Funding and organization of health services and social services

ORGANIZATION OF SERVICES:

current situation

and outlook

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Ministère de
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Our vision of health services and social services is often anecdotal or partial. It must not be forgotten that these services comprise a vast and diversified range of activities.

Each day the public system offers services to thousands of people and provides assistance and professional care to people suffering from a wide variety of problems. These persons receive services in establishments, in doctors' offices, in their home, in an adapted apartment or in their living environment, that is through ambulatory services. They benefit from health services, rehabilitation services, social services, and social integration, home care and home help services.

By way of example, here are some recent statistics on the services provided by professionals and the personnel of the health and social services, as well as their partners, during a given year.[1]

- *Nearly six million people received medical services; the average number of medical procedures per person was 9.8.*
- *More than 675,000 short-term hospital stays and 280,000 day surgery operations were carried out in general and specialized hospitals.*
- *Mental health problems accounted for 12% of hospital stays (one in eight).*
- *25,000 reports were made under the Youth Protection Act; prevention programs reached thousands of young people of all ages.*
- *Around 25,000 people suffering from alcoholism or drug addiction received rehabilitation services.*
- *Nearly 12,000 families with a disabled child received respite, child care and emergency relief services.*
- *Around 23,000 people with an impairment received care in rehabilitation centres. More than 90% of these persons live in the community*.
- *More than 170,000 elderly persons received home care from CLSCs; around 36,000 elderly persons with moderate or serious disabilities were accommodated in CHSLDs (residential and long-term care centres).*

The delivery of such a wide variety of services requires a complex organization. This organization has undergone a major transformation during the last ten years. Nevertheless, despite the changes that have been made, the health and social services system is still experiencing difficulties: sporadic crises in emergency rooms, waiting lists for certain kinds of surgery, budget deficits in certain establishments. On a day-to-day basis, care in many areas still seems to be characterized by discontinuities and a compartmentalization of services. This insistent problem, which has been discussed for at least twenty years in the public system in Quebec, seems to continue to worsen because care is still delivered by a panoply of different professionals who are usually responsible to different organizations. In short, the Quebec system often seems exhausted, even though the government has injected more than $4 billion extra over the last two years.

[1] These figures are for 1998 or 1999, or for the financial years 1997-1998 or 1998-1999, depending on the available statistical compilations.

1. PROVIDING OURSELVES WITH A VISION

What changes therefore need to be made to improve the organization of services? What kind of system do we want? There is no such thing as the ideal system, or at least no society has yet to devise one. But the experience of public systems in the Western nations over thirty or forty years provides some clear reference points. An efficient health and social services system possesses the following characteristics:

- ***a complete range of basic services, organized by natural geographic areas (districts or regional county municipality areas) and easily accessible. By basic services, we mean principally: general medical services, nursing care, psychosocial services, rehabilitation services, home care and home help services, residential and long-term care services, Info-Santé, and promotion and prevention programs;***
- ***specialized services that support the basic services and that are at the cutting edge of development;***
- ***services and professionals organized into a network within which the patient is assured of receiving the right service, at the right time, from the right person;***
- ***an efficient organization that makes it possible to offer the public a maximum of services, of the highest possible quality, on the basis of the money invested by the public;***

This is the type of system of services—one that is as close as possible to the needs of the public—that Quebec needs to build to meet the challenges of the 21st century. To accomplish this, the barriers that stand in the way of adaptation and change have to be removed. We then need to provide ourselves with the levers necessary to go forward.

2. IDENTIFYING THE OBSTACLES TO CHANGE

To pinpoint the current blockages, we have to return to the basic structural characteristics of the health and social services system. At the beginning of the 1970s, the public system was constituted on the basis of two key pieces of legislation, ***the Health Insurance Act and the Act respecting health services and social services***. These acts structured the organization of the two main pillars of our system of services: the individual professional practice on the one hand, and the establishment on the other hand. **Ever since, the way we allocate budgets, the way we organize work, our administration**—in short, all of the elements that shape the organizational framework of the services—**have been structured around these two elements**.

These two pillars actually corresponded to the way in which services were provided at the time. Indeed, when someone needed treatment, they went to an institution where they were generally taken care of throughout the period of their care, to the point of sometimes becoming a permanent resident of the facility. When seeking consultation, they went either to an establishment or to a doctor's office. Most of the time, care was provided by a single professional.

But times have changed. To be sure, the access points to services have changed little: we still go to a professional or to an establishment. However, changes in values, knowledge and practices have gradually broken down the boundaries of the establishment. **Today, most of the care that is given after the first consultation takes place either in the person's own milieu or in more than one establishment and with the involvement of other partners.**

This is the case for mental health, for services offered to youth in difficulty, for services provided to disabled and elderly persons, and even, for several years now, for short-term health services, where the hospital and the CLSC are now frequently called upon to co-ordinate their efforts.

Similarly, the current problems experienced by people who make use of a range of services are frequently handled by several professionals, each of whom often belongs to a different organization.

During this same period, the elements underlying the organizational framework of the services—budgetary allocation, the organization of work, methods of compensation, etc.—that were originally established on the basis of the establishment and the individual professional practice, **have changed little**. The reform programs, the strategic directions, indeed all of the decisions taken over the years, have not fundamentally changed this basic fact. The problems that result are of two kinds: the great difficulty that the system faces in providing complete and efficient basic services; and the difficulty of ensuring that services are co-ordinated and integrated.

The Underdevelopment of the Basic Services

It is generally recognized that 80% of health problems and social problems can be remedied by efficient basic services, what are called front-line services. The division of resources between the basic services and the specialized establishments is therefore an important factor affecting the efficiency of the system of services as a whole.

Nevertheless, in Quebec, the basic services are still experiencing developmental and organizational problems. The range of services varies from one geographical area to another; the access points to services and the hours of operation of a number of establishments and services are not always well known by the public. **Why, then, have we not succeeded in providing ourselves with a more efficient network of basic services?** There are three reasons.

First, although planners in the 1960s generally recognized that basic services were a priority, the **introduction of the CLSC**, which were created in the early 1970s in an effort to provide a point of entry to other services, **lagged to a certain extent**, for a number of reasons: under-financing, the resistance of the new establishments themselves to developing a common framework for organizing services, the resistance of the other establishments, and the resistance of doctors.

Second, the adoption of hospitalization insurance in 1961—nearly ten years before the creation of a full public system of health and social services—**served to reinforce the role of the hospital as the "point of entry" to services.** Thus, for a decade, Quebeckers turned directly to hospitals for medical assistance because the health services offered by the hospital (and only by the hospital) were free.

Third, the combination of these two factors established the trend that was to characterize the evolution of the public system for years to come, that is, the emphasis that was put on specialized services.

Nevertheless, the need to create an efficient network of basic services has never been questioned. However, when the CLSCs were created, doctors sought to create their own "front-line" network by quickly establishing several hundred medical clinics throughout Quebec.

Thirty years later, it is clear that neither the CLSCs nor the doctors are able, on their own, to provide access to a full range of efficient basic services. The two "networks" have developed very much in parallel, each having its own strengths and weaknesses.

This parallel development of doctors' offices and CLSCs has brought us to a point where we now have a range of different services, the access to which varies from one geographical area to another. The underdevelopment of basic services affects not only medical care, but also mental health services and social services. In fact, the institutional development model, which has guided *de facto* the evolution of the system since the beginning, has left a heavy mark.

Today, the effect of the underdevelopment of basic services is to put increased pressure on the specialized services, which then requires even more resources to respond to the demand. **The government therefore finds itself in a dilemma that has never been resolved: it must allocate more resources to specialized establishments, which in turn must respond to a constantly growing demand, thereby leaving a much reduced margin of manoeuvre to develop the basic services.**

The resulting mode of organization costs dearly.

The Fragmentation of Care

In general, in order to advance understanding and knowledge, fields of professional expertise have developed through a process of increasing segmentation of reality. This fragmentation has often been carried over into the practice and into the organization of work. It has sometimes even been used as the basis for compensating professionals, fee-for-service remuneration being the best example.

During this same time, problematics and interventions were moving in the exact opposite direction. Today, many different professionals are often called upon to provide care to the same person, in different settings, and without any adequate co-ordination of these different services. Measures that might encourage interprofessional work are, to all intents and purposes, utterly lacking. The framework of practice, fixed from the start, continues to shape the evolution of the professions and the relationships between professions.

Thus, the practice of general practitioners has not always adapted easily to change. It is sometimes difficult, in certain geographic areas, to mobilize doctors to respond to elderly persons who are experiencing a loss of autonomy. In the field of mental health, problems of access to service persist. The principal method of compensation that is still in effect—fee for service—does not lend itself to the continuity of services, to a global approach to the patient or to teamwork. A number of adjustments have been made over the years, but the basic problem remains.

As regards the social services, care is increasingly provided in people's home environment, which requires the professional workers involved to co-ordinate their efforts. Membership in different (and sometimes competing) organizations does not encourage such collaboration, leaving the co-ordination of activities difficult.

Attempts have been made over the years to better integrate the various professional services. Such efforts have been of three types. At first, emphasis was placed on **mechanisms of co-operation and partnership**, such as multi-sector committees, multidisciplinary teams, co-ordination groups, etc. Next, there was an attempt to provide a better structure of co-operation through the use of a range of **plans**—regional service organization plans, intervention plans, individualized care plans, etc. The third and most recent wave has focused on **establishment mergers**: CLSC-CHSLD, CH-CLSC, etc.

In fact, all of these past efforts have run aground on the same shoals: the lack of responsibility for the patient throughout the period of care. Thus, each professional and each establishment is responsible for one segment, one episode, or one part of the case. Often, it is the person himself or herself who must navigate through the system and establish the necessary connections. The problem is ten times worse for the most vulnerable individuals.

3. CORRECTING THE BASIC TRAJECTORY

Towards a Genuine Network of Basic Services: Reunifying Our Forces

Currently in Quebec we have two "networks" of basic services—the CLSCs and the medical clinics—neither of which can alone offer an optimal response to the needs of the public. **Does the solution lie in close co-operation between the actors concerned, a pooling of forces? Should this pooling be along professional lines, the organization of services to the public, rather than by means of structures?** All avenues merit exploration.

For the time being, the objectives of this collaboration are relatively clear. In a unified organization of basic services, the personnel would be organized in a genuine network; there would be a fluid exchange of information between professionals, with the linkages being established naturally; a multidisciplinary team would be available when the case so required; professionals working in the basic services would have direct access to specialized services when the situation required it. Most especially, they would take joint responsibility for the population in their area, a responsibility that would also make it possible to develop more sustained prevention activities.

Towards Better Co-ordination of the Services Provided to Individuals: Clear Responsibility and the Means to Exercise It

Although the need for co-ordination in the area of short-term care and services is important, it is crucial in long-term care, where interventions are numerous. To ensure this co-ordination, **do we need to provide genuine "service networks,"** established on the basis of particular groups (elderly persons experiencing a loss of autonomy, young people in difficulty, persons with disabilities, etc.) or on the basis of particular problems (cancer, cardiovascular disease, etc.) within which the user can move more easily? **What mechanisms need to be developed to organize relations among professions and establishments within these networks?**

Whatever the eventual response to this question, experience teaches us that two basic conditions have to be met. First, the responsibility to co-ordinate care, i.e., all of the episodes of care pertaining to one person, must be given to one professional (a doctor, a nurse or a social worker, depending on the circumstances). This clinical responsibility should be accompanied by the means necessary to act: a degree of discretion as regards the choice of treatments and membership in an organization that is responsible, administratively and financially, for the complete range of services for a particular population. Second, this responsibility must be assumed by a professional working in basic services and whose mandate is to respond to the needs of the individual.

Towards Improved Performance of the Organization of Services: Refocusing Specialized Establishments on their Primary Function—Treatment, Specialized Care

Does Quebec need to undertake to gradually rebalance the proportion of spending in the health and social services sector that it devotes to basic services and specialized services? Currently, the Quebec government still channels more money into services delivered by establishments than do its neighbours.

- In 1999, Quebec's spending on the category "hospitals and other establishments" accounted for 42.6% of total health care spending, compared to 39.2% in Ontario. This gap represents, in relative terms, an investment of $614 million more by Quebec.[2]

To achieve this goal, the specialized establishments would have to gradually refocus on their primary function: specialized treatment and specialized intervention. Indeed, **can we still ask hospitals to provide basic services, consultation, home care services, or any other service that the other components of the public network have not developed, at the same time that they are being called upon to further develop their technical support?**

Comparisons indicate that improvements can still be made in hospitals with a better organization of services. Thus, from 1994 to 1998, the reduction in the length of hospital stays was essentially achieved by compressing the pre-operating phase. Almost no gain (less than 1%) was registered after operations. In general, length of stay is still longer in Quebec than in Ontario and the other provinces. Thus, the average length of hospital stay (standardized) in 1997 (the latest year for which statistics are available) was 5.73 days in Quebec, compared to 4.54 days in Ontario.

This fact indicates that hospital performance does not only depend on the hospital itself. It rests more and more on the existence of services on the perimeter of the establishment and having a direct relationship to the establishment, thanks to efficient co-ordination mechanisms: complete and efficient basic services upstream; and well organized home care and home help services downstream. The same can be said for the other specialized establishments, which are being called upon to support the professionals working in the basic services.

4. ADAPTING OUR LEVERS OF ACTION

Allocate Budgets According to New Criteria: the Person, the Clientele and the Population

The way of allotting budgets—the budget allocation framework—is probably the element that matters most, the cornerstone of the organisation of services. It is for this reason, no doubt, that it is the most difficult to modify. But we have to face facts: **our method of allocating budgets is becoming more and more inappropriate**.

First, it preserves countless divisions, which are as much "corridors" as "silos" between the establishments. In fact, these establishments increasingly have to serve the same individuals day to day: the hospital and the CLSC, the youth centre and the CLSC, the hospital and the residential and long-term care centre, etc. And because the method of

[2] Canadian Institute for Health Information. The CIHI's categories of "hospitals" and "other establishments" were combined in order to cancel out classification differences from one province to another.

budget allocation adopted for the establishments has been reproduced in other sectors of the systems of services, we find ourselves with as many different envelopes: one for each establishment, one for the doctors (health insurance), and another for drugs (pharmacare plan). This fact creates a new set of divisions, one that is superimposed on the divisions between establishments noted above.

In this context, it is possible for a service provider to pass costs on to another provider, or to limit its co-operation, so as to reduce spending and stay within its budget. For example, a CLSC that is only just able to respond to the demand for home services will not benefit by helping a hospital to reduce the length of stays.

Second, by maintaining a budget envelope for each establishment, we remain locked into an enterprise culture in which each organization naturally seeks to expand its territory, to extend its range of services, a reflex that is just as normal both in the public and private sectors. Thus, over the years, some hospitals have put in place their own home services, some psychiatric hospitals have established resources in the community, some youth centres, which are also specialized establishments, have offered basic services, and so on.

We can well ask ourselves whether this duplication of services is too costly for society. At the very least, we know that it is confusing for the client, the user of the services, who sometimes has a hard time finding his or her way around the system.

Lastly, by financing establishments on the basis of past financing, historical disparities are reproduced year after year. Moreover, this method makes it very difficult to take account of population movements.

How can we escape from these shackles? Two complementary options are possible.

- **Finance the establishment on the basis of its activities instead of, as is presently the case, financing an installation, the personnel, an organization of work, equipment, and an administration.**

Allocating resources on the basis of the activities undertaken during a year means financing the demand for services—and the way of meeting that demand—rather than the supply of services. This approach requires that the cost of each service offered and of each treatment be precisely measured. This would provide performance indicators that would make it possible to compare establishments to each other, to implement measures to increase performance, and to stimulate healthy competition.

- **Base the allocation of budgets on the principle that "the money follows the client"**

Using the principle that "the money follows the client" allows the problem to be turned around: instead of financing the supply of services, it is real consumption that is financed.

In clear terms, the budget is allocated for either a particular clientele or the population of the area. An agency is designated to be responsible for responding to the overall needs of the clientele or the area's population, within the budget allocated to it. It therefore has the flexibility it needs to offer each person the right service, at the right time, at the best cost, and in the best place. In this model, service providers are financed on the basis of the services that they have actually offered.

These options have been experimented within a number of societies. What kind of adaptation is right for Quebec? How can a transition be made from the current mode of allocating resources? These questions remain open. Modifying the way of allocating budgets, of distributing resources within an organization as large as the health and social services system, is a complex undertaking that challenges existing ways of doing things, established rights, a tradition and an organizational culture. This is a very important decision, on the same scale as the potential for change that it offers.

Being Open to New Models of Collaboration

The health and social services system is an organization that must be open to its environment; it must maintain multiple links with partners from outside the system, particularly community organizations and enterprises in the social economy and the private sector. These relationships make it possible for organizations in the public network to better respond to the needs of the public and to innovate.

Partnerships with community organizations have evolved considerably in recent years. The increase in services delivered in the community setting requires a more flexible approach and new ways of collaborating. New organizations have also emerged--the enterprises of the social economy. There are now more than one hundred of these, spread throughout Quebec, supporting the CLSCs in home help services. This is an exceptional success.

The need for flexibility has led to new forms of partnership between the public and private sectors in a number of fields: management, home services, administrative services, and technological development. These partnerships should be developed further when they make it possible to improve the services provided to the public and to achieve gains in performance. However, such gains can only come through innovation, with partners from both inside and outside the system. **How, then, can administrators and professionals, particularly in the basic services, be given the manoeuvring room and the stimulus that they need in order to choose the solutions that they judge to be the most efficient?**

The public sector covers a huge field in which there are a multitude of skills that can be drawn upon. It must open up even more and demonstrate great flexibility in a world in which traditional borders have disappeared. Finally, it must take advantage of any opportunity to improve the efficiency of its services and its overall performance.

BETTER SERVICE TO THE INDIVIDUAL AND A BETTER RESPONSE TO THE NEEDS OF THE PUBLIC

Quebec innovated thirty years ago when it established a system of health and social services that integrated the two major types of services. This choice remains even more appropriate today than in the past because of the way in which problems and needs have evolved. The system was based on a number of generous principles that shaped its evolution: equity, access to services by everyone, without discrimination, and universality. These choices are not open to question.

Quebec also built and organized its public system of services on two principal foundations: the establishment and the professional practice. These foundations continue to underpin the current organization of services, but the rules that govern their operation need to be reinterpreted, to be redefined in relation to the new equilibrium that has to be established between the basic and specialized services, and the new--and imperative--requirements for co-ordination.

In order to properly carry out this restructuring, a new point of view has to be adopted. This point of view can only be that of services offered to the individual and the response to the needs of the public. In other words, the public system now has to give itself the means to better organize its activities, to adjust its mode of operation, and to adapt its methods to this central idea.

Once again, Quebec is urged to innovate.

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- **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);**
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