FUNDING:

current situation

and outlook

Québec
Ministère de
la Santé et des
Services sociaux

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june 2000

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la Santé et des
Services sociaux

Édition produite par :
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Dépôt légal
Bibliothèque nationale du Québec, 2000
Bibliothèque nationale du Canada, 2000
ISBN 2-550-36212-8

1. THE 1990s: RESULTS

Major cuts followed by a return to growth

Between 1990-1991 and 1999-2000, budgetary spending in the health and social services sector rose from $11.3 to $14.5 billion,[1] an increase of 27.9%. This rate of increase is significantly slower than in the 1980s, when between 1985-1986 and 1990-1991 alone, spending jumped 47.4%. This slowdown is attributable to the fact that, although the health and social services sector was allocated almost 50% of the government's manoeuvring room over the last ten years, it was required to carry out significant cutbacks.

For the period from 1995-1996 to 1998-1999, the health and social services sector made a total budget effort of $1.77 billion, including $980 million for network institutions. This effort included the non-funding of increases in the cost of existing services as well as the requested budget cutbacks In addition, the network had to achieve savings of $690 million to meet new needs in terms of national and regional priorities. Including the latter amount, the sector's overall budget effort exceeded $2.45 billion during this period, corresponding to 18.7% of the sector's funding in 1998-1999. Part of the effort required resulted in budget deficits for which the government then assumed responsibility. During that same period, the government reached its zero-deficit objective, which meant that a substantial budget effort of $4.7 billion was required of the other departments and agencies.

In June 1998, the government announced the reinvestment of $110 million in health and social services and, in March 1999, it announced that the cutbacks were over and that more than $1.7 billion would be reinvested over two years. Consequently, the sector ended the decade, in 1999-2000, with resources in real terms, i.e. adjusted for inflation, about 4.9% greater than in 1990-1991. With the additional reinvestment of $2.7 billion over two years announced in the 2000-2001 budget, funding for 2000-2001 in real terms is $15.4 billion, 13% above spending for 1990-1991.

At the budgetary level, the 1990s were essentially a decade during which overall spending was temporarily brought into balance by achieving significant savings. However, once these savings were achieved, the basic dynamics of needs and costs re-surfaced.

Constant erosion of federal participation

For the period from 1994-1995 to 2000-2001, the cuts announced in federal budgets since 1982 produced a cumulative revenue shortfall of $25.7 billion for Québec, including $14.7 billion for health alone. The federal contribution to social programs

[1] Excluding the government's assumption of responsibility for the accumulated deficit of institutions in 1999-2000.

funding (tax and cash transfers), even allowing for the extra funds allocated by the federal government in the 1999 and 2000 budgets, will fall from 32% of Québec's spending in 1984-1985 to 22% in 2004-2005. Over the same period, cash payments will plunge from 23% to 12% of such spending.

The last two federal budgets have offered no permanent solution to this disengagement. With the announcement in its 2000 budget of the payment in trust of an additional amount of only $600 million for Québec, the federal government has restored funding for the equivalent of only three days' operation of the health and social services network per year. These amounts are applicable for four years and encompass health, post-secondary education and income security. Accordingly, there is no comparison between the recurring investments made by the Québec government in health and social services and the trust accounts set up, on a provisional basis, by the federal government.

The federal government's successive cuts and changing decisions had a huge impact on the erosion of funding of the health and social services sector during the 1990s. They have been decried as the primary cause of the destabilization of services in all provinces. The government had to compensate for the drop in federal funding out of its own pocket.

Deteriorating financial situation

During the 1990s, health and social services institutions made substantial progress in terms of savings performance (e.g.: shortened length of stay, increased use of ambulatory care units, reduced administrative and support expenses). However, these gains were not enough to fully offset the budgetary constraints institutions were faced with: the result was a major deterioration in their financial situation and, consequently, the government assumed responsibility for the accumulated deficits.

Achieving and maintaining a sound financial situation is necessary if institutions are to provide needed public services. That is why the funds provided in 1998-1999 and 1999-2000 included $907 million to pay off the network's debt.

The government then decided, in its 2000-2001 budget, to both assume responsibility for the network's accumulated deficit of $462 million as at March 31, 2000 and raise on a recurring basis, in the amount of $425 million, the basic budgets of institutions in a deficit position to enable them to start off on the right foot. In addition, the network received $200 million in development funds. All the costs of program growth (salaries, inflation, debt service) were funded in 1999-2000 and 2000-2001. Also, the ministère de la Santé et des Services sociaux submitted bill 107 to the National Assembly. Under this legislation, a public institution is prohibited from incurring a deficit at the end of a fiscal year, and may no longer take out a loan to pay its operating expenses, unless authorized to do so by the Minister.

The general prescription drug insurance program, implemented in 1997, has also incurred significant overruns, in particular in costs for new members, financed by the Fonds de l'assurance médicaments (1.5 million persons insured). These overruns are

attributable to a rise in the gross cost of the plan of about 15% a year, due mainly to an increase in average drug consumption and the introduction of new drugs at generally high prices. The same type of growth is observed in the subsidized program for income security recipients and the elderly. To bolster the viability of the prescription drug insurance plan, the government tabled bill 117, *An Act to amend the Act respecting prescription drug insurance and the Act respecting the Régie de l'assurance maladie du Québec,* in the National Assembly last May 11. The legislation provides for increases in the maximum premiums applicable under the prescription drug insurance plan, though it does not raise the contribution of low-income persons.

Comparable public spending in relation to GDP

As a percentage of gross domestic product (GDP), Québec's public spending on health fell from 6.9% in 1990 to 6.3% in 1999, while remaining comparable with the Canadian average. *From the standpoint of ability to pay,* Québec's public spending on health – including all sources of funding – does not seem excessive on the whole, in the sense that it does not account, as it did in the 1970s and 1980s, for a higher proportion of collective wealth than the average of the other provinces. In 1980, Québec's public spending on health was clearly higher, in relative terms, than in Canada (6.6% compared with 5.5%). In 1999, Québec's public health spending accounted for a greater portion of the public wealth than did Ontario's (6.3% compared with 5.8%).

However, this conclusion does not allow for the division of the tax revenue needed to fund health spending between the federal government and the Québec government, nor for the government's overall financial situation (e.g.: total debt, tax burden, etc.).

Per capita public spending lower than in the other provinces

In 1999, per capita public spending on health was 11.7% lower than the Canadian average, making Québec the province spending the smallest amount per capita on health. This can be explained to a great extent by the fact that remuneration of physicians and other personnel, which accounts for about 80% of the sector's spending, is not as great in Québec as in the other provinces because of Québec's lower ability to pay.

In addition, per capita spending compares only the value of financial resources allocated to health. It does not reflect the various factors that determine the system's actual capacity to satisfy public needs (e.g.: physician and nursing staff levels, number of beds and nursing home spaces, etc.). Accordingly, this indicator is much too blunt to tell whether the amount of money allocated to health in Québec is appropriate, *seen from the standpoint of public needs.*

In this regard, Québec appears to have human and material resources that, in absolute terms, place it in a similar position for meeting the health needs of its population, assuming equivalent distribution and utilization of resources.

Private sector funding accounts for an incidental share of public sector health and social services spending

In 1999-2000, about 9.7% of the gross cost of the entire public health and social services sector was funded from various sources of deductible revenue other than Québec's Consolidated Revenue Fund. However, when certain items are excluded,[2] the private contributions paid by Quebecers amounted to some 7.6% of the gross expenditures of the public health and social services sector in 1999-2000.[3] Accordingly, it is incorrect to maintain, as it is sometimes said, that the private sector covers 30% of Québec's health system spending.

In addition, private contributions are tied to collective rather than private objectives and are not a source of unfairness. They are an inherent part of the funding formula of Québec's public health and social services system.

Private spending as a proportion of total health spending lower than the Canadian average

In 1999, the percentage of total health spending (public and private) funded from private revenue sources was 29.6% in Québec, compared with 24.5% in 1990. This definition of total health spending excludes social services and is independent of the public or private nature of the *producer*.[4]

The task force on the role of the private sector in health, chaired by Roland Arpin, concluded that the change in this percentage during the 1990s was attributable to a marked slowdown in public spending on health, while private spending on health continued to rise, though at a slower rate. The contributions and fees set by the government during the 1990s (e.g.: drug insurance, contributions by adults in nursing homes) were considered necessary to fund *public* services and were applied fairly, taking recipients' ability to pay into account.

Also, some medical and surgical services insured by the public system are now offered on the market (e.g.: laboratory services, cataract treatment). All things being equal, private spending for such services amounts to a very small percentage (less than 1%) of the total.

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2 For example: contributions by public agencies of Québec responsible for ambulance transportation (SAAQ) and medical services to traffic accident victims (CSST), as well as revenue received by institutions when they bill residents of other provinces or countries.

3 Private contributions, properly speaking, paid by Quebecers to the public system, are essentially contributions paid by adults in lodging centres and supplements for private and semi-private rooms in institutions, premiums and contributions by users for pharmaceutical services, and fees paid by users of ambulance services.

4 Private spending on health includes fees paid by individuals, directly or through their group insurance, for services provided by public institutions (e.g.: private rooms) or under a public program (e.g.: drug insurance). It excludes spending for services provided by the private sector but financed by public funds (physicians' private offices, grants to community organizations, etc.). Accordingly, the public or private nature of the financing is independent of that of the delivery of services.

On a comparative basis, private spending on health in Québec stood at $725 per capita in 1999, 15.4% less than the Canadian average and 28.5% less than in Ontario. In Canada, only Newfoundlanders incur less private spending for health ($603) than Quebecers.

Basic principles maintained, but concerns for the future of the system

Overall, the budgetary and financial results of the 1990s show that the health and social services sector in Québec was able to control its spending, given the basic dynamics of public needs, and that, in spite of the difficult context, the government placed a high priority on the sector's funding.

In addition, when considering the budgetary and financial results, it should be mentioned that the efforts of the 1990s essentially proved effective, in the sense that they helped maintain the basic principles of the system despite the accelerated decline of federal participation. They also helped secure the future of the system by contributing to restore order to Québec's public finances, which remain the system's major source of funding by far.

Quebecers now recognize that the budgetary efforts of the 1990s were necessary to safeguard the system. However, as needs increase, access to health and social services remains one of their chief concerns.

2. BUDGETARY AND FINANCIAL OUTLOOK

Major reinvestment for 2000-2001

To accelerate the consolidation of the system, the government is reinvesting $2.7 billion in health and social services this year to achieve three objectives in the short term.

First of all, the reinvestment will help **pay off the accumulated debt**. Thanks to the grants provided for institutions in a deficit position in 1999-2000, the network begins the 2000-2001 fiscal year debt-free. The reinvestment also **meets the needs of today and secures the future**. With the increase in funding, institutions in a deficit position will be in a more solid financial situation to meet public needs. Lastly, the reinvestment **improves access to services as well as their quality**. The additional funding allocated to satisfy priority user needs and purchase medical equipment will help treat more patients with better quality care.

At the budgetary and financial level, this reinvestment, in addition to pay increases relating to the renewal of collective agreements with public sector employees, will raise the **level** of health and social services spending Québec will have to finance over the coming years.

Accelerating growth in spending ahead

However, the major concern for the future stems from the prospect of accelerating growth in health and social services spending. Pressure will come mainly from demographic changes and technological advances.

Demographic changes

While the same situation is facing all industrialized countries, the ageing of the population will be faster in Québec and the consequences more profound, by the end of the next decade, when the baby boom generation reaches age 65.

While the number of persons over 65 is about 1 000 000 in Québec, it is forecast to rise to about 1 475 000 within fifteen years, an increase of 47%. During the same period, the number of persons 85 or over will grow by 75%. Demographic ageing in Québec will be among the fastest of the industrialized countries.

It is estimated that demographic changes alone could cause health and social services spending, in constant dollars, to rise by half within 25 years, and to double within 50 years. Spending could reach its maximum by about the year 2046, when the number of persons 80 or over will peak. According to some projections, demographic changes could cause health and social services spending to rise by 1.6% a year over the next quarter-century.

The ageing of the population means coming generations will have to bear a heavier financial burden. As the baby boom generations move into the 65-or-over age group, the active population (those 20 to 64) will decline substantially, which will cause the *dependency ratio* to rise. In practical terms, this means that while each person 65 or over is currently supported financially by almost five working age individuals, there will only be about 3.8 people providing that support in ten years, and only about two in 25 years.

Baby boomers enjoy considerably better health than did the generations preceding them. In addition, senior citizens will themselves fund a portion of the expected increase in public spending on health and social services, through the tax system. These factors could curb the increase in spending and mitigate its effects. However, both in terms of system funding and organization of services, it will be impossible to avoid the major consequences of the ageing of the population.

Advances in technology and practice

New generations of drugs and medical imaging, among other things, have helped improve care while at the same time reducing **unit costs** for many treatments (e.g.: shortened hospital stays). However, the new technologies allow more patients to be treated, in particular because care can now be provided for persons who previously could not be treated. For instance, in cardiac surgery, just a few years ago, very few bypasses

were done on patients over 70 years old. With new technology, such operations are now commonplace.

Result: the unit cost savings arising from the use of new technology are generally offset by significant additional costs due to the effect of numbers, producing a net increase in **total spending** on health. Advances in technology and practice are now seen by many authors as the primary source of growth in health costs, more so than demographic changes.

While spending in the health and social services sector was brought under control during the 1990s, indications are that the underlying forces of supply and demand will combine, over the coming years, to accelerate the dynamics of spending growth. Overall, a realistic estimate of the structural pressures that could bear on health and social services spending over the coming decade is between 3%[5] and 3.5% annually in constant dollars, or between 5% and 5.5% in current dollars.[6]

An untenable situation

All indications are that the structural growth rate of health needs exceeds the long-term growth potential of Québec's economy, which could be some 2% annually, on average, from now to 2010.[7] This is all the more likely since the government must make further cuts in Quebecers' tax burden, which remains among the highest on the continent. Reducing the debt load is another collective priority for the years ahead. Also, the importance of providing for other priority needs of Quebecers must be taken into account.

In the medium and long term, the acceleration in spending could exceed our collective ability to pay for health and social services. To illustrate, a difference of from 1% to 1.5% annually between the economy's long-term growth rate and the structural growth in spending in the health and social services sector (i.e. 3% or 3.5% less 2%) could, in ten years, amount to between $2.2 and $3.3 billion.

In the absence of preventive adjustments, this situation could jeopardize the ability of health and social services to meet growing public needs. It could also test inter-generation fairness.

In this context, it is necessary to re-examine the continuing ability of the state to fund the health and social services system according to the current model, as well as the level of taxation or contributions Quebecers are ready to accept for this purpose.

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5 This minimum assumption estimates the effect of demographic changes at about 1.5% and that of technological advances at 1.5%, without counting the effect of other non-quantifiable factors, such as rising expectations.

6 Under this minimum assumption, the general increase in wages and prices is equal to a rise in the CPI of 2%; implicitly, therefore, it assumes an increase in the cost of remuneration (including the cost of pay scale advancement) and the cost of non-pay expenses of roughly 2%.

7 Information provided by the ministère des Finances du Québec.

3. BREAKING THE DEADLOCK

The health and social services system is faced with a significant funding problem: the federal government is accumulating budget surpluses while the provinces must bear the ever-increasing costs. The system is under heavy pressure from the accelerated ageing of the population and by constant advances in technology, which add a further "turn of the screw" each year.

However, to free the public health and social services system from this straitjacket, financial solutions alone are not enough. Rather, the system's future seems to require a *new balance* involving an adaptation of the existing funding formula, a review of health and social services sector spending and its funding formula, a review of resource allocation procedures and of remuneration methods, and a review of the organization of services to make them more integrated and accessible, and deliver them at lower cost.

Adapt the funding formula of the public health and social services system while maintaining the system's integrity

The deadlock facing the system cannot be resolved without re-examining the collective choices that gave rise to the current balance between the public sector and the private sector in the funding of health and social services. Before suggesting possible solutions, consideration must be given to fundamental issues, such as the collective ability to fund the public health and social services system, the range of services the state must continue to fund and the tax increase the population is prepared to accept for this purpose.

Review spending and the funding framework

Finding a new balance between spending and *overall* funding of the sector seems to require making choices regarding four major types of intervention aimed at:

- reducing the *level* of non-essential or non-priority spending;
- slowing the *dynamics* of spending with high growth potential;
- implementing stable and predictable public funding as well as a fair division;
- eventually setting up a new budgetary and financial framework for the health and social services sector.

Improve resource allocation procedures and remuneration methods

To meet almost unlimited needs with limited resources, the system must ensure that these resources are distributed and used as efficiently as possible. Finding a new balance between spending and the system's *local and regional* funding seems to require:

- for institutions: correction of the weaknesses in distribution of the traditional method of renewing budgets by taking into account the relative needs of the population they serve as well as their economic performance;

- for the regional boards: implementation of responsible management focusing on results to be achieved;

- for human resources: adaptation of methods of remuneration of physicians and of certain clauses of the collective agreements of employees to the needs of an integrated services organization and of work.

Deliver services at lower cost

The organization of services and the organization of work must be such that services are delivered at lower cost. Possible solutions include those that would:

- allow better use of available skills and human resources;

- enable better use of the private sector (individuals, community sector and companies) in the delivery of public services.

The *status quo*, in terms of funding and of organization of services, cannot be maintained for long. To shed light on the approaches to follow, the Minister of State for Health and Social Services, Pauline Marois, has announced the formation of the Commission d'étude sur les services de santé et les services sociaux.

This Commission has been instructed to hold a public debate on the challenges facing the public health and social services system in Québec and on possible solutions to deal with them. The key objective of this debate is to gather the points of view of the public, of network partners and of organizations representing various trends within society, as well as of experts on the issues raised by the Commission.

Once it has completed its work, it will submit to the government possible ways of ensuring the sustainability of the public health and social services system.

It is to be hoped that this paper on funding will be useful in the discussions on the future of Québec's health and social services system, providing a clearer picture of the ground covered during the 1990s and the major challenges for the years ahead, at both the budgetary and financial levels.

Appendix

Preliminary list of funding-related questions

1. ADAPT THE FUNDING FORMULA OF THE PUBLIC HEALTH AND SOCIAL SERVICES SYSTEM WHILE MAINTAINING THE SYSTEM'S INTEGRITY

- Are Quebecers still prepared to support a public system providing care and services based on their health and their needs rather than on their income?
- What advantages of a public health and social services system do Quebecers value most?
- Are the current level of private funding in total health spending (public and private), roughly 30%, and the level of the private sector's contribution to the funding of the public health and social services sector, 8.8%, adequate? Too high? Too low?
- As a society, what is our capacity to fund the public health and social services system given the prospect of a rapidly ageing population, taking into account other needs and priorities?
- What level of taxation – and what increase in the tax burden – are we prepared to accept to do so?
- What range of services should the state continue to fund?

2. REVIEW SPENDING AND THE FUNDING FRAMEWORK FOR THE HEALTH AND SOCIAL SERVICES SECTOR

Implement stable and predictable overall funding and a fair division

- How can the public will bring the federal government to restore adequate health funding?
- How can budget envelopes better reflect the special dynamics of health and social services needs, while complying with the government's budget and financial objectives?

Reduce the *level* of non-essential or non-priority public spending

- Which services could be removed from insurance coverage?

- For what types of services – and under what terms and conditions – might a financial contribution be required of users without compromising access to such services?

Slow the *dynamics* of spending with high growth potential

- Which services that are currently not covered by the public plan could the state, in the future, avoid taking charge of or limit its participation in?

- For what types of services for which demand is growing could the government consider tax measures as an alternative to direct benefits?

Review the budgetary and financial framework of the health and social services sector

- To raise the profile of collective choices regarding spending and funding, should public health and social services be funded from a separate account, or should they continue to be funded, like other services, from the Consolidated Revenue Fund?

- To ensure fairness between generations in health and social services funding, should a financial reserve be built up gradually to eventually support the ability to pay of the coming generation?

3. IMPROVE RESOURCE ALLOCATION PROCEDURES AND REMUNERATION METHODS

Provide funding that reflects the relative needs of local and regional populations, while encouraging economic performance

- How could the weaknesses of the traditional budgeting method used by institutions be corrected, given available cost per diagnosis indicators for each institution?

- Which funding procedures would, at the local level, enable hospitals to maintain public services while keeping spending for the network as a whole under control?

- How could management and accountability focussing on results to be achieved be implemented in regional boards and institutions?

- How could economic performance be reflected in the allocation of institutional budgets?

Support network synergy and service integration

- What resource allocation mechanisms would be needed to implement new models of organization of integrated services designed to both improve access to services and their continuity and ensure that "the money follows the client"?

- How could resource allocation mechanisms encourage synergy between the various players by reflecting their ability to work as part of a network?

More flexible and better adapted remuneration procedures

- How should physicians' remuneration procedures be reformed to ensure better access to medical services:

  - by specialty,
  - by geographic distribution,
  - by type of practice (e.g.: in an institution or the physician's private office)?

- Could certain clauses of the collective agreements be adjusted to improve organization of services and of work without generating extra costs?

4. DELIVER SERVICES AT LOWER COST

- How can we make more efficient use of available skills and bring more streamlined methods to bear (e.g.: the issue of fields of professional practice) without compromising quality of care?

- How should the terms of cooperation or partnership with the private sector be adjusted to better respond to public needs at lower cost while meeting the basic objectives of the public system?

- In particular:

  - How can the linkage between physicians' private clinics and the network of public institutions be improved?

  - What services can be provided in private clinics or CLSCs, in cases where doing so would improve access and reduce cost? Under what conditions? According to what terms?

  - How can workers in the public network be associated in the reduction of the cost of peripheral services?

  - Could agreement be reached with them on new partnering models to enable hospital management to concentrate on its mission: direct public services?

- What opportunities are there to generate revenue from the excess capacity of certain administrative and support equipment without affecting the ability of institutions to provide public services?

- How can the private sector be involved in the delivery of services to senior citizens (e.g.: services at home, lodging) while enforcing standards of service?

Other publications are available in the **documentation** section of the ministère de la Santé et des Services sociaux Web site at **www.msss.gouv.qc.ca**

- **La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec: rapport du groupe de travail (rapport Arpin);**
- **La présence du privé dans la santé au Québec: état détaillé de la situation (rapport Arpin);**
- **Constats et recommandations sur les pistes à explorer: synthèse (rapport Arpin);**
- **Le financement des soins sociosanitaires (rapport Bédard);**
- **Le financement du système public de santé et de services sociaux du Québec (document d'information);**
- **Le système québécois de santé et de services sociaux (points de repères).**

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00-106-5A