv.qc.ca**, the Ministère des Finances **www.finances.gouv.qc.ca**, the RAMQ **www.ramq.gouv.qc.ca**, as well as from MSSS publications.

Table C1

Gross domestic product, government expenditures and amounts devoted to the Health and Social Services mission,

current dollars and 1997 constant dollars, Québec,
1990-1991 to 2008-2009

Aspect	Unit	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08[1]	08-09[2]
GDP[3]	current $ ($,000,000)	153,787	155,958	159,329	164,291	172,191	178,130	182,501	190,383	199,896	214,339	226,380	234,221	244,600	255,541	267,513	276,974	288,295	299,137	308,488
	$ per person	21,957	22,076	22,415	22,961	23,942	24,674	25,183	26,171	27,398	29,268	30,771	31,664	32,862	34,135	35,538	36,606	37,918	39,166	40,213
	constant $ ($,000,000)	172,369	168,784	167,702	170,056	175,822	180,183	184,378	189,996	197,122	205,549	209,612	212,950	217,637	222,600	227,983	231,297	237,442	241,857	244,832
	$ per person	24,610	23,892	23,593	23,766	24,447	24,958	25,442	26,118	27,018	28,068	28,491	28,789	29,240	29,735	30,287	30,569	31,230	31,666	31,915
Gov. exp.	current $ ($,000,000)	36,777	39,354	41,010	41,558	42,830	42,650	41,106	42,249	44,586	45,482	47,856	49,068	50,420	51,995	54,509	56,104	58,796	61,638	63,855
	$ per person	5,251	5,571	5,770	5,808	5,955	5,908	5,672	5,808	6,111	6,211	6,505	6,634	6,774	6,946	7,241	7,415	7,733	8,070	8,324
	GDP %	23.9	25.2	25.7	25.3	24.9	23.9	22.5	22.2	22.3	21.2	21.1	20.9	20.6	20.3	20.4	20.3	20.4	20.6	20.7
	constant $(,000,000$)	41,221	42,591	43,165	43,016	43,733	43,142	41,529	42,163	43,967	43,617	44,311	44,612	44,862	45,293	46,454	46,852	48,425	49,835	50,679
	$ per person	5,885	6,029	6,073	6,012	6,081	5,976	5,731	5,796	6,026	5,956	6,023	6,031	6,027	6,050	6,171	6,192	6,369	6,525	6,606
HSS mission	current $ ($,000,000)	11,312	12,342	12,698	12,943	13,070	13,107	12,875	12,938	14,596	14,828	16,101	17,189	17,916	19,026	20,582	21,163	22,453		
	$ per person	1,615	1,747	1,786	1,809	1,817	1,816	1,777	1,779	2,001	2,025	2,189	2,324	2,407	2,542	2,734	2,797	2,953	3,159	3,311
	GDP %	7.4	7.9	8.0	7.9	7.6	7.4	7.1	6.8	7.3	6.9	7.1	7.3	7.3	7.4	7.7	7.6	7.8	8.1	8.2
	Total % exp,	30.8	31.4	31.0	31.1	30.5	30.7	31.3	30.6	32.7	32.6	33.6	35.0	35.5	36.6	37.8	37.7	38.2	39.1	39.8
	constant $ ($,000,000)	12,679	13,357	13,365	13,397	13,346	13,258	13,007	12,912	14,393	14,220	14,908	15,628	15,941	16,573	17,541	17,673	18,492	19,505	20,160
	$ per person	1,810	1,891	1,880	1,872	1,856	1,836	1,795	1,775	1,973	1,942	2,026	2,113	2,142	2,214	2,330	2,336	2,432	2,554	2,628
Population		7,003,876	7,064,586	7,108,000	7,155,273	7,191,884	7,219,446	7,246,896	7,274,630	7,295,973	7,323,308	7,357,029	7,396,988	7,443,171	7,486,114	7,527,454	7,566,409	7,603,083	7,637,697	7,671,382
Implicit price index for allhealth care in Québec[4]		89.2	92.4	95.0	96.6	97.9	98.9	99.0	100.2	101.4	104.3	108.0	110.0	112.4	114.8	117.3	119.7	121.4	123.7	126.0

1. Credits.
2. Estimates.
3. GDP at market prices, based on calendar year, as provided by CIHI. Using the "0.75 + 0.25" rule provides the GDP based on the fiscal year. Figures for 2005-2006 were estimated; figures for 2006-2007, 2007-2008 and 2008-2009 were forecasted.
4. Calculated based on statistics drawn from Appendix B.3 of the CD that accompanies the document titled "National Health Expenditure Trends" produced every year by CIHI, 2007 edition.Figures for 2006-2007, 2007-2008 and 2008-2009 were forecasted.

Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**, and Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C2

Amounts devoted to
the major missions of the government,
by major mission, Québec,
1994-1995 to 2008-2009

Major mission	Unit	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09
Health and Social Services mission	$M	13,183	13,107	12,875	12,938	14,596	14,828	16,101	17,189	17,916	19,026	20,582	21,163	22,453	23,789	25,401
	%	31.2	30.7	31.3	30.6	32.7	32.6	33.6	35.0	35.5	36.6	37.8	37.7	38.2	38.8	39.6
	$ per person	1,833	1,816	1,777	1,779	2,001	2,025	2,189	2,324	2,407	2,542	2,734	2,797	2,953	3,115	3,311
Support for Individuals and Families mission	$M	4,286	4,698	4,681	4,709	4,863	4,805	4,831	4,842	4,616	5,048	5,028	5,079	5,200	5,346	5,413
	%	10.1	11.0	11.4	11.1	10.9	10.6	10.1	9.9	9.2	9.7	9.2	9.1	8.8	8.7	8.4
	$ per person	596	651	646	647	667	656	657	655	620	674	668	671	684	700	706
Education and Culture mission	$M	10,902	11,091	10,591	9,999	10,241	10,478	10,822	11,214	11,812	12,214	12,520	12,930	13,353	14,122	14,892
	%	25.8	26.0	25.8	23.7	23.0	23.0	22.6	22.9	23.4	23.5	23.0	23.0	22.7	23.0	23.2
	$ per person	1,516	1,536	1,461	1,375	1,404	1,431	1,471	1,516	1,587	1,632	1,663	1,709	1,756	1,849	1,941
Economy and Environment mission	$M	4,963	4,755	4,012	4,208	4,970	5,645	5,926	5,748	5,783	5,370	5,370	5,761	5,943	6,316	6,871
	%	11.7	11.1	9.8	10.0	11.1	12.4	12.4	11.7	11.5	10.3	9.9	10.3	10.1	10.3	10.7
	$ per person	690	659	554	578	681	771	805	777	777	717	713	761	782	827	896
Governance and Justice mission	$M	3,072	2,961	3,087	3,630	3,343	2,975	3,204	3,388	3,710	3,682	4,156	4,295	4,846	4,458	4,609
	%	7.3	6.9	7.5	8.6	7.5	6.5	6.7	6.9	7.4	7.1	7.6	7.7	8.2	7.3	7.2
	$ per person	427	410	426	499	458	406	436	458	498	492	552	568	637	584	601
Debt Servicing mission	$M	5,874	6,038	5,860	6,765	6,573	6,751	6,972	6,687	6,583	6,655	6,853	6,875	7,000	7,244	6,907
	%	13.9	14.2	14.3	16.0	14.7	14.8	14.6	13.6	13.1	12.8	12.6	12.3	11.9	11.8	10.8
	$ per person	817	836	809	930	901	922	948	904	884	889	910	909	921	948	900
All missions	**$M**	**42,280**	**42,650**	**41,106**	**42,249**	**44,586**	**45,482**	**47,856**	**49,068**	**50,420**	**51,995**	**54,509**	**56,103**	**58,795**	**61,275**	**64,093**
	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	$ per person	**5,879**	**5,908**	**5,672**	**5,808**	**6,111**	**6,211**	**6,505**	**6,634**	**6,774**	**6,946**	**7,241**	**7,415**	**7,733**	**8,023**	**8,355**
Population of Québec		7,191,884	7,219,446	7,246,896	7,274,630	7,295,973	7,323,308	7,357,029	7,396,988	7,443,171	7,486,114	7,527,454	7,566,409	7,603,083	7,637,697	7,671,382

Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**; Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C3

Amounts devoted to
the health and social services portfolio,
by program of Québec's official budget structure,
1990-1991 to 2008-2009

Programmes budgétaires	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08[1]	08-09[2]
1 - Québec-wide functions																			
$ thousands	192,903	218,157	212,643	208,562	207,665	202,781	166,433	160,429	160,350	162,366	212,642	208,521	224,842	246,608	263,276	267,558	287,552	342,586	357,133
Annual change in %		13.1	-2.5	-1.9	-0.4	-2.4	-17.9	-3.6	-0.05	1.3	31.0	-1.9	7.8	9.7	6.8	1.6	7.5	19.1	4.2
Progressive index	100	113	110	108	108	105	86	83	83	84	110	108	117	128	136	139	149	178	185
2 - Regional functions																			
$ thousands	8,459,722	9,186,485	9,464,682	9,601,253	9,617,048	9,512,513	9,493,030	9,651,060	11,027,712	11,125,085	11,895,845	12,636,102	13,030,930	13,908,033	14,559,181	15,201,287	16,483,123	17,556,550	18,312,428
Annual change in %		8.6	3.0	1.4	0.2	-1.1	-0.2	1.7	14.3	0.9	6.9	6.2	3.1	6.7	4.7	4.4	8.4	6.5	4.3
Progressive index	100	109	112	113	114	112	112	114	130	132	141	149	154	164	172	180	195	208	216
3 - OPHQ[3]																			
$ thousands	40,753	38,301	40,216	38,449	39,636	47,553	44,612	43,716	42,795	34,115	50,895	58,243	55,814	52,576	53,318	57,083	11,653	12,585	12,681
Annual change in %		-6.0	5.0	-4.4	3.1	20.0	-6.2	-2.0	-2.1	-20.3	49.2	14.4	-4.2	-5.8	1.4	7.1	…	8.0	0.8
Progressive index	100	94	99	94	97	117	109	107	105	84	125	143	137	129	131	140			
4 - Régie de l'assurance maladie du Québec[4]																			
$ thousands	2,618,866	2,899,348	2,980,152	3,094,573	3,205,851	3,282,429	3,217,827	3,134,511	3,365,483	3,507,924	3,938,925	4,295,046	4,609,716	4,876,754	5,235,919	5,346,325	5,670,177	6,148,818	6,719,193
Annual change in %		10.7	2.8	3.8	3.6	2.4	-2.0	-2.6	7.4	4.2	12.3	9.0	7.3	5.8	7.4	2.1	6.1	8.4	9.3
Progressive index	100	111	114	118	122	125	123	120	129	134	150	164	176	186	200	204	217	235	257
5- Promotion and development of the national capital region																			
$ thousands	…	…	…	…	…	…	…	…	…	…	…	…	…	…	…	…	…	63,666	67,512
All programs																			
$ thousands	**11,312,244**	**12,342,291**	**12,697,693**	**12,942,837**	**13,070,200**	**13,045,276**	**12,921,902**	**12,989,716**	**14,596,340**	**14,829,490**	**16,098,307**	**17,197,912**	**17,921,302**	**19,083,971**	**20,111,694**	**20,872,253**	**22,452,505**	**24,124,205**	**25,468,947**
Annual change in %		**9.1**	**2.9**	**1.9**	**1.0**	**-0.2**	**-0.9**	**0.5**	**12.4**	**1.6**	**8.6**	**6.8**	**4.2**	**6.5**	**5.4**	**3.8**	**7.6**	**7.4**	**5.6**
Progressive index	**100**	**109**	**112**	**114**	**116**	**115**	**114**	**115**	**129**	**131**	**142**	**152**	**158**	**169**	**178**	**185**	**198**	**213**	**225**

. . . : Not relevant.

1. Credits.

2. Estimates.

3. The "Services for handicapped persons" element was transferred to the Ministère de l'Emploi et de la Solidarité sociale in the 2006-2007 Public Accounts.

4. Amounts regarding the medications and pharmaceutical services dispensed to members of the prescription drug insurance plan are not included.

Sources: Public Accounts, Ministère des Finances du Québec **www.finances.gouv.qc.ca**; Estimates, Secrétariat du Conseil du trésor du Québec **www.tresor.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C4

Operating expenses[1] of under-agreement public and private institutions of the Québec health and social services network,

by exclusive mission, no matter the institution responsible,
1997-1998 to 2006-2007

Exclusive missions	97-98 ($,000)	(%)	98-99 ($,000)	(%)	99-00 ($,000)	(%)	00-01 ($,000)	(%)	01-02 ($,000)	(%)
CLSC	891,207	9.4	966,669	10.1	1,067,736	10.6	1,166,747	10.6	1,261,472	10.7
CH = CHSGS + CHSP	5,265,130	55.5	5,230,969	54.8	5,496,521	54.7	6,034,659	54.9	6,434,682	54.8
CHSLD	2,048,227	21.6	2,047,908	21.5	2,111,692	21.0	2,287,902	20.8	2,428,099	20.7
CR = CR PAT + CR PDI + CR PDP	639,652	6.7	646,604	6.8	691,416	6.9	743,871	6.8	825,937	7.0
CJ = CPEJ + CR JDA + CR MDA	635,508	6.7	637,236	6.7	671,939	6.7	727,436	6.6	773,650	6.6
ARSSS	9,790	0.1	9,363	0.1	10,328	0.1	25,218	0.2	28,295	0.2
TOTAL	**9,489,514**	**100.0**	**9,538,749**	**100.0**	**10,049,632**	**100.0**	**10,985,833**	**100.0**	**11,752,135**	**100.0**

Exclusive missions	02-03 ($,000)	(%)	03-04 ($,000)	(%)	04-05 ($,000)	(%)	05-06 ($,000)	(%)	06-07 ($,000)	(%)
CLSC	1,329,968	10.9	1,458,694	11.2	1,516,360	11.4	1,637,484	11.6	1,732,550	11.6
CH = CHSGS + CHSP	6,669,364	54.4	7,094,142	54.4	7,294,532	54.6	7,799,597	55.0	8,226,514	55.0
CHSLD	2,517,976	20.5	2,614,943	20.0	2,621,627	19.6	2,712,748	19.1	2,839,743	19.0
CR = CR PAT + CR PDI + CR PDP	888,888	7.3	977,226	7.5	1,023,516	7.7	1,087,045	7.7	1,163,064	7.8
CJ = CPEJ + CR JDA + CR MDA	816,262	6.7	862,886	6.6	872,356	6.5	906,631	6.4	950,219	6.4
ARSSS	33,137	0.3	35,287	0.3	21,341	0.2	28,748	0.2	35,381	0.2
TOTAL	**12,255,595**	**100.0**	**13,043,178**	**100.0**	**13,349,732**	**100.0**	**14,172,253**	**100.0**	**14,947,471**	**100.0**

1. The gross direct costs associated with the PRIMARY activities of institutions, as presented at the bottom of page 650 of the annual financial reports of institutions (AS-471). Accordingly, these costs exclude expenses for ancillary activities, capital assets and charges not allocated according to cost objective. It should be noted that, in gross direct costs, amounts relating to "deductions" (sale of services, collections, general cost transfers) were not subtracted.

Source: M30 system grouping together the annual financial reports of under-agreement public and private institutions within the network (AS-471 form), Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C5

Change in expenses[1] incurred for
the primary activities of under-agreement public and private institutions of the Québec health and social services network,
by expenditure coverage[2],
1990-1991 to 2006-2007 (in thousands of dollars)

SCOPE EXPENSES	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Scope total	**8,040,771**	**8,718,050**	**9,057,113**	**9,319,866**	**9,351,542**	**9,275,116**	**9,275,996**	**9,275,073**	**9,304,506**	**9,809,313**	**10,721,187**	**11,453,066**	**11,942,995**	**12,715,281**	**13,100,101**	**13,867,547**	**14,630,788**
SCOPE %	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Services	5,026,124	5,497,907	5,760,144	6,010,073	6,084,385	6,110,465	6,090,973	6,102,747	6,313,902	6,681,042	7,372,576	7,876,847	8,301,228	8,911,331	9,208,515	9,799,729	10,326,731
SCOPE %	62.5	63.1	63.6	64.5	65.1	65.9	65.7	65.8	67.9	68.1	68.8	68.8	69.5	70.1	70.3	70.7	70.6
Administration	1,024,254	1,111,187	1,157,298	1,145,075	1,136,520	1,094,775	1,024,707	982,861	974,765	1,038,316	1,129,850	1,221,341	1,280,393	1,358,046	1,379,666	1,431,985	1,535,259
SCOPE %	12.7	12.7	12.8	12.3	12.2	11.8	11.0	10.6	10.5	10.6	10.5	10.7	10.7	10.7	10.5	10.3	10.5
Operation	1,885,453	2,006,400	2,036,218	2,048,834	2,023,865	1,965,675	1,877,130	1,816,254	1,833,772	1,895,414	2,061,720	2,210,284	2,227,675	2,310,885	2,367,243	2,478,803	2,604,639
SCOPE %	23.4	23.0	22.5	22.0	21.6	21.2	20.2	19.6	19.7	19.3	19.2	19.3	18.7	18.2	18.1	17.9	17.8
Research, trainingand development	64,031	65,037	64,769	64,359	59,118	56,692	62,060	30,411	14,338	14,405	14,087	14,859	15,246	15,418	23,073	24,306	27,098
SCOPE %	0.8	0.7	0.7	0.7	0.6	0.6	0.7	0.3	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2
Miscellaneous	40,909	37,519	38,684	51,525	47,654	47,509	221,126	342,800	167,729	180,136	142,954	129,735	118,453	119,601	121,604	132,724	137,061
SCOPE %	0.5	0.4	0.4	0.6	0.5	0.5	2.4	3.7	1.8	1.8	1.3	1.1	1.0	0.9	0.9	1.0	0.9
Total support[3]	3,014,647	3,220,143	3,296,969	3,309,793	3,267,157	3,164,651	3,185,023	3,172,326	2,990,604	3,128,271	3,348,611	3,576,219	3,641,767	3,803,950	3,891,586	4,067,818	4,304,057
SCOPE %	37.5	36.9	36.4	35.5	34.9	34.1	34.3	34.2	32.1	31.9	31.2	31.2	30.5	29.9	29.7	29.3	29.4

1. Net expenses, i.e., excluding deductions and revenues generated by institutions through their primary activities, as well as all ancillary activities, capital assets and expenses not allocated by cost objective.
2. The application of expenses is determined based on a two-setting code, where the first indicates the scope and the second, the sector of application. These codes were allocated by the people responsible for the SIFO database, based on their interpretation of the definition of the scopes used within the network, which appear in the various financial management manuals. Consequently, this structure differs from that developed at the Direction de l'allocation des ressources, which is based on nine service programs and two support programs.
3. The sum of the administrative, operating, research, training and development expenses, as well as the "miscellaneous" portion.

Source: SIFO database, 1990-1991 to 2006-2007 Service de développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table C6

Actual net expenses by client program,

1993-1994 to 2001-2002, and by service program and support program, 2001-2002 to 2006-2007,

within under-agreement public and private institutions of the Québec health and social services network

(in thousands of dollars)

Program[1]	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07
Clientele-programs	**9,380,514**	**9,432,579**	**9,387,041**	**9,262,656**	**9,147,673**	**9,386,781**	**9,918,060**	**10,857,347**	**11,628,511**	**…**	**…**	**…**	**…**	**…**
Physical health	4 416,377	4,434,659	4,400,022	4,141,671	4,095,930	4,281,721	4,567,504	5,017,065	5,398,273	…	…	…	…	…
Mental health	817,021	853,491	846,736	874,182	906,824	890,017	928,623	1,002,522	1,040,006	…	…	…	…	…
Public health	187,913	181,950	188,874	219,976	238,327	238,451	244,678	249,783	272,877	…	…	…	…	…
Seniors with decreasing autonomy	2,355,053	2,285,725	2,283,167	2,356,816	2,318,535	2,297,760	2,388,027	2 611,615	2,827,647	…	…	…	…	…
Mental impairment	488,864	503,979	491,033	479,347	466,818	488,906	509,800	575,186	620,722	…	…	…	…	…
Physical impairment	317,853	340,424	341,349	358,331	361,477	385,495	425,495	474,845	479,387	…	…	…	…	…
Alcoholism and addiction	45,773	46,824	50,934	54,117	53,852	57,259	62,159	68,248	74,545	…	…	…	…	…
Youth and their families	751,660	785,527	784,926	778,216	705,910	747,172	791,774	858,083	915,054	…	…	…	…	…
Service programs	**…**	**…**	**…**	**…**	**…**	**…**	**…**	**…**	**8,455,749**	**8,943,784**	**9,609,196**	**9,918,685**	**10,574,244**	**11,162,124**
Physical health	…	…	…	…	…	…	…	…	3,780,843	4,067,325	4,376,838	4,518,388	4,972,056	5,243,525
Mental health	…	…	…	…	…	…	…	…	715,606	757,121	794,630	819,704	836,630	900,464
Public health	…	…	…	…	…	…	…	…	145,393	163,612	190,750	221,287	237,113	252,289
Loss of autonomy linked to aging	…	…	…	…	…	…	…	…	1 841,716	1,880,588	1,994,996	2,035,385	2,089,350	2,204,955
Mental impairment and PDD[2]	…	…	…	…	…	…	…	…	507,446	535,332	584,716	590,291	642,644	689,039
Physical impairment	…	…	…	…	…	…	…	…	311,633	317,787	355,145	368,380	393,044	408,646
Addiction	…	…	…	…	…	…	…	…	57,226	60,683	64,953	71,481	73,662	78,307
Youth in difficulty	…	…	…	…	…	…	…	…	720,282	760,933	823,748	820,377	850,591	874,637
General services-Clinical and help activities	…	…	…	…	…	…	…	…	375,604	400,403	423,420	473,392	479,154	510,262
Support programs	**…**	**…**	**…**	**…**	**…**	**…**	**…**	**…**	**3,172,760**	**3,257,208**	**3,409,417**	**3,512,443**	**3,648,667**	**3,852,885**
Administration and support	…	…	…	…	…	…	…	…	2,028,739	2,087,582	2,204,166	2,265,888	2,317,224	2,437,779
Building and equipment management	…	…	…	…	…	…	…	…	1,144,021	1,169,626	1 205 251	1 246 555	1,331,443	1,415,106
"Services/support" total									**11,628,509**	**12,200,992**	**13,018,613**	**13,431,128**	**14,222,911**	**15,015,009**

. . . : Not relevant.

1. The programs were restructured in 2001-2002; the eight clientele programs were redefined into nine service programs and two support programs.

2. PDD: Pervasive developmental disorder

Sources: Health and social services network expenses by clientele program, Direction générale du financement et de l'équipement, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**; financial outline, health and social services service programs and support programs, Direction générale de la coordination, du financement et de l'équipement, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C7

Trends in selected statistical indicators

of hours devoted to the primary activities[1] of under-agreement public and private institutions

of the Québec health and social services network,
1994-1995 to 2006-2007
(in thousands of dollars)

Indicator	Unit	94-95	95-96	96-97	97-98	98-99	99-00	00-01
Number of worked hours		274,416	267,703	258,040	250,528	252,140	261,235	267,142
Number of paid hours		349,417	342,681	335,135	324,906	324,364	337,616	347,931
Salaries and benefits	($,000)	7,320,864	7,275,865	7,295,398	7,261,812	7,137,925	7,448,276	8,121,900
Gross direct costs	($,000)	9,546,589	9,472,231	9,478,093	9,489,150	9,538,736	10,049,643	10,984,760
"Worked hrs / Paid hrs" ratio		0.79	0.78	0.77	0.77	0.78	0.77	0.77
Sal.+ ben. / gross dir. costs	(%)	76.7	76.8	77.0	76.5	74.8	74.1	73.9
Sal.+ ben. / Paid hrs	($)	20.95	21.23	21.77	22.35	22.01	22.06	23.34
Gross dir. costs / Worked hrs	($)	34.79	35.38	36.73	37.88	37.83	38.47	41.12

Indicator	Unit	01-02	02-03	03-04	04-05	05-06	06-07
Number of worked hours		272,183	275,709	281,982	285,462	291,531	295,308
Number of paid hours		356,284	360,374	368,416	374,521	380,622	388,102
Salaries and benefits	($,000)	8,598,044	8,892,788	9,398,941	9,552,118	9,767,965	10,223,674
Gross direct costs	($,000)	11,751,094	12,254,616	13,041,970	13,397,178	14,169,895	14,942,332
"Worked hrs / Paid hrs" ratio		0.76	0.77	0.77	0.76	0.77	0.76
Sal.+ ben. / gross dir. costs	(%)	73.2	72.6	72.1	71.3	68.9	68.4
Sal.+ ben. / Paid hrs	($)	24.13	24.68	25.51	25.50	25.66	26.34
Gross dir. costs / Worked hrs	($)	43.17	44.45	46.25	46.93	48.61	50.60

1. The primary activities are those directly associated with the mission(s) the institution is normally required to take on. Ancillary and commercial activities, on the other hand, must in principle be self-financed.

Source: SIFO database, Service du développement de l'information, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Table C8

Change in the amounts **devoted to home support,** Québec, *1994-1995 to 2006-2007*

Fiscal year	Amounts granted ($ thousands)	Progressive index	Annual growth rate (%)	Amounts per person ($)	Proportion of the HSS mission (%)
1994-1995	297,495	100		41.37	2.28
1995-1996	331,959	112	11.6	45.98	2.53
1996-1997	383,754	129	15.6	52.95	2.98
1997-1998	409,589	138	6.7	56.30	3.17
1998-1999	457,964	154	11.8	62.77	3.14
1999-2000	508,703	171	11.1	69.46	3.43
2000-2001	554,720	186	9.0	75.40	3.45
2001-2002	596,349	200	7.5	80.62	3.47
2002-2003	625,402	210	4.9	84.02	3.49
2003-2004	688,544	231	10.1	91.98	3.62
2004-2005	726,465	244	5.5	96.51	3.53
2005-2006	759,104	255	4.5	100.33	3.59
AAC[1] (%)	8.7			8.2	

1. Average annual change.

Source: Direction de l'allocation des ressources, Direction générale adjointe du budget, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, March 2008.

Table C9

Administration fees and costs of programs administered

by the Régie de l'assurance maladie du Québec,
1990-1991 to 2006-2007

Program	Indicator	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	A.A.C.[7] (%)
Medical services	($,000)	1,925,009	2,082,877	2,161,565	2,229,787	2,284,673	2,294,882	2,304,027	2,239,502	2,300,691	2,737,754	2,671,789	2,830,498	3,001,422	3,170,297	3,394,144	3,410,161	3,571,571	3.94
	Progressive index	100	108	112	116	119	119	120	116	120	142	139	147	156	165	176	177	186	
Medications and pharmaceutical services[1]	($,000)	518,093	629,383	653,934	694,283	755,780	821,878	739,627	876,332	1,032,160	1,230,623	1,518,059	1,729,713	1,914,108	2,121,542	2,273,277	2,423,400	2,638,305	10.71
	Progressive index	100	121	126	134	146	159	143	169	199	238	293	334	369	409	439	468	509	
Dental services[2]	($,000)	116,411	140,836	110,384	116,189	116,792	120,542	106,694	109,087	94,502	97,153	81,844	83,432	130,574	87,369	108,719	104,795	103,821	-0.71
	Progressive index	100	121	95	100	100	104	92	94	81	83	70	72	112	75	93	90	89	
Hospital services[3]	($,000)	127,021	133,337	124,231	113,571	119,035	112,485	99,064	94,372	93,567	94,196	102,720	88,237	105,114	119,213	131,217	140,917	151,849	1.12
	Progressive index	100	105	98	89	94	89	78	74	74	74	81	69	83	94	103	111	120	
Technical aid	($,000)	45,835	47,876	71,378	89,828	93,596	88,738	87,677	68,256	71,733	75,610	83,436	90,615	101,611	107,546	102,493	109,337	127,667	6.61
	Progressive index	100	104	156	196	204	194	191	149	157	165	182	198	222	235	224	239	279	
Optometric services	($,000)	52,490	59,732	42,819	26,431	24,570	25,293	24,794	24,247	23,776	25,758	26,890	36,009	32,828	31,741	34,349	35,448	35,604	-2.40
	Progressive index	100	114	82	50	47	48	47	46	45	49	51	69	63	60	65	68	68	
Other[4]	($,000)	28,336	32,763	13,133	13,169	13,192	13,050	8,545	8,767	9,060	10,509	12,901	10,292	9,501	22,584	11,705	11,291	10,230	-6.17
	Progressive index	100	116	46	46	47	46	30	31	32	37	46	36	34	80	41	40	36	
Domestic assistance services[5]	($,000)								3,410	8,023	19,890	31,108	37,189	41,263	41,810	42,840	42,080	45,715	
Administration fees	($,000)	69,240	72,800	85,940	77,992	74,572	73,223	81,968	90,428	92,839	94,678	95,885	104,638	114,002	136,083	127,596	131,768	137,357	4.37
	Progressive index	100	105	124	113	108	106	118	131	134	137	138	151	165	197	184	190	198	
TOTAL[6]	**($,000)**	**2,882,435**	**3,199,604**	**3,263,384**	**3,361,250**	**3,482,210**	**3,550,091**	**3,452,396**	**3,514,401**	**3,726,351**	**4,386,171**	**4,624,632**	**5,010,623**	**5,450,423**	**5,838,185**	**6,226,340**	**6,409,197**	**6,822,119**	**5.53**
	Progressive index	**100**	**111**	**113**	**117**	**121**	**123**	**120**	**122**	**129**	**152**	**160**	**174**	**189**	**203**	**216**	**222**	**237**	

1. Institution of prescription drug insurance on August 1st, 1996.
2. Some amounts for 2004-2005 were reclassified to adjust the classification by program to that applied in 2005-2006.
3. Hospital services outside Québec.
4. Includes scholarships and research grants as well as aid for people infected with the hepatitis C virus.
5. Financial exoneration for domestic assistance services instituted in October 1996, administered by the RAMQ since December 1997.
6. Collections from third-party delivery agents and foreign nationals for hospital care were not subtracted ($3.8 M in 1998-1999 and 1999-2000; $4.3 M in 2000-2001; $3.9 M in 2001-2002; $4.6 M in 2002-2003; $5.9 M in 2003-2004; $4.6 M in 2004-2005; $6 M in 2005-2006; and $7.3 M in 2006-2007). The $3.7 M loss on disposal of investment was not added in 2002-2003.
7. Average annual change.

Source: Annual management report of the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca**, Financial Statements, respective years.

MSSS, SDI, March 2008.

Table C10

Amounts paid **to "active" physicians,** by compensation method, Québec, *1990 to 2007*

Calendar year	Fee-for-service and by unit ($)	Salary-based ($)	Flat rate fees ($)	Total ($)
1990	1,529,495,177	82,434,407	122,800,072	1,734,729,656
1991	1,623,977,961	84,808,871	146,778,808	1,855,565,640
1992	1,710,803,418	87,747,986	158,653,379	1,957,204,783
1993	1,770,578,673	87,550,871	165,097,297	2,023,226,841
1994	1,800,428,132	91,645,101	167,885,522	2,059,958,755
1995	1,828,196,420	87,501,659	179,437,538	2,095,135,617
1996	1,804,786,520	83,345,205	191,509,614	2,079,641,339
1997	1,796,078,154	77,463,890	198,630,671	2,072,172,715
1998	1,820,587,801	70,914,368	209,690,998	2,101,193,167
1999	1,924,360,122	66,926,361	237,991,119	2,229,277,602
2000	1,942,003,641	66,646,692	342,620,679	2,351,271,012
2001	2,118,205,824	68,496,123	401,995,073	2,588,697,020
2002	2,134,292,680	71,682,996	444,080,150	2,650,055,826
2003	2,289,402,548	74,963,539	504,897,108	2,869,263,195
2004	2,398,696,706	73,579,775	569,436,867	3,041,713,348
2005	2,436,499,143	72,371,027	589,217,845	3,098,088,015
2006	2,510,078,820	70,886,936	614,512,732	3,195,478,488
2007[1]	2,633,485,080	69,590,680	676,944,076	3,380,019,837

1. The numbers for 2007 were forecasted.

Source: Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table C11

Number, cost and average cost of dental services covered by the Québec health insurance plan,

fee-for-service compensation, all programs combined,
1990 to 2007

Indicators	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07[1]
Number of services																		
	4,579,728	4,775,133	4,072,992	3,585,622	3,740,723	3,862,672	3,879,945	2,727,042	2,730,478	2,613,198	2,468,204	2,365,941	2,275,126	2,222,834	2,226,289	2,145,806	2,091,374	2,058,924
Progressive index	100	104	89	78	82	84	85	60	60	57	54	52	50	49	49	47	46	45
Annual change (%)		4.3	-14.7	-12.0	4.3	3.3	0.4	-29.7	0.1	-4.3	-5.5	-4.1	-3.8	-2.3	0.2	-3.6	-2.5	-1.
Cost of services																		
($)	110,393,087	115,267,206	114,109,777	117,184,579	120,056,790	123,876,529	125,314,698	84,769,069	86,174,832	82,962,394	79,234,188	76,595,054	74,401,957	89,853,182	96,205,850	92,603,790	89,775,470	86,431,323
Progressive index	100	104	103	106	109	112	114	77	78	75	72	69	67	81	87	84	81	78
Annual change (%)		4.4	-1.0	2.7	2.5	3.2	1.2	-32.4	1.7	-3.7	-4.5	-3.3	-2.9	20.8	7.1	-3.7	-3.1	-3.7
Average cost of services																		
($)	24.10	24.14	28.02	32.68	32.09	32.07	32.30	31.08	31.56	31.75	32.10	32.37	32.70	40.42	43.21	43.16	42.93	41.98
Progressive index	100	100	116	136	133	133	134	129	131	132	133	134	136	168	179	179	178	174
Annual change (%)		0.1	16.1	16.7	-1.8	-0.1	0.7	-3.8	1.5	0.6	1.1	0.8	1.0	23.6	6.9	-0.1	-0.5	-2.2

1. The numbers for 2007 were forecasted.
Source: Information extracted from the RAMQ **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table C12

Number, cost and average cost of optometric services covered by the Québec health insurance plan,

all programs combined,
1990 to 2007

Indicators	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07[1]
Number of services																		
	3,613,693	3,756,057	3,256,111	1,999,652	1,567,459	1,592,476	1,633,476	1,581,585	1,606,423	1,661,722	1,704,064	1,758,605	1,825,392	1,882,491	1,982,234	2,011,238	2,095,031	2,132,857
Progressive index	100	104	90	55	43	44	45	44	44	46	47	49	51	52	55	56	58	59
Annual change (%)		3.9	-13.3	-38.6	-21.6	1.6	2.6	-3.2	1.6	3.4	2.5	3.2	3.8	3.1	5.3	1.5	4.2	1.8
Cost of services																		
($)	53,267,573	57,177,905	48,623,688	30,850,195	24,573,726	24,978,918	25,716,923	24,566,584	24,753,869	25,894,443	27,798,751	29,122,176	30,051,105	31,307,598	32,652,250	33,047,765	34,158,232	35,274,679
Progressive index	100	107	91	58	46	47	48	46	46	49	52	55	56	59	61	62	64	66
Annual change (%)	7.3	-15.0	-36.6	-20.3	1.6	3.0	-4.5	0.8	4.6	7.4	4.8	3.2	4.2	4.3	1.2	3.4	3.3	
Average cost of services																		
($)	14.74	15.22	14.93	15.43	15.68	15.69	15.74	15.53	15.41	15.58	16.31	16.56	16.46	16.63	16.47	16.43	16.30	16.54
Progressive index	100	103	101	105	106	106	107	105	105	106	111	112	112	113	112	111	111	112
Annual change (%)		3.3	-1.9	3.3	1.6	0.1	0.4	-1.3	-0.8	1.1	4.7	1.5	-0.6	1.0	-1.0	-0.2	-0.8	1.4
Average cost per participant																		
($)	34.23	35.78	35.77	34.14	33.43	33.51	33.63	32.43	31.62	31.64	31.72	32.04	35.19	35.48	36.39	36.25	36.51	37.12
Progressive index	100	105	104	100	98	98	98	95	92	92	93	94	103	104	106	106	107	108
Variation annuelle (%)		4.5	0.0	-4.6	-2.1	0.2	0.4	-3.6	-2.5	0.1	0.3	1.0	9.8	0.8	2.6	-0.4	0.7	1.7

1. The numbers for 2007 were forecasted.
Source: Information extracted from the RAMQ **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table C13

Volume and cost of medications and pharmaceutical services covered by the Québec prescription drug insurance plan, by group of insured persons, *1990 to 2007*

Clienteles	Indicators	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07[1]
Employment assistance recipients																			
	Number of prescriptions	6,954,192	7,590,717	8,356,739	8,714,738	9,256,904	9,800,409	9,698,222	9,205,239	9,725,595	10,458,418	11,696,297	13,009,471	14,223,305	15,375,143	16,675,403	17,684,882	18,851,187	20,713,757
	Progressive index	100	109	120	125	133	141	139	132	140	150	168	187	205	221	240	254	271	298
	Gross cost of prescriptions ($)	122,355,138	143,801,392	172,655,242	188,242,484	198,758,437	217,551,982	217,036,015	231,287,646	264,572,406	305,288,639	359,083,479	408,761,528	455,029,640	497,537,177	534,779,183	555,049,287	589,177,117	596,200,000
	Progressive index	100	118	141	154	162	178	177	189	216	250	293	334	372	407	437	454	482	487
	Average gross cost per prescription ($)	17.59	18,94	20,66	21,60	21,47	22,20	22,38	25,13	27.20	29.19	30.70	31.42	31.99	32.36	32.07	31.39	31.25	28.78
	Deductible and coinsurance							10,932,094	34,321,168	31,537,525	27,575,706	15,643,088	15,386,328	15,424,870	15,923,150	15,930,888	15,558,872	15,336,059	15,500,000
	Net cost of prescriptions ($)	122,355,138	143,801,392	172,655,242	188,242,484	198,758,437	217,551,982	206,103,921	196,966,478	233,034,881	277,712,933	343,440,391	393,375,200	439,604,770	481,614,027	518,848,295	539,490,415	573,841,058	580,700,000
	Number of participants	418,994	463,233	505,454	551,195	582,652	606,735	591,917	498,328	467,292	436,837	414,706	398,038	387,648	379,828	372,004	362,401	355,395	373,398
	Progressive index	100	111	121	132	139	145	141	119	112	104	99	95	93	91	89	86	85	89
	Average net cost per participant($)	292.02	310,43	341,58	341,52	341,13	358,56	348,20	395,25	498.69	635.74	828.15	988.29	1,134.03	1,267.98	1,394.74	1,488.66	1,614.66	1,555.18
	Progressive index	100	106	117	117	117	123	119	135	171	218	284	338	388	434	478	510	553	533
Seniors (or: persons 65 years of age or older);																			
	Number of prescriptions	21,710,641	23,584,225	22,931,305	22,540,168	23,775,582	25,363,390	26,784,594	26,565,539	28,739,100	31,641,365	36,027,927	41,187,683	45,953,330	51,163,797	56,963,651	61,847,463	68,226,542	77,533 ,81
	Progressive index	100	109	106	104	110	117	123	122	132	146	166	190	212	236	262	285	314	357
	Gross cost of prescriptions ($)	387,469,671	453,378,124	476,206,344	501,859,850	569,247,003	623,308,515	647,758,630	648,247,693	724,239,232	834,008,602	995,457,705	1,160,618,226	1,309,093,498	1,460,090,529	1,603,082,582	1,704,618,338	1,852,423,364	1,901,400,000
	Progressive index	100	117	123	130	147	161	167	167	187	215	257	300	338	377	414	440	478	491
	Average gross cost per prescription ($)	17.85	19.22	20.77	22.27	23.94	24.58	24.18	24.40	25.20	26.36	27.63	28.18	28.49	28.54	28.14	27.56	27.15	24.52
	Deductible, $2 contribution and coinsurance					35,492,227	37,494,972	84,714,204	177,264,836	185,609,166	202,456,763	225,215,069	247,608,675	279,803,372	320,632,543	345,162,445	361,715,177	384,758,004	393,000,000
	Gross cost of prescriptions ($)	387,469,671	453 378,124	476,206,344	501,859,850	533,754,776	585,813,543	563,044,426	470,982,857	538,630,066	631,551,839	770,242,636	913,009,551	1,029,290,126	1,139,457,986	1,257,920,137	1,342,903,161	1,467,665,360	1,508,400,000
	Number of participants	653,481	673,953	685,564	710,250	734,684	757,526	777,940	728,960	739,221	755,159	771,121	789,950	803,365	818,632	835,902	854,163	877,982	911,932
	Progressive index	100	103	105	109	112	116	119	112	113	116	118	121	123	125	128	131	134	140
	Average net cost per participant ($)	592.93	672.71	694.62	706.60	726.51	773.32	723.76	646.10	728.65	836.32	998.86	1,155.78	1,281.22	1,391.91	1,504.87	1,572.19	1,671.63	1,654.07
	Progressive index	100	113	117	119	123	130	122	109	123	141	168	195	216	235	254	265	282	279
Members of the prescription drug insurance plan																			
	Number of prescriptions	…	…	…	…	…	…	…	9,548,024	11,266,119	12,713,749	14,326,361	15,785,593	16,822,638	17,386,226	18,198,995	18,774,627	19,852,025	20,819,774
	Gross cost of prescriptions ($)	…	…	…	…	…	…	…	239,878,905	303,015,942	364,500,139	434,013,814	502,620,059	560,638,132	607,427,826	649,324,666	675,811,319	731,368,177	749,400,000
	Average gross cost per prescription ($)	…	…	…	…	…	…	…	25.12	26.90	28.67	30.29	31.84	33.33	34.94	35.68	36.00	36.84	35.99
	Deductible and coinsurance ($)	…	…	…	…	…	…	…	75,330,892	85,209,066	97,587,684	110,889,703	123,895,666	139,432,598	157,367,223	168,250,738	177,025,906	189,913,334	195,300,000
	Gross cost of prescriptions ($)	…	…	…	…	…	…	…	164,548,013	217,806,876	266,912,455	323,124,111	378,724,393	421,205,534	450,060,603	481,073,928	498,785,413	541,454,843	554,100,000
	Number of members	…	…	…	…	…	…	…	1,391,941	1,510,485	1,609,848	1,675,605	1,723,204	1,725,331	1,714,897	1,715,058	1,718,464	1,699,649	1,703,437
	Number of participants	…	…	…	…	…	…	…	824,743	907,325	969,182	1,007,572	1,033,625	1,031,008	1,014,330	1,009,234	1,015,784	1,022,890	1,145,173
	Average net cost per participant ($)	…	…	…	…	…	…	…	199.51	240.05	275.40	320.70	366.40	408.54	443.70	476.67	491.03	529.34	483.86

. . . : Not relevant.

1. The numbers for 2007 were estimated.

Source: Information extracted from the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table C14

Average cost per beneficiary of technical aid services

covered by the Québec health insurance plan, by program,
1990 to 2007

Programs	Indicators	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07[2]
Devices that Compensate for Physical Disabilities																			
	Number of beneficiaries	44,198	47,436	51,179	52,651	46,625	47,726	49,618	50,858	53,476	53,656	58,429	62,384	64,785	65,899	69,307	71,423	74,688	76,917
	Program cost ($)	34,167,027	35,856,810	41,562,714	46,048,282	43,400,771	43,205,764	45,848,157	43,126,531	46,008,793	45,581,821	50,518,205	55,401,957	61,568,473	65,247,555	70,312,046	75,082,441	81,002,661	85,463,514
	Average cost per beneficiary ($)	773.04	755.90	812.10	874.59	930.85	905.29	924.02	847.98	860.36	849.52	864.61	888.08	950.35	990.11	1,014.50	1,051.24	1,084.55	1,111.11
External Breastforms Program																			
	Number of beneficiaries	2,280	2,069	2,834	7,411	8,579	9,647	7,744	3,010	8,845	4,192	8,151	4,729	8,133	5,048	8,259	5,657	8,346	6,372
	Program cost ($)	121,242	123,455	637,185	2,697,765	2,297,298	2,585,209	1,862,845	688,974	1,895,186	884,723	1,737,829	1,004,179	1,737,161	1,070,462	1,769,274	1,200,428	1,787,631	1,287,939
	Average cost per beneficiary ($)	53.18	59.67	224.84	364.02	267.78	267.98	240.55	228.90	214.27	211.05	213.20	212.34	213.59	212.06	214.22	212.20	214.19	202.12
Hearing Devices Program																			
	Number of beneficiaries	8,790	9,680	10,184	34,128	58,164	66 279	71,982	44,705	18,058	23,143	28,018	27,676	45,303	48,425	50,329	52,837	56,002	58,208
	Program cost ($)	3,400,442	4,036,679	4,839,157	14,579,663	22,673,083	19,650,032	19,317,056	11,368,790	9,069,510	12,353,308	15,317,891	14,620,410	16,700,469	18,300,086	19,704,448	22,249,490	27,812 ,876	31,364,033
	Average cost per beneficiary ($)	386.85	417.01	475.17	427.21	389.81	296.47	268.36	254.31	502.24	533.78	546.72	528.27	368.64	377.91	391.51	421.10	496.64	538.83
Ostomy Appliances Program																			
	Number of beneficiaries	6,727	6,798	7,376	8,138	8,202	8,436	7,922	8 639	8,927	9,037	9,227	9,443	9,608	9 730	10,001	10,211	10,319	10,538
	Program cost ($)	2,180,055	2,418,663	4,756,517	5,454,368	5,239,182	5,756,593	5,036,972	5,505,199	6,058,442	5,758,724	5,868,117	6,061,484	6,192,096	6,282,057	6,506,629	6,662,321	7,116,646	7,371,882
	Average cost per beneficiary ($)	324.08	355.79	644.86	670.23	638.77	682.38	635.82	637.25	678.66	637.24	635.97	641.90	644.47	645.64	650.60	652.47	689.66	699.55
Visual Devices Program[1]																			
	Number	2,674	3,053	3,293	4,136	5,098	5,721	6,062	5,833	6,241	6,631	7,372	7,263	7,789	7,991	8,149	8,147	8,680	8,778
	Program cost ($)	1,642,807	1,922,024	2,611,338	3,790,987	4,621,043	4,845,601	4,230,894	2,446,826	2,943,362	3,237,433	4,241,736	3,720,751	3,872,205	3,940,994	4,383,106	4,033,206	4,635,129	4,681,235
	Average cost per beneficiary ($)	614.36	629.55	793.00	916.58	906.44	846.98	697.94	419.48	471.62	488.23	575.38	512.29	497.14	493.18	537.87	495.05	534.00	533.29
Ocular Prostheses Program																			
	Number of beneficiaries	1,893	1,790	1,871	1,919	1,957	1,999	2,019	1,980	1,931	1,963	2,011	2,058	2,039	2,143	2,149	2,253	2,225	2,286
	Program cost ($)	117,685	151,990	390,523	371,905	396,520	386,300	371,905	336,004	340,510	356,406	336,029	332,653	341,887	370,379	369,816	386,044	352,713	382,136
	Average cost per beneficiary ($)	62.17	84.91	208.72	193.80	202.62	193.25	184.20	169.70	176.34	181.56	167.10	161.64	167.67	172.83	172.09	171.35	158.52	167.16
All programs																			
	Number of beneficiaries	66, 562	70,826	76,737	108,383	128,625	139,808	145,347	115,025	97,478	98,622	113,208	113,553	137,657	139,236	148,194	150,528	160,260	163,099
	Program cost ($)	41,629,258	44,509,621	54,797,434	72,942, 970	78,627,897	76,429,499	76,667,829	63,472,324	66,315,803	68,172,415	78,019,807	81,141,434	90,412,291	95,211,533	103,045,319	109,613,930	122,707,656	130,550,739
	Average cost per beneficiary ($)	625.42	628.44	714.09	673.01	611.30	546.67	527.48	551.81	680.32	691.25	689.17	714.57	656.79	683.81	695.34	728.20	765.68	800.44

1. Including maintenance costs for guide dogs from 1999 onward.

2. The numbers for 2007 were forecasted.

Source: Information extracted from the Régie de l'assurance maladie du Québec **www.ramq.gouv.qc.ca** annual statistics.

MSSS, SDI, April 2008.

Table C15

Amounts granted to community organizations,

by organization type, Québec,
1991-1992 to 2007-2008

Fiscal year	Regional organizations ($)	National organizations ($)	Total ($)	Annual growth rate (%)	Proportion of the HSS mission (%)
1991-1992	..	..	65,089,600		0.5
1992-1993	..	..	76,430,000	17.4	0.6
1993-1994	..	..	85,585,600	12.0	0.7
1994-1995	..	..	98,147,437	14.7	0.8
1995-1996	..	..	127,485,854	29.9	1.0
1996-1997	..	..	150,380,572	18.0	1.2
1997-1998	..	..	181,367,477	20.6	1.4
1998-1999	..	..	199,764,598	10.1	1.4
1999-2000	..	..	212,565,423	6.4	1.4
2000-2001	227,362,694	4,913,110	232,275,804	9.3	1.4
2001-2002	250,871,226	5,728,006	256,599,232	10.5	1.5
2002-2003	268,366,138	5,967,160	274,333,298	6.9	1.5
2003-2004	295,571,548	6,791,001	302,362,549	10.2	1,6
2004-2005	318,106,349	8,452,632	326,558,981	8.0	1,6
2005-2006	340,591,460	8,284,272	348,875,732	6.8	1.6
2006-2007	361,547,494	8,384,619	369,932,113	6.0	1.6
2007-2008	390,417,145	8,822,890	399,240,035	7.9	1.6
AAC[1] (%)			12.0		

. . : Data non available.

1. Average annual change

Sources: Data extracted from the SBF-R system by the Service des activités communautaires, Direction générale des services sociaux; Direction de l'allocation des ressources, Direction générale adjointe du budget, Ministère de la Santé et des Services sociaux du Québec **www.msss.gouv.qc.ca**.

MSSS, SDI, April 2008.

Appendices

APPENDIX 1

SHORT HISTORICAL REFERENCES REGARDING REGIONALIZATION WITHIN THE QUÉBEC HEALTH AND SOCIAL SERVICES SYSTEM

The primary objective of regionalization is to better adapt the organization of health services and social services to the reality of each region, taking into account the demographic, socioeconomic and health and social characteristics of each. A number of bills marked the evolution of the regionalization movement in Québec. The most important include bills 65, 27, 120, 116, 28, 25 and 83. Aside from the latter one, each one of these bills was preceded by a study commission. Although each of these bills comprises its own particular aspects, they all shared the ultimate goal of moving closer to the fundamental objective, i.e., regionalization.

Regional Health and Social Services Councils

The first major milestone towards regionalization was reached in November 1966, when the Commission of Inquiry on Health and Social Welfare was created. This Commission, chaired by Claude Castonguay until March 1970 and then by Gérard Nepveu, proposed, among other reform elements, an administrative decentralization based on three regions, each one with its own regional health office (or office régional de la santé (ORS)), to ensure the planning, programming and administrative control, as well as a regional health council (or conseil régional de la santé (CRS)) to prompt public participation.

When Minister Castonguay took political office, he gave concrete expression to some of the recommendations made by the Castonguay-Nepveu commission. Because the decentralization formula presented in a first version of Bill 65 did not seem very feasible, he proposed grouping together authorities, dividing the territory into twelve health and social services regions and creating the regional social affairs office (or Office régional des affaires sociales (ORAS)). It was only with the final version of Bill 65 that the regional health and social services councils (or conseils régionaux de la santé et des services sociaux (CRSSS)) were created.

In time, however, it became evident that the CRSSSs had no real authority and that the boards of directors favoured the presence of representatives from the institutions to the detriment of membership by public representatives. Accordingly, in 1981, the government sanctioned Bill 27, which, on the one hand, modified the composition of the boards of directors to increase their representativeness and, on the other hand, gave the CRSSSs a little more responsibility.

Regional Health and Social Services Boards

Following the work of the Rochon commission, instituted in 1988, it was proposed that the CRSSSs be replaced by regional health and social services boards (or régies régionales de la santé et des services sociaux (RRSSS)) with managerial autonomy and greater responsibility. With the adoption in 1991 of Bill 120, the regional boards were finally created by Minister Marc-Yvan Côté. Their boards of directors were officially constituted on October 1st, 1992. In this way, Bill 120 marked the beginning of the modern era of regionalization.

In 1996, Minister Jean Rochon passed Bill 116, which amended the composition of the boards of directors of the regional boards to increase their representativeness.

The Clair Commission, created in 2000, not only confirmed the need for regional boards responsible and accountable to the MSSS, but also suggested giving them extensive leeway along with the necessary autonomy to enable them to update departmental thrusts, organize the services in the region and allocate financial resources to institutions.

Results-based management combined with increased accountability between the various levels of management came into play in the health and social services network as a result of Bill 28, sanctioned in 2001. It was also through this legislation that the Forum de la population (people's forum) was created. Its mandate included ensuring the implementation of various methods of public consultation on issues associated with health and well-being based on the dynamics of each region.

Regional Health and Social Services Agencies

Bill 25, sanctioned in 2003, brought with it a significant new cycle of change in Québec's health and social services network. In addition to keeping the Forum de la population in operation and confirming the need for the regional level of authority, this bill aimed for greater decentralization to the local level.

The regional boards were replaced by regional agencies for the development of local health and social services networks (or agences de développement de réseaux locaux de services de santé et de services sociaux (ADRLSSSS)). In fact, during a two-year transition period, the duties and responsibilities of the regional boards were transferred to the agencies. The latter were also given two new responsibilities: the creation and coordination of local services networks (or réseaux locaux de services (RLS)).

Then, in 2005, Bill 83 made it possible to take an important step in the organization and administration of health and social services. Among other things, this new legislation clarified the responsibilities of the system's various levels of authority following the establishment of the 95 local services networks. The latter comprise one or more CLSCs, CHSGSs and CHSLDs, overseen by a local authority: the health and social services centre (or centre de santé et de services sociaux (CSSS)). Moreover, the ADRLSSSSs became regional health and social services agencies (or agences régionales de la santé et des services sociaux (ARSSS)).

APPENDIX 2

BRIEF HISTORICAL REFERENCES REGARDING THE PUBLIC'S PARTICIPATION IN THE MANAGEMENT OF QUÉBEC'S HEALTH AND SOCIAL SERVICES SYSTEM

One of the fundamental principles of democratic societies is to involve citizens in decisions that affect them. When it comes to health and social services, as in other fields, the participation of citizens in these decisions becomes an important factor for the successful achievement of the goals set by a government. Accordingly, because public participation is a predominant aspect of democratic governance, public systems increasingly seek to give citizens the means of directly influencing the organizations that provide them with services.

First steps

The first important step in ensuring the public's participation in the network's decision-making authorities was taken in November 1966, when the Commission of Inquiry on Health and Social Welfare was created. The latter, chaired by Claude Castonguay until March 1970, and then by Gérard Nepveu, proposed, among other reform elements, an administrative decentralization based on three regions, each with its own regional health council (or conseil régional de la santé (CRS)), to prompt public participation. The resulting final version of Bill 65 saw the implementation of the merger of CRSs with other authorities to create the regional health and social services councils (CRSSS).

By establishing the public's participation using the parameters of Québec's new health and social services system, the commissioners made of the decisional participation—for the users of health and social services—and consultative participation—for the population in general—the mechanisms that would ensure the system's ongoing adaptation to the ever-changing needs of Québec's population.

These two groups of participants thus joined the health professionals who already exerted a significant influence on the system. As well, with the unionization movement and the emergence of new, more open management approaches, network employees also became participants in the system's governance.

Refocusing participation on citizens

In time, however, it became evident that the CRSSSs had no real authority and that the boards of directors favoured the presence of representatives from the institutions to the detriment of membership by public representatives. The public's participation in the system's management somewhat waned following that, leaving more room for other groups to get involved.

Accordingly, in 1981, the government sanctioned Bill 27, which, on the one hand, modified the composition of the boards of directors to increase their representativeness and, on the other hand, gave the CRSSSs a little more responsibility.

In the 1990s, successive reforms also aimed to correct the situation by attempting to refocus the participation on citizens, on the one hand, through the election of members to the boards of directors of institutions and, on the other hand, thanks to the integrative role of the regional boards, the regional authorities that came after the CRSSSs. Unfortunately, the very limited number of elected public representatives and the inability of local and regional players to face the whims of the various interest groups within the system itself brought about a sense of failure with regard to the goal of true public participation in the management of the health and social services system.

The people's forum

Bill 28, sanctioned in June 2001, re-opened the issue of public participation. The principle of direct public representation on the boards of directors of the institutions was maintained, as was its decisional weight, but the method of appointment gave regional authorities more flexibility. Accordingly, the goal was not to democratize the system's management but to increase the institutions' accountability to the regional boards. While the managers' role was established, that of the users in the system's governance was maintained, despite a decline in all categories of member on the boards of directors of institutions.

However, this change in the population's decisional participation in the network's management did not signal the end of its consultative participation. Accordingly, following a recommendation made by the Clair Commission, the law amending governance in the network of health and social services made the creation of the Forums de la population [people's forums] official. Composed of 15 to 20 members designated by the regional board's board of directors, the forum acts as a user committee in a health and social services institution. It represents the region's citizens, makes recommendations to the regional board's board of directors on regional thrusts, and implements various public consultation processes on issues associated with health and welfare, based on the dynamics of each region.

The consultation forum

Several other public consultation mechanisms have been set up in recent years.

First, at the local level, each of the 95 health and social services centres (CSSS), created following Bill 25, is required to consult the population it serves, both to prompt its participation in the organization of services and to learn its degree of satisfaction with the services provided. At the regional level, each of the 18 regional authorities—which succeeded the regional boards when Bill 25 was adopted—must establish a people's forum.

At the provincial level, following the appointment of a Health and Welfare Commissioner in the summer of 2006, a Forum de consultation [consultation forum] was instituted. Composed of 27 members, including 18 citizens representing each of Québec's health and social services regions, this forum serves as advisor to the Commissioner as regards the fulfilment of his mandate.

In conclusion

The fact that there is no perfect method of ensuring the public's involvement does not take away from the need for public input, in whatever form, to help public organizations operate smoothly, in particular those that provide health services and social services. Necessary for the revival, in time, of organizational governance within a democratic context, the public's participation should make it possible to establish a true link between services and users for the greater benefit of the community.

APPENDIX 3

BRIEF HISTORICAL REFERENCES TO THE PRIVATE SECTOR'S PARTICIPATION IN THE QUÉBEC HEALTH AND SOCIAL SERVICES SYSTEM

Emergence of the private sector

Prior to 1930, the majority of people paid for the care they needed; only the really poor could benefit from free care in accordance with the *Québec Public Charges Act*, promulgated in 1921.

The Great Depression gave rise to the first connections between private insurance and hospital care. Thanks to the initiatives of the Montréal Board of Trade, a private hospital insurance company was created. With the support of major medical and hospital organizations as well as important entrepreneurs and insurers, the Blue Cross was founded in 1942. The ultimate goal of this non-profit company was to prevent at all costs the establishment of a government monopoly in the area of health insurance. It initiated the spectacular development of private health insurance that started during World War II.

With major commercial (i.e., for-profit) insurance companies following suit, Québec's health system in the post-war era became a mixed, predominantly private system, with the state maintaining responsibility for the poor. The rest of the population had to get insurance or pay the costs of care directly.

Consequently, at the beginning of the 1950s, the stage seemed set for the establishment of a health care system similar to that seen in the US.

Failure

In the period following the war, the challenge faced by private insurers was making insurance accessible to the majority of the population. Yet, coverage peaked at 43% of the population, and only one person out of ten could count on full coverage. The others opted for insurance plans providing partial coverage. As well, skyrocketing hospital costs led to a significant rise in the cost of insurance, thus threatening access to the latter for people with lower incomes, as insurance companies found themselves incapable of providing coverage adapted to this clientele.

By basing insurance prices on the rising cost of medical and hospital care, private insurance contributed to the rising costs of health services, thus making it incapable of making good on its promises.

In the early 1960s, the predominantly private mixed health care program failed, especially within a social context where social inequities and the arbitrary power of political and employer authorities were strongly criticized. The universal health insurance plan was thus instituted in the wake of this failure.

Establishment of a public plan

With the adoption of the *Hospital Insurance and Diagnostic Services Act* in 1957 and of the *Medical Care Act* in 1966, the federal government sought to encourage the establishment of a universal public health insurance plan in each of Canada's provinces.

The 1957 legislation had two great objectives: on the one hand, to make sure that all citizens had access to medically required services in a timely manner, regardless of their capacity to pay; and, on the other hand, to make sure that no citizens would be exposed to excessive financial loss from having to cover health care bills.

As the government was the only entity with sufficient capital at its disposal to develop a full network of institutions across Québec and ensure access to the latter for the entire population, it fostered, in the 1960s, the use of the public sector for the generation of health services. Although medical clinics remained in private ownership, existing health institutions belonging to charity organizations were acquired by the government and their staff became government employees.

And so, in January 1961, Québec adopted the *Hospital Insurance* Act, which saw the implementation of a public insurance plan covering the services dispensed in hospital institutions providing short-term care. Ten years later, in January 1971, with the institution of a universal health insurance plan, medically required medical services became free for all residents of Québec, i.e., covered by the state.

Later, in 1984, the central government sanctioned the *Canada Health Act* setting out four great fundamental principles that are still applied today: universality, comprehensiveness, accessibility, and portability. The public administration of the health and social services system, often considered the fifth great fundamental principle of the 1984 legislation, underlines the obligation to adopt a single-payer model, with the payer being a provincial government. In the end, this is more an element of administrative efficiency that in no way forbids the delivery of services by the private sector.

The state takes charge of care

Driven by the recommendations of the Castonguay-Nepveu Commission, the 1970s saw Québec lay the foundations for today's health and social services system. Health services and social services were henceforth part of a global policy on social development in Québec.

However, contrary to what had been planned, costs continued to rise. This situation, combined with the economic crisis of the early 1980s, led the health system into an impasse.

Accordingly, in 1985, the government created the Rochon Commission, mandated, among other things, to find solutions to the system's funding problems. The commission rejected the option of resorting to private funding for health services already insured by the state. According to the commission, this solution raised serious equity issues and did not in any way guarantee a better return on financial resources invested in the health and social sector.

In a report bearing his name, published a lot later (in 1999), Roland Arpin drew the same conclusions. He spoke out against privatization and recommended upholding provisions preventing private insurance companies from covering medical and hospital services already insured by the public plan.

Opening to the private sector

However, despite all efforts to correct them, some basic problems persist: the inadequacy of front-line services, coordination problems between the various intervention levels, complementarity problems between services and, of course, financing problems.

And so, in 2000, the government created the Clair Commission to once again examine these issues. In its report, the commission reasserted the importance of maintaining the public funding of the system, but also suggested re-examining the partnership with the private sector, from the viewpoint of complementing the services generated by the public sector.

As well, in 2005, although the Ménard report on the study of the sustainability of Québec's health and social services system insisted on the importance of financing the system using solely public funds, it opened the door for the private sector for the purchase of specific diagnostic and therapeutic services and certain capital projects.

That same year, the Supreme Court of Canada, in Chaoulli and Zeliotis, adjudicated that the prohibition against private insurance for services covered by the public plan infringed on the Québec Charter of Human Rights and Freedoms.

In the document titled *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality*, published in February 2006, the Minister responded to the Chaoulli-Zeliotis decision. His response took the form of a public mechanism for access to specific medical procedures, combined with a limited openness to private insurance for hip and knee replacement surgeries as well as for cataract surgeries.

Moreover, the *Act to amend the Act respecting health services and social services and other legislative provisions*, sanctioned in December 2006, provided for the possibility for a hospital centre to become affiliated with a private medical clinic to dispense specialized medical care to some of its users. It should be noted that these users will not have to pay to obtain these services as these continue to be covered by the state. For users, there will accordingly be no real difference compared to a service obtained at a hospital, as only the delivery of the services is privatized.

In addition, the *Act to amend the Act respecting health services and social services and other legislative provisions* amended the *Health Insurance Act*, providing the possibility for a person to obtain a private insurance contract to cover the cost of specific covered medical services required. The act also amended the *Hospital Insurance Act* to maintain the prohibition against insurance contracts comprising a guarantee of payment for the cost of insured hospital services.

Lastly, in June 2007, the Cabinet entrusted a task force chaired by Claude Castonguay with the general mandate to make recommendations on the best ways of ensuring adequate funding for Québec's health and social services system. One of the four components of its mandate was to specify the role that the private sector could play to improve access and reduce wait times, all while preserving a public system intent on maintaining the values that characterize it.

APPENDIX 4

BRIEF HISTORICAL REFERENCES ON THE PARTICIPATION OF THE FEDERAL GOVERNMENT TO THE FUNDING OF QUÉBEC'S HEALTH AND SOCIAL SERVICES SYSTEM

Federal/provincial context

To understand the structure of the health and social programs in effect in Québec, one must consider that, since the *Constitution Act, 1867*, Québec is a member of the Canadian confederation. Unlike a unitary state, a state that is a member of a federation must share its fields of jurisdiction according to variable criteria.

At the constitutional level, two fundamental aspects must be considered in government interventions, particularly on matters of health services and social services, that is, the sharing of jurisdictions between the federal and provincial governments and the federal-provincial arrangements worked out alongside the Constitution.

Thus, under the Canadian Constitution, health services and social services are under provincial jurisdiction, except for certain citizens, for example, members of the armed forces and First Nations people, and for certain services, for example, drug approval. But, for the most part, the federal government's participation in the funding of health and social services consists in indirect interventions made pursuant to its general spending power. Accordingly, without having any jurisdiction over health, the federal government gives the provinces and territories subsidies with particular conditions attached, allowing it to intervene indirectly in exclusively provincial areas of jurisdiction.

Beginning of federal funding

In 1957, the Government of Canada enacted the *Hospital Insurance and Diagnostic Services Act*. This act guaranteed that the federal government would finance 50 percent of the provinces' hospital insurance programs. Québec was opposed to this type of arrangement and instead demanded a transfer of tax resources. This was why it did not join the program until 1961. In 1964, Canada offered the provinces the opportunity to fund hospital insurance and social assistance programs through a tax transfer in the form of equalization. Only Québec took up the offer under the *Established Programs Act*.

Health insurance then came under a financing act. In fact, the federal government was led to contribute to the health insurance plans in 1965 and passed the *Medical Care Act*. As was the case for hospital insurance, Canada assumed approximately 50% of the provinces' expenses in this regard.

The transfer of tax points

From 1977 onwards, the funding of these established programs was ensured under the *Established Programs Financing Act*. The Established Programs Financing (EPF) included a cash component and a tax point transfer. When it was instituted, the tax component of this transfer plan depended on the pace of the economy, that is, the development of the gross domestic product (GDP is a measure of goods and services produced in a country, regardless of the residents' citizenship), while the cash component depended on the gross national product (GNP is a measure of goods and services produced by citizens of a country, regardless of their place of residence). The federal government has since imposed several changes and measures that have markedly reduced transfers to the provinces.

The federal government's decreased participation in the funding of health and social services programs was given effect first through the 1984 *Canada Health Act* which imposed new restrictions on the provinces, then through Bill C-96 in 1986 which restricted federal contributions to GDP growth minus two percentage points. 1989 saw a new reduction by one percentage point based on GDP growth. There was another reduction in 1990, based on a freeze on contributions to EPF at the 1989-1990 level, which was valid for a period of two years. In 1992, this agreement was extended until 1996.

A new transfer program

In 1996, the federal government adopted the Canada Health and Social Transfer (CHST), which replaced the Established Programs Financing (EPF) and the Canada Assistance Plan (CAP), the latter having existed since 1966. As this new transfer program was introduced, the federal government made substantial reductions in cash transfers to the provinces.

However, in 1999-2000, periodic supplements and an increase in basic amounts were granted to the provinces. In September 2000, the provinces and the central government reached an agreement aimed at increasing transfers but under certain conditions set by the federal government that were strongly criticized by some provinces, especially Québec.

The new millennium: Kirby versus *Romanow*

In the spring of 2001, the Canadian Senate adopted a motion authorizing the Standing Committee on Social Affairs, Science and Technology to examine "*. . . the state of the health care system in Canada.*" The committee was chaired by Michael Kirby. In fact, the work of the Kirby committee covered the role of the federal government in the health care system.

As regards funding, the Kirby committee proposed that it be public, predictable and stable, in terms of services provided under the CHA, which presupposes both an approach that includes the sharing of costs by the federal government and the provinces and a review of the pool of insured services. The committee ruled out the use of a deterrent fee, but suggested a tax increase and the use of a parallel private system for those with the financial means to do so.

At the same time, the Canadian government created the Commission on the Future of Health Care, chaired by Roy Romanow. The commission proposed all-around public funding along with a more "pan-Canadian" vision of health services in which new federal institutions would govern the system's principal parameters, such as a Canadian Health Care Covenant (CHCC), a kind of solemn commitment to health on the part of governments, and a Council of the Federation on Health, an organization for the resolution of jurisdictional conflicts.

Although the Kirby Committee and the Romanow Commission agreed on a number of points—the preservation of the universal public system financed directly by the government, greater national public coverage, increased funding from the federal government with specific conditions, and the creation of a fund devoted specifically to health—they disagreed on many others. In short, according to the Romanow Commission, the governance structure must be modified to give the health system a more "Canadian" feel and "national standards" established to orient provinces and better oversee (bureaucratize) the targeted transfer tool. The Kirby Committee's position, however, can be summarized as follows: a service organization model relying more heavily on public-private partnerships and resting on reporting obligations, new taxation, service contracts, regional (provincial) authorities, and hospitals.

The accords of 2003 and 2004

In January 2003, inspired by the recommendations of the Romanow Commission, the federal government issued proposals to reform the health system. Basically, the federal government aimed for targeted reinvestments building on the accord signed with the provinces and territories in September 2000.

A few days later, the provinces and territories established their bargaining position by mutual agreement. The latter included, among other things, an immediate and progressive increase of the federal government's financial contribution to reach 25% of the provinces' total health expenditures by 2010, the immediate removal of the equalization ceiling including a review of its allocation formula to make it fairer, and the creation of the Canadian Health Transfer (CHT) to increase accountability and transparency.

In February 2003, an accord was signed by the federal, provincial and territorial governments. The 2003 agreement followed from the one established in September 2000. At its core was the inclusion of new financial measures extending to 2011.

In this accord, the federal government undertook to create a five-year fund, the Health Reform Fund (HRF), specifically aiming to improve the delivery of front-line services, home care and prescription drugs. The accord also provided for extending the progressive transfer period from 2008-2009 to 2010-2011. Finally, the federal government undertook to create the CHT in 2004.

Building on the February 2003 accord, the September 2004 accord was mainly characterized by the allocation of new financial measures to 2014, with an index adjustment rate set at 6%.

Compared to the 2003 accord, the one established in 2004 contained little in terms of targeted funds in addition to less new money over the same period of time—18 billion over six years instead of 22 billion. The predictability of funding over the next ten years was the biggest plus for the provinces. However, on the negative side, the provinces criticized the federal government for setting the bar for the transfers too low.

APPENDIX 5

LAWS ADMINISTERED, IN FULL AND IN PART, BY THE MINISTER OF HEALTH AND SOCIAL SERVICES

Hospital Insurance Act (R.S.Q., c. A-28)

Health Insurance Act (R.S.Q., c. A-29)

An Act respecting prescription drug insurance (R.S.Q., c. A-29.01)

An Act respecting Cree, Inuit or Naskapi Native persons (R.S.Q., c. A-33.1)

Non-Catholic Cemeteries Act (R.S.Q., c. C-17)

An Act respecting the Health and Welfare Commissioner (R.S.Q., c. C-32.1.1)

An Act respecting the Corporation d'hébergement du Québec (R.S.Q., c. C-68.1)

An Act to provide for balanced budgets in the public health and social services network (R.S.Q., c. E-12.0001)

An Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration (R.S.Q., c. E-20.1)

An Act respecting Héma-Québec and the haemovigilance committee (R.S.Q., c. H-1.1)

Burial Act (R.S.Q., c. I-11)

An Act respecting the Institut national de santé publique du Québec (R.S.Q., c. I-13.1.1)

An Act respecting medical laboratories, organ, tissue, gamete and embryo conservation, and the disposal of human bodies (R.S.Q., c. L-0.2)

An Act to ensure that essential services are maintained in the health and social services sector (R.S.Q., c. M-1.1)

An Act respecting the ministère de la Santé et des Services sociaux (R.S.Q., c. M-19.2)

An Act to implement the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (R.S.Q., c. M-35.1.3)

An Act respecting the Health and Social Services Ombudsman (R.S.Q., c. P-31.1)

Youth Protection Act (R.S.Q., c. P-34.1)

An Act respecting the protection of persons whose mental state presents a danger to themselves or to others (R.S.Q., c. P-38.001)

An Act respecting the Régie de l'assurance maladie du Québec (R.S.Q., c. R-5)

Midwives Act (R.S.Q., c. S-0.1)

Public Health Act (R.S.Q., c. S-2.2)

An Act respecting health services and social services (R.S.Q., c. S-4.2)

An Act respecting health services and social services for Cree Native persons (R.S.Q., c. S-5)

An Act respecting pre-hospital emergency services (R.S.Q., c. S-6.2)

Tobacco Act (R.S.Q., c. T-0.01)

An Act respecting bargaining units in the social affairs sector (R.S.Q., c. U-0.1)

APPENDIX 6

LIST OR ORGANIZATIONS UNDER THE AUTHORITY OF THE QUÉBEC MINISTER OF HEALTH AND SOCIAL SERVICES

In alphabetical order:

- Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS);
- the Bureau de gestion des projets de modernisation des centres hospitaliers universitaires de Montréal (Centre hospitalier de l'Université de Montréal, Centre universitaire de santé McGill, Centre hospitalier universitaire Sainte-Justine);
- Comité central d'éthique de la recherche;
- Comité d'hémovigilance;
- Comité d'éthique de santé publique;
- Comité provincial pour la prestation des services de santé et des services sociaux aux personnes issues des communautés ethnoculturelles;
- Provincial Committee on the dispensing of health and social services in the English language;
- Health and Welfare Commissioner;
- Conseil du médicament ;
- Corporation d'hébergement du Québec;
- Corporation d'urgences-santé (Urgences-santé);
- Institut national de santé publique du Québec;
- Office des personnes handicapées du Québec;
- Régie de l'assurance maladie du Québec.

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